9

BEING LOYAL AND FAIR TO CLIENTS

Case Study: Sex With a Former Client

Client loyalty requires maintaining independence of judgment (Cohen & Cohen, 1999). This means that therapists practice mindful of personal interests or aversions that prevent them from being objective in the provision of therapy, and, therefore, do not take on professional roles when their

> personal, scientific, professional, legal, financial or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation. (American Psychological Association [APA], 2016, 3.06)

Fairness, as equitable distribution of counseling services, sets important limits on what a therapist can ethically do for one client at the expense of another. For example, therapists who become personally involved with particular clients not only lose independence of judgment by allowing their personal interests to cloud their professional judgment, but they also fall short of being fair, by virtue of their unjustified, differential treatment of their clients, especially those clients with whom they become personally involved.

In some cases, a therapist's personal aversion to a certain client population may make it prohibitive to work with such clients. For example, some therapists may find it difficult to exercise objectivity in working with clients with pedophilia. In other cases, the therapist may have a visceral dislike for an individual client. As human beings, therapists are not immune from having such personal emotional responses. Here, the greatest danger lies not in having the aversion, but instead in the refusal to acknowledge it and take appropriate action to refer the client to a therapist who can be objective in the provision of counseling services.

CONFLICTS OF INTEREST

Independence of judgment can be compromised when a therapist has a *conflict of interest*. Such conflicts exist when therapists have one or more interests that place a strain on their ability to remain objective in the provision of competent counseling services (Davis, 1982). For example, a therapist may have a conflict of interest if the therapist's interest in continuing to receive payment from the client (say due to financial difficulties) inclines the therapist to keep the client in therapy longer than necessary.

Conflicts of interest can be actual or apparent. A therapist has an *apparent* conflict of interest when the client perceives the therapist to have a conflict of interest even if she actually does not. For example, an agnostic therapist who is counseling a religious client may not have any personal problem counseling a believer; however, the client may perceive the therapist to have such a problem. In this case, the appearance of a conflict can be just as problematic, in the provision of effective counseling services, than that of an actual conflict of interest, and, as such, may be just cause for referring the client to another therapist who does not have a real or apparent conflict of interest related to counseling the client.

Dual or Multiple Role Relationships

Conflicts of interest, real or apparent, often arise in the context of *dual or multiple role relationships* (APA, 2016, 3.05.a; National Association of Social Workers [NASW], 2017, 1.06). A dual role relationship exists when a therapist has *exactly one additional relationship*, such as a business or social relationship, with a client or someone closely associated with the client; for example, when a therapist becomes a friend of a current or former client, or of the client's close friend or partner. A multiple role relationship exists when a therapist has *one or more additional relationships* with a client or someone closely associated with the client; for example, when a therapist is a business associate of the client's close friend and a fellow parishioner of the client.

Multiple or dual role relationships may occur *simultaneously* or *consecutively* (NASW, 2017, 1.06[c]). The former type of relationship exists when two or more roles are assumed or ongoing at the same time. For example, such a relationship exists when the instructor of a student is also simultaneously the student's therapist, or when a therapist is having a sexual relationship with a current client. In contrast, consecutive multiple or dual role relationships exist when the roles occur consecutively, that is, one after the other. Such a relationship would exist if an instructor who also counsels takes on a former student as a client. A therapist who begins a sexual relationship after the therapy has terminated would also assume a consecutive dual role relationship.

As emphasized in this book, constructive client change can occur within the therapeutic relationship only if clients can trust their therapists. While healthy therapist-client relationships empower clients to make their own decisions, they are, by their nature, *fiduciary* relationships, that is, ones founded on trust (Bayles, 1989). As discussed in Chapter 2, the trust-based character of the relationship provides the climate under which client empowerment thrives. As an essential part of this fiduciary climate, clients must trust their therapists to apply, with undivided devotion, their professional expertise (knowledge and skills) to facilitate constructive client change rather than to advance

personal self-interest through client manipulation and deception. Consequently, any dual or multiple role relationship (simultaneous or consecutive) involving even the appearance of conflict of interest can potentially undermine this sacred bond of trust. As such, therapists should avoid such relationships inasmuch as there is risk of exploitation or harm to clients or former clients (Kitchener, 1988; NASW, 2017, 1.06[c]).

Dual role relationships are also problematic to the extent that role expectations conflict or compete (Kitchener, 1988). For example, business associates expect that transactions be mutually beneficial wherein clients expect their therapists to act in ways that promote clients' welfare, not their own. Similarly, friends are mutually self-interested; and students expect their teachers to be objective in assigning grades, whereas clients expect their therapists to be concerned about their emotional welfare. So the expectations in a teacher-student relationship or that of friends diverge greatly from that of a therapist-client relationship. In general, "the greater the incompatibility of expectations is, the greater the role strain for the individual in the role" (Kitchener, 1988, p. 218).

Dual or Multiple Role Relationships in Rural Communities

Some dual or multiple role relationships may not easily be avoided, however. For example, in rural areas where there is only one psychologist serving the community at large, there is strong probability that the psychologist may assume multiple dual role relationships with others in the community. Thus, the psychologist may buy his groceries from the owner of the town market who happens to attend the same church as the psychologist. In such a case, it may not be feasible, in a practical sense, to avoid such multiple role relationships when the grocer is also the psychologist's client. Where such conditions arise, the therapist should mitigate factors that may potentially contribute to client harm. This would include avoiding overlap of interaction as much as possible (e.g., not going to a social function if it could be avoided) and making a concerted effort on the part of both the client and the therapist to keep the expectations of each role separate (e.g., not expecting a client teacher to give one's child special treatment). Accordingly, it is important that the therapist discuss with the client such relationship boundaries at the inception of therapy as part of the informed consent agreement and reinforce this understanding throughout the counseling process (Burgard, 2013).

