

## Dual Relationships and Boundary crossing: A Critical Issues in Clinical Psychology Practice

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**Abstract:** The issue of boundary and dual relationship has been a major subject of concern in psychological practice. Ethics complaints on dual relationship and boundary crossing continue to rise both in nature and variety. This paper examine and shed light on the complexities of dual relationship and boundary crossing in clinical psychology and explain the pertinent moral and clinical worries that clinical psychologist's face daily in their practice. In realising this objective, the paper analysed three underlying themes: 1) using an empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing, 2) learn whether involving in dual relationships, negatively or positively influences therapeutic outcome, 3) using the decision making model to address the concept, challenges and variances associated with dual relationship in clinical psychology and comes up with strategies that help psychologists to make flawless ethical standards and offer moral guidance. Finally, study shows that, though, dual relationships sometimes enhanced therapy, aids the treatment strategy, and promotes the clinician-client working relationship; it also weakens the treatment process, hampers the clinician-client cooperation, and brings instant or lasting damage to the service user.

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### Introduction

The issue of boundary and dual relationship has been a major subject of concern in psychological practice. Of most concern is the fact that the issues has developed in the context of professionalization. In fact, no time in the history of the profession has the ethics of professional conduct being questioned or confronted with a wide range of contemporary ethical problems like it is today in our society. The profession has been besieged with clear messages about the immorality of dual relationship and boundary crossings to the extent that, the values and moral foundation of the discipline was seriously challenged by both clients and consumers. From psychology course guidelines, to literatures on moral values, and clinical internships, it has been reported as inappropriate, for clinical psychologists to involve in the following circumstances: unofficial work or private relationship with clients, taken gifts offer, engage in physical contact and last but not the least, socialize with clients. This position is also accord with a large number of researchers, who one way or the other have made massive contributions to our understanding of the subject, particularly as regards boundary crossing and dual relationships in clinical practice (Corey 2009). On the other hand, professional training also highlights that boundary crossing is likely to impacts on clients 'right and is one of the causes of unjust sexual contacts. Although these acts are reported as immoral and often linked to abuse and harm, its continuous existence in clinical practice remains an issue of concern. The question is, how can

we as psychologist blend our professional roles and personal needs without compromising our professional responsibilities?

Interestingly, each health professional association obligates their members to ethical standards and codes of conduct that guide, regulate and protect clients from experiencing bad practice. However, for clinical psychologist, navigating through ethical practice is a difficult mountain to climb. Psychologist and clients are regularly hindered by circumstances that allow a porous boundary between therapeutic and social relationships. Most research studies confirmed that a dual role relationships can either be harmful or helpful to clients and therapist (Edwards, 2007; Kitson & Sperlinger, 2007; Lazarus, Zur, & Doverspike, 2004; Pugh, 2007). Corollary to this assertion is the religious and rural communities, who particularly stuck with the prospect of dual relationships, and view it as an inevitable reality of clinical practice (Catalano, 1997; Doyle, 1997; Sidell, 2007). As earlier mentioned, work on boundary crossing has in recent time, provided guidance to difficult issues that we came across as we make a judgement on certain boundary issues in our relationship with clients. Similarly, reports in the early 80s give special consideration to issues that are scientifically related to beliefs and behaviours about boundaries. Among the problems that emerged from numerous study include: therapist sexual category, career (psychiatrist, psychologist, social worker), knowledge, marital status, practice situation (private or public), locality, client sexual category, (such as

solo or group private practice and outpatient clinics), practice area (size of the community), and last but not the least, theoretical belief.

Moreover, psychology profession uses ethical principles to advance moral code and moderate professional behaviour of their members (Beauchamp & Childress, 1994). Also, all other health professionals have guidelines and principles that regulate and contain a prohibition of dual relationships. Although most research on the dual relationship focus on role theory, the issue of social roles covers innate anticipations about how somebody in a specific role is to conduct himself or herself, along with the rights and responsibilities that goes with the function. Still, conflicts arise when the beliefs and expectations linked to one role call for conduct which is unsuited to that of another role (Kitchener, 1988). A dual role relationship happens when a particular person or an individual concurrently or successively partakes in double role (Kitchener, 1986). In line with this postulation, Carroll, Schneider and Wesley (1985) established that a dual relationship occurs when, in addition to the professional rapport, there is some other rapport with the person: colleague, relative, student or business partner.