Nonelective Dual or Multiple Role Relationships

Dual or multiple role relationships may also be *nonelective*; that is, therapists may not intentionally choose to take them on. Instead, the additional relationships may arise as a result of the unforeseen actions of others or by unanticipated changes in circumstances. For example, a therapist who teaches may have a client sign up for one of his classes, thereby placing the therapist in the precarious situation of counseling a current student. Or a therapist whose child attends elementary school might be counseling a client who ends up being the therapist's child's teacher. Or a therapist might counsel a client whose child ends up becoming best friends with the therapist's child. While, in such nonelective cases, it may not have been the therapists' wish to end up in such relationships, the therapists ordinarily still have the power to terminate the therapy (except for unusual cases such as judge-ordered counseling) and refer the client to a therapist who does not have any known conflicts of interest. Further, the therapist can also take precautions against

ending up in such relationships. For example, the therapist who has reason to believe that a prospective client may be poised to take one of his classes can choose not to accept this individual as her client, or she can inform the prospective client in advance that it is not her policy to counsel students. Indeed, where there are conditions ripe for such potential conflicts of interest, therapists can act proactively by including a disclaimer (e.g., not counseling students, or not counseling clients with close familial connections to the therapist) as part of the client's informed consent.

Sexual Relationships

Among the most harmful relationships are ones involving sex with current or former clients. Clearly, the role expectations of a sex partner seeking sexual gratification are incompatible with that of a therapist, and the potential for loss of objectivity or independence of judgment is therefore extremely high. Yet, notwithstanding that such relationships are avoidable (unlike some arising as a result of living and practicing in a small rural community, for instance), the most frequent professional liability allegations made against counselors involve inappropriate sexual relationships with their clients or the partners or family members of their clients (CNA & HPSA, 2014). The following case illustrates the serious danger of conflicts of interest, competing or incompatible expectations, loss of independence of judgment, client manipulation, and harm generated by a therapist's succumbing to sexual attraction.

A CASE OF SEXUAL ATTRACTION TO A CLIENT

George Langston, LCSW, in the state of Florida, was seeing Antonio Carlson for depression. Antonio's partner, Karl, had passed away 2 years prior from metastatic liver cancer. Previously, a well-regarded fashion designer, Antonio had refused to move on with his life. Living a solitary lifestyle, he was unwilling to return to the work for which he once harbored strong passion. Nor was he willing to date or engage in other social activities. Most of his "friends," who were more interested in his celebrity and wealth than in him personally, had since abandoned him. His younger sister, Gina, was the only one with whom Antonio kept in contact, and it was she who convinced him to seek counseling with George Langston, a close friend of Gina.

After about 2 months of therapy, Antonio began to open up to Langston about pervasive personal issues in his life: his struggle with being gay in a homophobic world, being rejected by his parents, intimate details of his relationship with Karl, and how Karl had inspired him to pursue his dream of becoming a fashion designer. Antonio talked about how the two would meet each day for lunch at an outdoor café called the Gemini, where he said he made contact with his muse.

As Antonio began to speak freely, Langston resonated with Antonio's life story, which reawakened his own unresolved painful feelings: his parent's refusal to accept that he was gay, his personal struggle with coming out, and his recent breakup with a man whom he deeply loved. This similar history and set of feelings formed a deepening emotional bond between the two, which eventually turned into reciprocal sexual attraction. Here there was ongoing transference and

counter-transference, but Langston still believed that there was remarkable progress and remained convinced that he could continue to facilitate constructive client change through the counseling relationship.

However, Antonio began to express his love for Langston and a renewed desire to return to work. Rebuffed by Langston, who cautioned Antonio about the importance of keeping their relationship professional, Antonio became enraged, and in the midst of a session, left Langston's office in tears. Fearful that Antonio might do something foolish, he contacted him. Antonio offered to see Langston over lunch and suggested meeting at the Gemini. Unable to convince Antonio to schedule an appointment at the office, Langston reluctantly agreed to meet at the Gemini, and the two dined.

It was evident to Langston that he could no longer counsel Antonio and offered to be friends. Antonio said that he wanted more from the relationship than friendship, and Antonio left the café abruptly leaving Langston sitting alone. Two days later Langston called Antonio; the two agreed to discontinue the counseling relationship, and they began a sexual relationship.

The romantic relationship appeared to be going well. Antonio returned to work, Langston moved in with him, lunched regularly at the Gemini, and Antonio claimed to have, once again, found his muse. However, the depression began to return as the relationship became increasingly contentious. In a particularly heated argument, Langston told Antonio that he "needed to stop feeling sorry for himself because he was gay." Langston collected his belongings, moved out, and the two parted. Six months later, Langston listened to the evening news, which announced that the famous fashion designer had taken his life.

Shaken by the news, Langston referred his clients to another therapist who agreed to take them on and closed his practice. However, after 2 months of quietly grieving the loss of his former client and partner, Langston returned to his practice, this time vowing never again to counsel single, attractive gay men.

SEXUAL RELATIONS WITH CURRENT CLIENTS

The case of Antonio is edifying with respect to the risks and dangers of entering into sexual relationships with clients. In fact, all states legally proscribe sexual relationships with *current* clients based on the palpable fact that clients, by virtue of their vulnerability, are subject to exploitation by therapists (Morgan, 2013). And all codes of ethics governing psychotherapy back up this proscription. For example, according to the ACA Code (2014, A.5.a), "[s]exual and/or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited." The American Psychological Association (2016) states succinctly, "Psychologists do not engage in sexual intimacies with current therapy clients/patients" (10.05). And the National Association of Social Workers makes plain that there are no exceptions, even with the claimed "consent" of the client. "Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced" (NASW, 2017, 1.09[a]).

SEXUAL RELATIONS WITH FORMER CLIENTS

This proscription, with qualification, also legally applies to sexual relations with *former* clients. For example, according to Florida statute, "Any psychotherapist who commits sexual misconduct with a client, or former client when the professional relationship was terminated primarily for the purpose of engaging in sexual contact, commits a felony of the third degree . . ." (FS 491.0112[1]); where "sexual conduct" means "the oral, anal, or vaginal penetration of another by, or contact with, the sexual organ of another or the anal or vaginal penetration of another by any object" (FS 491.0112[4][c]). Accordingly, as a Florida mental health practitioner, George Langston is potentially guilty of sexual misconduct, a third degree felony, when he terminates therapy with his client Antonio for purposes of beginning a sexual relationship with him. Further, the legal case may be complicated by the fact that Antonio subsequently commits suicide. Arguably, if a causal connection can be proved to exist between the commission of the felony of sexual misconduct and the subsequent client suicide, it may meet the standards set by Florida statute for third degree murder (FS 782.04[4]). In fact, there is evidence to suggest a possible connection. According to one study of 958 individuals who had engaged in sexual relations with a therapist, 14% attempted suicide and 1% succeeded in committing suicide (Pope & Vetter, 2001).

Further, according to the Florida Administrative Code (64B4-10.003), for purposes of determining whether sexual misconduct has been committed, the therapist-client relationship is "deemed to continue for a minimum of 2 years after termination of psychotherapy or the date of the last professional contact with the client." However, the code adds, "the psychotherapist shall not engage in or request sexual contact with a former client at any time if engaging with that client would be exploitative, abusive or detrimental to that client's welfare." This means that waiting a minimum of 2 years after termination of the therapist-client relationship to have a sexual relationship with the client may not be sufficient to avoid a charge of sexual misconduct. What is also requisite is that such a relationship cannot be shown to be harmful to the client. However, according to the aforementioned study, most of the harms due to sexual intimacy (80% for females, 86% for males), including hospitalization, suicide, and attempted suicide, occurred in cases in which the sexual relationship began *after* termination of the therapist-client relationship (Pope & Vetter, 2001). In our opinion, this evidence militates against establishing a sexual relationship with clients even after waiting a set amount of time.

According to the ACA Code of Ethics (2014, A.5.c), a sexual relationship with former clients or their romantic partners or family members is prohibited for a period of 5 years after the last professional contact. Further, the therapist must document in writing whether the sexual relationship would in any way be exploitive or harmful to the former client. However, the therapist is arguably not a credible witness regarding whether the relationship would be exploitative or potentially harmful to the client inasmuch as he may have an actual or apparent conflict of interest. Hence, a therapist contemplating a sexual relationship with a former client, even after 5 years, may be justly advised to seek consultation from an impartial colleague about whether the relationship would, indeed, be in any way exploitative or harmful to the former client.

The APA is less stringent than the ACA regarding the length of time a therapist must wait in order to have sexual intimacy with a former client. According to the APA (2016,

10.08), "Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy." Further, after the 2-year period, the therapist does not engage in a sexual relationship with the client "except in the most unusual circumstances." Again, the practitioner must demonstrate that there has not been exploitation.

However, the APA provides criteria for determining whether the therapist has exploited the client by beginning a sexual relationship. They include: (a) the amount of time transpiring since termination of therapy; (b) the "nature, duration, and intensity" of therapy; (c) the circumstances under which therapy was terminated; (d) the "personal history" and (e) "current mental status" of the client; (f) the probability of "adverse impact" on the client; and (g) any statements the therapist may have made prior to termination about the possibility of beginning a sexual relationship after termination (APA, 2016, 10.08). While the aforementioned criteria appear to provide constructive standards for determining sexual misconduct (e.g., pursuant to Florida statute), the reliance on the therapist, who may be conflicted, to document that these standards have been safely satisfied is problematic, in our opinion. Requiring that the therapist seek consultation with a qualified therapist who can confirm or disconfirm the satisfaction of these standards would offer a more objective determination. Quite clearly, Langston is not prepared to make such an objective determination given his own unfinished business and seeming inability to transcend his countertransference. Inasmuch as the risks of serious consequences arising from sex with former clients are substantial, including attempted suicide and commission of suicide, a virtuous practitioner would avoid a sexual relation with a former client in the first place and, in the very least, would not venture to make such an awesome decision without a competent ethics consult.

The case of George Langston also illustrates the firm basis in both law and ethics for a strong proscription against establishing sexual relationships with former clients. As human beings, therapists are not immune from having strong emotions in their personal relationships, which may be irrational or misdirected. Given the very clear incompatibility of expectations in the role of therapist and that in sexual relationships, it is not remarkable that a therapist who engages in a sexual relationship with a former client might confuse the two to the detriment of the former client and sex partner. In Langston's case, he admonishes Antonio to "stop feeling sorry for himself because he was gay." Here, Langston uses a deeply painful and personal fact disclosed in confidence by a client to his therapist to castigate Antonio for not meeting up to his expectations in their personal relationship. Such a confusion of role relationships is not only a potential problem of having sexual relationships with former clients, but it also is a predictable one, given the imperfect nature of humans. Indeed, it is expecting too much to require therapists never to say or do what they ought not, or to keep their composure without exception, even in the most emotionally and behaviorally challenging occasions of an intimate relationship. This is simply expecting too much; and this underscores the profound importance of not mixing close personal relationships (including but not limited to sexual intimacy) with a therapist-client relationship.

Further, the Langston case demonstrates the magnitude of discriminatory and unfair treatment of clients that can arise in the context of sexual involvement with them. Langston not only fails to help Antonio, but also his personal relationship with him deprives him of the competent therapy he so sorely needs. Thus, there is an inherent

inequity arising out of having forged a personal relationship with Antonio. On the one hand, Langston's other clients, with whom he maintains independence of judgment, receive competent counseling services. On the other hand, Antonio, whom he finds to be sexually attractive, receives inferior counseling services, and, in the end, no professional help whatsoever. This treatment is not only damaging to Antonio's best interest (in the end, it cost him his life), but it also is grotesquely unfair.