While the idea about health professionals guiding against dual relationships is ambitious in nature to say the least, it still remains a goal that must be reached if good professional conduct is to be attained. Even though professionalism is desirable, it is evident that the idea is difficult to circumvent totally in clinical practice (Haas & Malouf, 1989; Kieth-Spiegel & Koocher, 1985). For example, clinical psychologist serves their clients in various capacities, i.e., Counsellor, psychotherapist, advisor and supervisor to mention a few, and thus bring about contacts and relationships. On the other hand, due to their possibly thoughtful consequences, some dual relationships like sexual relationships with clients have been specially forbidden, (APA, 1977). Although evidence from the American Psychological Association, ethical principles (APA, 1992) recognize "multiple dealings," the code admits that in particular circumstances," It might not be possible or sensible for psychologists to evade other non-professional interaction with their clients" (p. 1601). Nonetheless, the code restraints against going into such interactions if, "it looks likely that such interaction or dealing might prejudice the psychologist's fairness, hinder his or her professional practice, or abuse the other party" (p. 1601). Therefore, the question remains: what and what should be prohibited or condoned when working with clients? Which boundary crossings were therapeutically helpful and harmful? And what therapeutic methods are acceptable or not acceptable for certain culture or communities? Despite all these

challenges, a large number of research and literatures on boundary and dual relationship has aided and change our thoughts and knowledge, and therefore, shaping the base for what appears to be the main opinion of boundaries these days.

### **Purpose**

Though practitioners often miss the mark or fail to understand the possibility for dual relationships and how to cope with a specific relational dilemma, the issue still remain a major discuss in clinical psychology till date. This paper will examine and shed light on the complexities of dual relationship and boundary crossing in clinical psychology and explain the pertinent moral and clinical worries that clinical psychologist's face in their practice. The paper will also look at how the concepts influence the decision making process and make a distinction between the following: risky boundary violations, useful boundary crossings and inevitable or caring dual relationships. To realize this, the paper focuses on two underlying themes: 1) using an empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing, 2) learn whether involving in dual relationships, negatively or positively influences therapeutic outcome. Lastly, the paper uses the decision making model to address the concept, challenges and variances associated with dual relationship in clinical psychology and come up with strategies that help psychologists to make flawless ethical standards and offer moral guidance regarding dual relationships.

### **Methodology**

This paper analysed and reviewed empirical literature in order to investigates and check new empirical studies that highlights the complexities of dual relationship and boundary crossing in clinical psychology. The study collated and reviewed relevant articles, books, journals, and meta-analysis on dual relationship, boundary crossing and ethical decision making. Both the ERIC and PSYCHLIT databases were searched using the following key words: ethical decision making, boundary crossing, dual relationship and clinical psychology. This procedure initially reported about 1298 articles, journals, technical reports, paper presentation and book chapters covering more than 23 year period. Based on the abstracts retrieved from this initial 1298 plus articles and publications, the search was lessened to a relatively few hundred of studies that are pertinent and relevant to the theme of this paper. The contents of the remaining several hundred of articles cum journals were further scrutinised and only those that reported empirical findings were kept aside and used in this review, while others were left out of further

consideration. This process shows that only a few studies documented empirical findings on boundary crossing and dual relationship in clinical psychology practice. To verify references, manual searches of relevant journals and articles related to the paper are performed.

## Literature Review

### Dual Relationship and Boundaries in Clinical Practice

As we all know, the major concern of psychology profession is to promote the well-being and welfare of others, however, this statement as well as it sound, has come to the utmost scrutiny in recent time. Clinical psychologist faces daily, how to handle the issue of dual relationships and boundary crossing without compromising their professional conduct and practice. Earlier research, particularly during the 80s and 90s established how hypothetical orientation, community size, psychoanalyst sexual characteristics, client sexual category, occupation, and other issues, impacts on the level that therapists involved in dual relationship or crossing several boundaries in their profession, particularly, feelings about the nature and suitability of borderline crossings. Besides, the period between the 1980s and 1990s also witnessed a practical outburst of healthy argument and considerate works on dual relationships, bartering, companionable touch, out of office consultation and other nonsexual boundary matters to mention a few, that faces health professionals. Also, there were thought-provoking and considerate literature that observed the constructive and undesirable aspects, the dangers and advantages of different boundaries and boundary crossings. A typical example of this is the article by American Psychologist in 1992 requesting for drastic changes in the ethics code.