SEXUAL ATTRACTION TO CLIENTS

But it is not the sexual attraction per se that creates the problem. As human beings, it is not unexpected that a therapist will occasionally be sexually attracted to certain clients. In itself, sexual attraction need not present a problem so long as the attraction does not impair the therapist's ability to maintain independence of judgment (Cohen & Cohen, 1999). However, this is not the case with George Langston. Unfortunately, his own unfinished business (including parental rejection, his struggle with living authentically as a gay person, and his recent breakup) provides the occasion for countertransference and loss of independence of judgment. Realizing that this is the case is sufficient for referring the client rather than continuing to work with him. Here, the therapist harbors a rationalization that because there has been "remarkable progress" he could continue, under the present circumstances, to facilitate further constructive client change by preserving the counseling relationship. No doubt, it is difficult for Langston to make an appropriate referral. Indeed, he is personally invested; however, the personal investment is what blurs his objectivity. The essential boundary between helping his client overcome his depression and helping himself work through his own psychological problems is breached; thus, there is client manipulation rather than client respect. The client becomes a mere means to promote the therapist's own perceived self-interest rather than an end in itself. Therefore, the sacred trust by which the client trusts the therapist to act to promote his welfare rather than his own self-interest is breached.

In the aftermath of Antonio's suicide, Langston decides not to counsel single, attractive gay men. Clearly, a gay man does not present with a tag that says "I'm gay," and Langston would not necessarily surmise that a prospective client is, indeed, gay. Nor would it be appropriate to ask a client if he is gay before accepting him as a client. The problem here underscores the more general problem with attempting to deal with unfinished business by avoiding working it through. Langston is correct that he ought not counsel clients with whom he has a problem that would impair his professional judgment; however, the issue may also be whether he is capable of counseling *any* clients if he cannot work through his issues. For example, Langston's issue includes having been rejected by his parents. However, heterosexuals can also be rejected by their parents. Parental rejection is a *human* issue wherefore the potential for countertransference may still be present across the gamut of client populations. Unfortunately, Langston does not himself seek appropriate counseling, even after the tragic consequences of not having worked through his issues. However, therapists who practice within the boundaries of competence are aware of, and monitor their physical, mental, or emotional problems. They seek assistance when

such problems impair their professional judgment, *and*, when necessary, they suspend, terminate, or appropriately limit their practices until such problems have been adequately addressed (American Counseling Association [ACA], 2014, C.2.g).

Therapists who confront such potential conflicts appropriately take an inventory of the relevant welfare and interests that are at stake. As discussed in Chapter 3, this can be done by taking account of the stakeholders involved and the welfare and interests that are at stake. Table 9.1 provides an illustration.

Clearly, a careful, objective articulation of the relevant welfare and interests at stake, as presented in Table 9.1, points to the need to refer the client to another therapist who can competently counsel him. Acting on the sexual interests shared by both stakeholders fueled by transference and countertransference would have been seen as destructive of both party's welfare and legitimate interests. Langston has a legitimate interest in providing competent counseling services, and his welfare lies in working through his problems through appropriate channels—by seeking professional help. Continuing to counsel Antonio accomplishes neither. Instead, it has the potential to adversely affect Antonio's welfare—his ability to work through his depression and avoid the injury suffered by the termination of much needed therapy. In this light, the best interest of the client is served by terminating the counseling relationship and making an appropriate referral. The option of terminating only to embark on a sexual relationship would have been seen as unequivocally wrong from not only a client-oriented perspective but also from a self-interested and social perspective. From a self-interested perspective, Langston risks criminal charges of sexual misconduct. From a social perspective, he risks contributing to a negative stereotype of therapists as willing to "jump into bed" with their clients. As a mental health professional, Langston owes his profession more than this.

TABLE 9.1 ■ Stakeholder/Welfare/Interests

Stakeholder	Welfare (Positive/Negative)	Interests
Antonio	• Working through his depression • Not being harmed by therapy	• Sexual attraction to Langston and starting an affair with him (due to transference) • Being served by a competent therapist • Having a therapist who does not manipulate or deceive him
Langston	• Working through his own problems by seeking professional help • Not being charged with a felony for sexual misconduct	• Providing competent counseling services • Sexual attraction to Antonio (due to countertransference) • Not contributing to a negative image of the counseling profession

Further, Langston has a responsibility to Antonio to inform him of his personal issues when it becomes evident to him that his professional judgment has been impaired by them. Because there may be potential for a client to blame himself for the discontinuation of therapy, Langston needs to be candid with his client. "I have emotional problems dealing with my own personal issues related to my life experiences as a gay man, and I am having a difficult time keeping my personal life separate from the problems you are confronting. When such conflicts arise, it is my professional responsibility to refer you to another therapist." Here, Langston would have made sufficient disclosure so that Antonio would not be misled by his decision to terminate counseling. Unfortunately, Langston chooses to mislead Antonio by presenting the façade that he is acting consistently to promote the welfare and legitimate interests of his client in having a competent therapist who would not manipulate or deceive him.

ONLINE RELATIONSHIPS

The case of Langston would not have been substantially different if the counseling relationship was a distance one via the Internet. Cyber relationships can involve sexually stimulating chat sessions and conversation and/or cybersex, such as capturing mutual masturbation through a web camera (Smith, 2011). Online sexual relationships with current or former clients have similar proscriptions as do in-person sexual relationships (ACA, 2014, A.5.c). This is because they raise similar emotional issues of attachment and discordant role expectations as do in-person sexual relationships, including jealousy and betrayal (Smith, 2011).

Social Media Relationships

Social media such as Facebook, Twitter, and Pinterest have also created the occasion for the sharing of personal facts about oneself. While privacy used to be a highly prized value, it has become increasingly less so in cyberspace. One can now "friend" hundreds and thousands of people whom one does not know in person and share with the connected universe very personal facts about oneself. Therapists who get involved with posting to social media need to keep in mind that they may be setting the stage for confusing professional relationships with personal ones. In therapy, personal disclosure is appropriately restricted to information that is relevant to the client's situation. There is, therefore, opportunity to control the extent to which personal information is disclosed. However, social media websites typically permit members of their online communities to post very personal facts about themselves—from provocative photos to anecdotes about sexual encounters to intimate details about their likes and dislikes. Such information, therefore, exceeds the modest limits of disclosure in the professional context. Inasmuch as the Internet is a public facility and these posts may be publicly accessible, therapists who post to such websites raise the potential for blurring the lines between personal and professional relationships.

As discussed, apparent conflicts of interests can be just as problematic as actual ones, which means that a therapist who shares intimate personal information online may still feel comfortable with counseling another individual who may have had access to this information. However, the client may not feel comfortable with it or it may have

repercussions on the therapist-client relationship. For example, a client who learns about her therapist's sexual desires from the Internet or sees the therapist in a sexually provocative pose online may come to think of the therapist as having sexual interests in them or otherwise entertain ideas about the therapist's sexuality that impede therapeutic progress. There is, therefore, abundant need for constraint by therapists in posting things to the Internet. Inasmuch as it is safe to suppose that what gets posted to the Internet stands a strong chance of remaining in some form online, the need for exercise of discretion cannot be overstated.

Therapists should not establish "personal virtual relationships" with their current clients (ACA, 2014, A.5.e), for example, friend them on Facebook; nor should they accept requests from them on professional social media networks such as LinkedIn. Again, such virtual interactions raise the risks of blurring the lines between personal and professional roles. Because LinkedIn or other collegial websites create occasion for establishing professional relationships, which have a different set of expectations than those of the therapist-client relationship (e.g., the exchanging of professional services and employment opportunities), therapists who do not keep such lines separate risk finding themselves in the crosshairs of potentially problematic dual role relationships such as bartering for fees (American Psychological Association, 2016, 6.05) or entering into business or employer-employee relationships with current clients (Cohen & Cohen, 1999).

Conversely, therapists should avoid accepting as clients individuals with whom they already have personal virtual relationships. For example, a therapist should avoid accepting a personal Facebook friend as a client. Again, even if the therapist can maintain independence of judgment, the client may not be so inclined, and the appearance to the client that the therapist has a conflict may be just as damaging as a real conflict.

Therapists should also avoid entering into personal virtual relationships with former clients to the extent that such relationships portend harm to the clients (ACA, 2014, A.5.e). As in nonvirtual (in-person) relationships, embarking on such a consecutive dual role relationship can provide the occasion for blurring of lines between personal and professional relationships because the expectations of each relationship may conflict. Thus, the client may continue to view the therapist as one with whom he can share confidential information to help him confront his behavioral or emotional problems; whereas the therapist may now be seeing the client as an online friend and, thus, no longer a professional charge. In our opinion, because the risks are significant for such role confusions, possible misuse of confidential client information in the context of the personal virtual relationship, and the appearance if not the reality of conflicts of interest, we would caution against entering into such relationships as a general policy.

The American Counseling Association enjoins that therapists who wish to maintain both a professional and personal social media presence should keep separate their personal and professional websites and profiles (2014, H.6.a). However, this may not be sufficient to address the problem of confusing the therapist-client relationship with personal virtual relationships. Therapists may not exercise caution regarding what they post to their personal websites, with whom they share what they post, and how restricted they make access to the personal information on their personal websites. For example, the public option on Facebook permits anyone, even those who do not have a Facebook account, to view one's information while the friends setting permits only friends to see one's personal information (Facebook, n.d.). However, restricting information, as by using the friends

setting, still requires meticulous care as to whom one accepts as friends. So keeping personal virtual relationships separate from professional ones is not cut and dried. Of course, having only a professional presence on social media may be the best option for keeping one's personal information separate from one's professional profile.

Respect for clients' self-determination also requires that therapists respect the boundaries of client's privacy regarding their online identities. This means that therapists should avoid initiating social media contacts with clients such as attempting to friend a client. It further requires that therapists do not attempt to view clients' personal online information without their prior consent (ACA, 2014, H.6.c).

BARTERING FOR FEES

Bartering, that is, exchanging counseling services for goods or services provided by the client, can be potentially problematic because there is potential for confusion of expectations and the perception of conflicts of interest. A client expects her therapist to give undivided attention to her welfare and interests, while there is also potential for the bartering arrangement to create the perception of divided loyalties. For example, the client may believe that the therapist is dissatisfied with the quality of services she has rendered and that this will, in turn, affect the quality of the therapist's counseling services. Further, therapists who truly are dissatisfied with the goods or services provided by the client may encounter an actual conflict of interest. For example, suppose the client is providing lawn services in exchange for counseling; however, the client is not trimming bushes adequately or leaving trimmings on the property instead of hauling them off according to their agreement. Under such a situation, the therapist may be hard put to express dissatisfaction with the client's lawn services without alienating him or otherwise introducing a potentially damaging element into the therapist-client relationship.

On the other hand, according to Zur (2016), bartering can have positive therapeutic benefits, such as helping a poor client overcome low self-esteem and shame by proving to the therapist that she has talents and/or resources that can be beneficial. Further, it is already a norm for some cultures such as Hispanic, Native American, and some agricultural communities (Zur, 2016). However, being a norm does not necessarily mean that it does not create the potential for harm. Nor is it necessarily the case that a client who gains a sense of self-worth through the provision of goods or services is necessarily making therapeutic progress; for the sense of self-worth attained is a conditional one based on such abilities or resources rather than one of unconditional self-acceptance (Ellis, 2001).

Nevertheless, in poor communities where money is a scarce resource, but talents, skills, and tradable assets are plentiful, bartering for fees may be an accessible option for receipt of needed counseling services. According to the ACA (2014, A.10.e), in such cases, therapists should enter into a bartering arrangement only if the client requests it, the arrangement has not resulted in client exploitation or harm, and it is an accepted practice in the given community. Further, therapists should discuss with the client potential problems that can arise when distinct roles having competing expectations are combined and document the arrangement in a clearly articulated, written contract.

PRO BONO COUNSELING SERVICES

While therapists are not reasonably expected to work entirely without compensation, a possible alternative to bartering for fees in certain cases is the provision of *pro bono* counseling services to a percentage of indigent individuals who are in serious need of therapy. Such services are provided free of charge. Indeed, a fair-minded therapist welcomes the opportunity to help clients who are in serious need of therapy who would otherwise not receive it. For, it is not the amount of money clients have that determines whether or not they are worthy of receiving therapy; it is their psychological need for such services. The fair therapist understands this, and is willing to sacrifice some measure of monetary gain for promotion of client best interest.