Unfortunately, the literature reveals that many people have been victims of ethical issues for years. These problems have been linked to lack of clarity and awareness on when and how to engage with clients. For instance, the Committee on Ethics of the American Psychological Association in their report from 1990 to 1992 highlighted that around 40% to 50% of the complaints received during this period are on dual relationship issues. Also, Sonne (1994) complemented this statement by mentioned that, of all the problems facing APA members, the issue of dual relationship was the most common reason for their membership termination. On the contrary, research also sees boundary crossings as well-fashioned treatment strategies that increase the therapeutic success (Lazarus & Zur, 2002). Also the recent APA Code of Ethics of 2002 offers a new insight into the issues by dropping the statement, "Psychologists ordinarily refrain from bartering", that was in the 1992

code and incorporate a new sentence, "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (APA, 2002, section 3.05), to the multiple relationships unit. As a result of the ambiguity surrounding the concepts, it attracted serious litigation and other disciplinary cases such as ethics committee hearings, and complaints to professional boards of licensure.

Moreover, from the logical viewpoint, practically, not all boundary crossings are harmful to clinical work. Research maintains a distinction between boundary crossing and violations in clinical practice (Remley & Herlihy 2009). According to literature, boundary violations are more injurious to clients, whereas, some boundary crossing is beneficial (Knapp & Slattery 2004). Thus, professionals must endeavor to always differentiate between conducts that are boundary cross and those that are boundary violations. To support this, the new APA Code of Ethics of 2002 made some clarification that prevents the authorities, courts and ethics committees from employing the logical or community yardstick to evaluate non-logically oriented psychologist, who tactically embrace boundary crossing oriented interventions in societies where dual relationship and boundary crossing are inevitable. Additionally, some school of thought, i.e., behavioural, and humanistic, often embrace numerous forms of supportive boundary crossing that focus client's wellbeing (Lazarus, 1994; Williams, 1997) as predicting therapeutic outcomes. Interestingly, a body of psychology literature (Roth & Fonagy, 1996, Hubble et al; 1999) established the therapeutic implication of the clinician-client relationship. According to Roth and Fonagy (1996) and Hubble *et al.* (1999), client variables and extra-therapeutic elements are identified as responsible for 40 percent of progress made in therapy, while 30 percent are accounted for the therapeutic relationship. Thus, a dual relationship happens when there is a multiple roles or external relationship between a clinician and a client (Bleiberg and Skufca, 2005; Moleski & Kiselica, 2005; Ringstad, 2008). This can be business, social, communal, familial, sexual, and professional oriented to mention a few (Nigro, 2004). Research also classifies dual role relationships into two types: sexual and non-sexual (Corey, Corey & Callahan, 2007). Besides, Corey, Corey, and Callahan (2007) linked sexual dual-role relationships with negative outcomes in the client. They conclude that such relationship is the probable cause of harm to client wellbeing. These interactions are categorized as a little harmful to more deliberate double roles that have bigger potential for negative outcomes (Bleiberg & Baron, 2005; Kolbert, Morgan & Brendel, 2002; Reamer, 2003). Though, this is not made equal, they

are structured this way in this paper in order to distinguish the degree of harm they bring to clients.

In addition, research on dual relationship emphasis more on a sexual misconduct between client-therapist (Gutheil, 1989, Corey, Corey & Callahan, 2007) and less on other complex boundary crossings, which to some extent, less noticeable but pose difficulties for clinicians. Though, most psychologist belief that they have a better understanding of boundary issues, using it when working with clients remains difficult. This is made more difficult by the propensity of the legal system, particularly complainants' lawyers, who see any act of boundary crossing as immoral, flawed, and injurious to their clients. Empirical research, advises that boundary violations often go along with or lead to sexual misconduct (Corey, Corey & Callahan, 2007, Gutheil & Gabbard, 1998), but the abuses themselves do not constantly institute misconduct or misdemeanours or even bad method. Moreover, many researchers consider this upshot to be inherently harmful and therefore seen as consistently inhibit or undermine clinical practice (Epstein & Simon, 1990; Simon, 1992). Thus, research advocates that all dual relationships are intrinsically dangerous and clinicians must endeavour to prevent it during practice.