Codes of ethics in the mental health professions have also recognized the value of providing pro bono counseling services. For example, in its Introduction, the ACA Code of Ethics states, "[C]ounselors are encouraged to contribute to society by devoting a portion of their professional activities for little or no financial return (pro bono publico)." In explicating its core aspirational principles or values, the NASW's Code of Ethics (2017) similarly states, "Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service)." However, these codes provide no explicit guidelines on how to fulfill such virtuous aspirations. For example, what sort of work might qualify? How many hours of pro bono services would be appropriate?

In contrast, there are professional standards that have been set elsewhere. For example, the legal profession recognizes a professional responsibility to render 50 hours of pro bono legal services each year. According to Rule 6.1 of the American Bar Association's Model Rules of Professional Conduct (2016),

> [e]very lawyer has a professional responsibility to provide legal services to those unable to pay. A lawyer should aspire to render at least (50) hours of pro bono publico legal services per year.

Using 50 hours as a benchmark, therapists might similarly strive to advance the service goal encouraged by codes of ethics such as the ACA and NASW codes.

Programs such as the Pro Bono Counseling Project (2016), established in 1991 to provide pro bono counseling services to Maryland residents in need, can serve as a model for focusing attention on underserved populations. For instance, it has special programs for:

- Caring for the Caregivers
- Parenting Alone: Building Healthy Families
- Private Counseling for Public Service
- The Jean Steirn Cancer Program
- Transition & Depression: Elderly & Underserved
- Victims of Violence

Therapists can contact organizations (e.g., hospitals, nursing homes, assisted living facilities, prisons, Veterans Affairs, and other federal or state agencies) that serve underserved, indigent populations who would otherwise not receive needed therapy. Here, the standard for determining whether pro bono counseling services are warranted is the seriousness of the need. Thus, an individual who is having a crisis coping with an end-of-life decision may need pro bono counseling more immediately than an individual who is temporarily unemployed but not in crisis mode.

SLIDING SCALES

Fair practitioners are also prepared to provide a sliding scale of fees commensurate with the client's ability to pay (Cohen & Cohen, 1999). The ACA Code of Ethics (2014, A.10.C) provides that, when legally permitted, counselors adjust their fees to accommodate client's ability to pay. Similarly, according to the NASW's Code of Ethics (2017, 1.13[a]), in setting fees, "consideration should be given to clients' ability to pay." Here, we are referring to clients who do not have mental health insurance. Clients who have mental health insurance would still need to pay for deductibles unless the health care company was willing to waive the fee (Chamberlin, 2009).

There has, however, been controversy in the past about the fairness of sliding scales. For example, in 2008, the ACA Chief Professional Officer stated,

> Nothing in the ACA Code of Ethics prohibits the use of a sliding fee scale. However, the ACA Ethics Committee recommends against using a sliding scale. Why? Because it is discriminatory. A sliding fee scale charges people with larger incomes more for the exact same service that is being provided to clients with lesser incomes. (Walsh & Dasenbrook, 2008)

We submit that this argument engenders a confusion between equity and equality. While a wealthier individual may pay more for the same service under a sliding scale arrangement, this inequality is not necessarily an iniquity. As discussed in Chapter 2, the Justice Standard enjoins that *relevantly* like cases be treated alike and relevantly unlike cases be treated differently (Feinberg, 1973). For the purpose of the provision of counseling services, the standard of relevance is the need for counseling, not the amount of money one has. The fact that two clients with different financial means may be treated differently does not, therefore, necessarily make the disparate treatment unjust unless one of the two is being deprived of needed services or is receiving inferior services. To the contrary, it is unjust to provide competent counseling services to one individual but not to another because the former has more money than the latter. If relying on a sliding scale in distributing mental health care is "discriminatory," it is not *unfairly* discriminatory. It is unfairly discriminatory to allow the wealthy to receive competent (mental or physical) health care services while allowing those with less money but equal need to go without such services. Again, need, not money, is the ethically relevant criterion for doling out health care. While fair-minded therapists cannot eliminate the systemic iniquity that

currently pervades our health care system, they can contribute to a more equitable system by providing a sliding scale commensurate with clients' ability to pay.

RECEIVING GIFTS FROM CLIENTS

Not uncommonly, therapists are also the recipients of gifts from clients. Unlike bartering, which always involves reciprocal arrangements discussed and agreed on in advance, therapists may not anticipate or agree in advance to accept a gift from a client. The client's motivation for offering the gift may be to express gratitude or respect, and it may be motivated by custom or ritual according to the client's culture (Corey, Corey, & Callanan, 2011; Zur, 2015). As such, therapists should consider the cultural context in which the gift is offered (ACA, 2014, A.10.f). Ordinarily, accepting small gifts having symbolic import whose monetary value is low, such as candy, flowers, or fruit, would be acceptable; whereas accepting gifts that have relatively high monetary values, for example, a television set, airline tickets, or a computer, would be unacceptable. As in bartering for services, accepting valuable gifts runs significant risk of generating competing expectations that can strain independence of judgment of both client and therapist. For example, a client may expect his therapist to give him priority over other clients; or he may worry that the therapist may not like the gift enough. Conversely, the therapist may have an uncomfortable feeling that she "owes" the client a debt of gratitude, or that the client has such expectations (Cohen & Cohen, 1999).

The timing of gift giving can also be significant (Zur, 2015). For example, after termination of therapy, receiving a small symbolic gift is more likely to be innocuous than if the gift is given in the midst of a client's working through her issues. In the latter case, the gift itself may take on additional meanings related to the client's issues. For example, a client who is working through a self-destructive demand for approval may be seeking the therapist's approval in providing a gift, even if it is an inexpensive one, such as a homemade cake.

Thus, in deciding whether or not to accept a gift from a client, a therapist should consider such facts as the gift's cultural significance, its monetary value, the motivation for offering it, and the timing of the offer. Empathetic, morally sensitive therapists understand that rejecting the client's gift can chill the therapist-client relationship. However, if the therapist determines that it would be inappropriate to accept the client's gift, the therapist should discuss with the client her reasons for not accepting the gift. As in the case of multiple or dual relationships where there is significant potential for loss of independence of judgment, actual or apparent conflicts of interest, or conflicting expectations, the virtuous therapist acts mindful of the client's best interest in maintaining the therapist-client trust.

As discussed in this chapter, the cultural background of clients can be an important factor in deciding how to treat gift giving or other dual or multiple role relationships that may place a strain on the therapist's independence of judgment or lend an appearance of such. The next chapter, accordingly, examines more closely the need to demonstrate respect for the cultures of diverse client populations (multiculturalism) in the counseling relationship. More specifically, it examines the importance of multicultural training for beginning therapists in the context of the supervisory relationship.

Questions for Review and Reflection

1. What does it mean to maintain independence of judgment, and why is it important in counseling?
2. What does it mean to have a conflict of interest? What is the difference between an actual and an apparent conflict of interest? Does the fact that the latter conflict of interest is only apparent mean that it cannot be problematic? Explain.
3. What is a dual role relationship? What is a multiple role relationship? Provide an example of each that is not provided in this chapter. Does either of these relationships involve a conflict of interest, real or apparent? Is either of these relationships problematic? Explain.
4. What factors can make a dual or multiple role relationship problematic?
5. How might a counseling relationship in a rural community lead to potentially problematic dual or multiple role relationships? What can be done to avoid or reduce the possibility of such problems?
6. What is a nonelective dual or multiple role relationship and how can they be problematic? Provide at least two examples. What can be done to avoid or reduce the possibility of such problematic relationships?
7. In the case of George Langston, Antonio's sister, Gina, is a close friend of Langston. Is such a dual role relationship potentially problematic? Explain.
8. What type of dual role relationship discussed in this chapter is encumbered by an exceptionally high number of liability claims filed against counselors? Why are such relationships so problematic?
9. What do state laws and codes of ethics unequivocally have to say about sex with current clients? What does the American Counseling Association (ACA) Code of Ethics state about sex with former clients? What does the American Psychological Association (APA) Code state?
10. What standards does the APA provide for determining whether sex with a former client is exploitative? List them.
11. In your estimation, does a therapist have at least an appearance of conflict of interest in attempting to document the acceptability of entering into a sexual relationship with a former client? If not, explain. If so, what might a therapist in such a situation do to avoid the appearance of conflict with respect to documenting the decision?
12. In the case of George Langston, in your estimation, does Langston commit sexual misconduct pursuant to Florida state statute? Explain.
13. Is there any empirical evidence that sex with former clients can be harmful?
14. After Langston begins a personal relationship with Antonio, at one juncture he states, "Stop feeling sorry for yourself because you are gay." What problem does this illustrate about establishing personal relationships with former clients?
15. In what way or ways is Langston's personal involvement with Antonio unfair or unjust?

16. Is sexual attraction to a client in itself a sufficient reason to refer a client? Is sexual attraction in the case of George Langston problematic? Explain.
17. What role does Langston's countertransference play in the problematic nature of his dual role relationship with his client?
18. In the aftermath of Antonio's suicide, Langston decides not to counsel single, attractive gay men. Is this a satisfactory way of dealing with his issues? Explain.
19. What is the advantage of doing a stakeholder analysis such as the one provided in Table 9.1? If Langston had, contrary to fact, prepared such an analysis, what ethical decision would it have supported? Why? In answering this question, consider the primary client responsibilities as well as the other-regarding and self-regarding responsibilities discussed in Chapter 3.
20. Does Langston have a responsibility to Antonio to inform him of his personal issues when it becomes evident to him that his professional judgment has been impaired by them? Explain.
21. Can online sexual relationships with clients be as problematic as physical ones? Explain.
22. What potential problems are raised when counselors post very personal facts about themselves or photos of themselves (not necessarily restricted to sexually provocative ones) on the Internet? How should therapists address such potential problems?
23. Is it acceptable for therapists to establish virtual friendships with current clients? What about former clients? Explain.
24. Is it acceptable for therapists to accept as clients individuals with whom they have had virtual friendships? Explain.
25. What does the ACA maintain about having both a personal as well as professional presence on the Internet? Is the ACA's response adequate? Explain.
26. Is it okay for therapists to view clients' personal online information or to friend their clients? Explain.
27. Is bartering for fees ever acceptable? Are there any potential risks in such arrangements? Can they have any positive value? Explain. What does the ACA say about bartering for fees?
28. Do therapists have a professional responsibility to provide pro bono counseling services, that is, services rendered without remuneration to poor clients? If not, why not? If so, in what ways might a therapist discharge such a responsibility?
29. Is it fair for therapists to provide sliding scale fees to their clients based on their ability to pay for counseling services? Why or why not? What did the ACA Ethics Committee in 2008 claim about such fee arrangements? Was its argument for its position a convincing one? Explain.
30. Is it ever ethically acceptable to accept a gift from a client? If not, why not? If so, what factors should be considered in deciding whether or not to accept the gift? Provide examples of gift giving to illustrate your response.

Cases for Analysis

1. Alberta Seabrook is a licensed mental health counselor who has a large teenage clientele. One of her clients, Bettina, age 15, was referred to counseling as part of a misdemeanor diversion program because she is caught shoplifting. Seabrook is developing a good rapport with her client, and Bettina is beginning to make progress toward her goals in therapy. Yesterday, Seabrook heard her own daughter's phone ring and looked at the screen. The missed caller's name was displayed and it read "Bettina." Alberta stood still in shock. "How many teenage *Bettinas* could there be in our town?" she asked herself. Alberta now wants to question her daughter about her new friend, but doesn't want to disclose that she has a client with the same name. Furthermore, Seabrook is alarmed that her daughter may be friends with a girl who shoplifts and Seabrook does not want her daughter to associate with Bettina. All this is further complicated by the fact that if Seabrook's daughter is, indeed, friends with Seabrook's client, then a nonelective dual role relationship will be in place. What should Seabrook do? What are her ethical responsibilities? To whom does Seabrook have primary responsibility, her client or her daughter? Should Seabrook mention to her daughter or her client that she knows that her daughter has a new friend named Bettina. Could this question, if asked of Seabrook's daughter, violate client confidentiality in any way?