Furthermore, the American Associate for Marriage and Family Therapy (2001) documents that when a dual relationship builds a situation that promotes abuse, the clinician must looked-for a way out or take a safety measures. According to the literature, many definitions are used to explain dual relationship. Some of this is recognized by functions (Doyle, 1997; Edwards, 2007; Kitson, 2007; Nigro, 2003), while others are known by interpersonal closeness (Pugh, 2007). Functional interactions are defined as a situation where clients have an outside contact with a clinician in shared or professional means like community or business affiliation. Also, a relational dual role happens when service users and clinicians develop external relationships due to friendship or other connection that are outside professional practices. The former can happen without the service users and clinicians' knowledge; though, the latter has been revealed to grow with the understanding of the clinician (Borys & Pope, 1989). Besides, psychoanalytic theory also highlights the significance of boundaries and the unbiased position of the clinician. In reference to the traditional analysts, active and proper management of transference and other therapeutic process needs a flawless and reliable boundary that allow the clinicians to sustain the analytic setting of therapy (Langs, 1988). Like many ideas in clinical practice, such as "therapy," "transference," and "association," the concept shows link when observes closely. Therefore, clinical

psychologist needs to understand and take cognisance of the three values that govern the relationship between boundaries, boundary violations, boundary crossings, and sexual misconduct.

To start with, sexual misconduct starts with slight boundary violations. This shows an upsurge incursion into the patient's space and culminates to sexual contact. As mentioned by Gabbard (1989) and Simon (1989), the act of engaging in sexual misconduct takes the following sequence: moving from calling each other the last-name to the first-name ; engaging in the personal or private discussion that hamper professional duty, involving in body contact i.e., pats on the shoulder, massages, and hugging each other; outdoor outing; sessions at lunch; having dinner together, going for movies and any other social event together; and last but not the least engaging in sexual intercourse. Additionally, not all the act of boundary crossings or violations promotes or signifies sexual misconduct. An act of boundary violation of one professional ideology may be a normal professional practice for another. For instance, a "Christian psychiatry movement" might encourage clinicians to attend church service with one or more clients, while some permit an inherent boundary violation that support employing clients in therapy by using them for experiment treatment setting. Though, negative training, messy practice, lapses of judgment, unconventional treatment ideas, and social-cultural condition are all revealed as actions that promote boundary violation, they are not necessarily promoting sexual misconduct or action that pushes professional away from the principle and standard of care. Despite all this aforementioned, professional ethics committee, criminal juries, regulating boards, to mention a few, still see the act of boundary violations or crossings as a probable evidence of, or substantiate accusations of sexual misconduct.

Historically, some psychology school of thought does not see anything bad in inflexible boundary crossing or violation. For instance, studies show that some professional therapeutic leaning permitted inflexible boundaries by using Freud as an example. This school of thought illustrates how Freud himself occasionally sent cards to his clients, borrowed them books, gave out gifts, discusses his personal life with clients, eat with them while on vacation, carried out outdoor analysis and last but not the least, analysed his own biological daughter. This, according to Guthiel and Gabbard formed the basis for emerging research that focuses on "explorations," and developmental framework on *boundary crossings* or *violations* and echoed the authenticities of clinical practice. According to Guthiel and Gabbard (1993), Judgments must base on the following situation and specifics:



*If exploration is to be beneficial, professionals should accept the resolution that*

*"boundary crossing" is a descriptive word, neither admiring nor disapproving.*

*Therefore, judges should determine the effect of a boundary crossing on*

*individual basis with emphasis on context and situational-facts like probable*

*harmfulness of the violation to the client. A violation, then, represents a harmful*

*crossing, a transgression, of a boundary. (p. 190)*

In addition, Gutheil and Gabbard (1993) also look at border crossings and different boundary violations from the context of role, time, place and space, money, gifts, services, clothing, language, self-disclosure, and physical contact. Though, they underlined that border crossing sometimes is salutary, neutral, and harmful", they also concluded that the nature, clinical effectiveness, and influence of a particular crossing "can be measured through systematic consideration of the clinical environment" (pp. 188-189). This argument confirmed the belief that psychology profession is still confronted with how to handle and resolve boundary crossing and dual relationship in clinical practice, particular, in a way that will take into consideration, both the theoretical orientation and contextual situation. This was addressed some years later by Gutheil and Gabbard (1998) in their article title "Misuses and misunderstandings of boundary theory in clinical and regulatory settings".