2. Diana Duncan is a clinical psychologist who is a professor in a private college. She also maintains a small private practice. Duncan is careful not to take as clients anyone who is presently a student at the college or who plans to attend her college. At the very beginning of the fall semester this academic year, a student in one of Duncan's classes waits after class to speak to her. "Hi, Dr. Duncan. My name is Dennis Burgess. I'm so glad to finally meet you. You were my wife's therapist. She's Isla Burgess. She still talks about you, and it's been a year already since she finished therapy."

Duncan is very surprised by this disclosure and tells Dennis that she is glad to meet him, but that she has concerns about having him as a student in light of his relationship with a former client of hers. She suggests that he register for another section of the same class with another instructor. Dennis states that his wife is fully aware that he is enrolled in Duncan's class and she is okay with it. He maintains that he wants to remain in Duncan's class. Duncan remembers that Dennis's wife had worked on issues relating to verbal abuse and is concerned because the class that he is now enrolled in covers that topic. She wonders whether Dennis might bring up topics in class that have relevance to his own marital situation. What do you think Duncan should do in this situation? Does she have a legal or ethical right to acknowledge that Isla, Dennis's wife, was, in fact, her client? Does Duncan have an ethical right or responsibility to contact Dennis's wife? Who are the stakeholders in this situation? What are some of the possible dangers of this dual role relationship?

3. Simeon Lemon is a 28-year-old male who is receiving counseling from Irene Waters, a licensed mental health intern. Waters is 26 years old. Both Lemon and Waters are single. One Friday night, the two happen to be at the same local club and Lemon strikes up a conversation with Waters. Waters is at first hesitant to socialize with Lemon and tells him that their socializing is unprofessional. Later that night, after both consume several drinks, Lemon

asks her to dance and she consents. At his next session the following week, Lemon tells Waters that he "really likes her" and is discontinuing his therapy with her so that the two can date. Waters explains that she should not have danced with Lemon and must refer him to another therapist because of the nature of what happened on Friday night. Lemon states that he will not see another therapist and will report Waters to her supervisor if she refuses to date him. Waters fears that her conduct will lead to professional censure and that she will not be able to become licensed. What should she do at this point? What are her ethical or legal responsibilities at this juncture? What might be the possible role of Waters' clinical supervisor? How would a virtuous therapist proceed?

References

American Bar Association, Center for Professional Responsibility. (2016). *Model rules of professional conduct*. Chicago, IL: Author. Retrieved from https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/model_rules_of_professional_conduct_table_of_contents.html

American Counseling Association. (2014). *ACA code of ethics.* Alexandria, VA: Author.

American Psychological Association. (2016). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author. Retrieved from http://www.apa.org/ethics/code/?item=11#805

Bayles, M. D. (1989). *Professional ethics* (2nd ed.). Belmont, CA: Wadsworth.

Burgard, E. L. (2013). Ethical concerns about dual relationships in small and rural communities: A review. *Journal of European Psychology Students*, *4*, 69–77.

Chamberlin, J. (2009). How to offer a financial break: Six ways psychologists can help patients who can no longer afford therapy. *Monitor on Psychology*, *40*(1). Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/monitor/2009/01/fees.aspx

CNA & HPSA. (2014). Understanding counselor liability risk. Retrieved from http://www.hpso.com/Documents/pdfs/CNA_CLS_COUNS_022814p_CF_PROD_ASIZE_online_SEC.pdf

Cohen, E. D., & Cohen, G. S. (1999). *The virtuous therapist: Ethical practice of counseling and psychotherapy*. Belmont, CA: Wadsworth.

Corey, G., Corey, M., & Callanan, P. (2011). *Issues and ethics in the helping professions*. Belmont, CA: Brooks/Cole.

Davis, M. (1982). Conflict of interest. *Business and Professional Ethics Journal*, *1*(4), 17–27.

Ellis, A. (2001). *Feeling better, getting better, staying better: Profound self-help therapy for your emotions.* Atascadero, CA: Impact.

Facebook. (n.d.). Privacy facts. [Facebook Privacy Basics]. Retrieved from https://www.facebook.com/about/basics/manage-your-privacy/posts#1

Feinberg, J. (1973). *Social philosophy*. Englewood Cliffs, NJ: Prentice-Hall.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling & Development*, *67*(4), 217–221.

Morgan, S. (2013). *Criminalization of psychotherapist sexual misconduct*. Washington, DC: National Association of Social Workers. Retrieved from http://c.ymcdn.com/sites/www.naswca.org/resource/resmgr/imported/7_13_legal_issue.pdf

National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers.* Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English.aspx

Pope, K. S., & Vetter, V. A. (2001). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy*, *28*(3), 429–438. Retrieved from https://www.kspope.com/sexiss/sex2.php

Pro Bono Counseling Project. (2016). About us. Baltimore, MD: Author. Retrieved from http://probonocounseling.org/about_us

Smith, B. L. (2011). Are internet affairs different? *Monitor on Psychology*, *42*(3). Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/monitor/2011/03/internet.aspx

Walsh, R. J., & Dasenbrook, N. C. (2008). The complications of sliding scale fees. *Counseling Today.* Alexandria, VA: American Counseling Association. Retrieved from https://ct.counseling.org/2008/04/private-practice-in-counseling-the-complications-of-sliding-fee-scales/

Zur, O. (2015). *Gifts in psychotherapy & counseling: Ethics, cultural and standard of care considerations.* Sebastopol, CA: Zur Institute. Retrieved from http://www.zurinstitute.com/giftsintherapy.html#cultural

Zur, O. (2016). *Bartering in psychotherapy & counseling: Complexities, case studies and guidelines.* Sebastopol, CA: Zur Institute. Retrieved from http://www.zurinstitute.com/bartertherapy.html