### **Boundary Decisions in Context**

The theoretical momentous recorded in literature provided a basis for us as a clinical psychologist to decide whether or not it is appropriate to cross a particular boundary with a client at a particular time and for a specific purpose. This can be achieved by carefully observe and analysis the following factors: the context of the therapy, the clinician and client to mention a few. But then, this decision must base on a holistic approach to ethics. Occasionally, this might look difficult, particularly, when we look at the factors such as the intense focus, the historical arguments, and the doubt and worries that follow the boundaries decision, make it appear like boundary decision are a weird and forbidding part of clinical practice, and require a specific guideline and decision different from the general code of conduct of clinical profession. Therefore, approach to boundaries should base on our attitude to ethical decision-making. Research shows that people, sometime do not perceive their actions as having negative implication on others (see, e.g., Rest, 1983). Thus, the following basic assumptions about the ethical awareness and decision-

making were revised from ethics literature (Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2007).

1. As a clinician, ethical consciousness is a constant process that contains constant probing and individual obligation. For instance, conflicts with managed care companies, the intensity of clients' needs, the likelihood of formal criticisms of clients or condemnation by professional co-workers about boundary decision taken, mind-deadening procedures undertaken in the course of our duties, exhaustion, just to mention a few, can have adverse effect on our individual awareness and cloudy our sense of personal obligation. These factors, if not properly consider can overpower, drain, divert, lull us into ethical slumber, and make us more vulnerable to the extent that people around us will start questioning our ability and decision making.

2. Consciousness of professional codes and ethics is a vital feature of critical thinking and ethical decisions. Our professional codes and values enlighten rather than control our ethical judgments. As a psychologist, we cannot substitute this for our emotional and thinking when we face ethical problems. At the same time, they cannot defend us from ethical tussles and doubt that confronted us daily. Besides, we should understand and appreciate individual uniqueness, particularly among clients and therapist, irrespective of their similarities, and appreciate the fact that situation is unique and constantly evolves. Moreover, we should understand that our professional inclination coupled with our community belief, client's orientation, and culture and many other contextual factors influences our perception of ethical decision.

3. The knowledge about the emerging profession and scientific theory and research is another vital feature of ethical competence. The assertions and conclusions from research should not be inactively acknowledged or automatically applied irrespective of their popularity and acceptability. We must receive published statements and recommendation with active and complete enquiring.

4. Though, majority of psychologist and counsellors are reliable, devoted, thoughtful individuals, and dedicated to high ethical standards, but none is infallible. As a human being, we are all prone to mistakes in our professional duties. We sometimes overlook things that are important, make wrong choices in our profession, work from limited viewpoint, make a wrong conclusion, and have a strong view about things that are unwise. We should endeavour to always examine and assess our judgement, i.e., "What if I'm wrong about this? Is there something I'm not seeing? Is there any other way to approach this situation? Is there any other effective or creative way to answer?"

5. As a psychologist, we often find it easier to query the ethics of others -- particularly in a tough and contentious area like boundaries, while placing our own opinions, expectations, and actions of bounds. For us to query the other colleague's ethical decision we must first and foremost, question our own decision and conduct and be ready for others to question us. We must take it as duties to challenge and question our self, as we engage in pointing out weaknesses, flaws, mistakes and ethical blindness observed in other colleagues. This action helps us to be productive and awake to the new challenges and possibilities in our profession.

6. Also, as a psychologist, we tend to question our ability in areas where we are unclear, while, we find it harder to query our self about what we are more certain of or beyond questioning. It will be more productive and beneficial for us as a clinical psychologist, if we ask questions about what we know and follow it to any conclusion. Though, this might take us to a new challenge, it will also make people around us to see our action as "psychologically improper" (Pope, Sonne, & Greene, 2006).

7. As a psychologist, we frequent bump into ethical problems that devour of clear and easy answers. This mostly happens in boundary issues than any other matter. We might be threatened with vast needs that are unsurpassed by adequate resources, conflicting duties that appears difficult to resolve, and other uncountable problems that we face in our duty to help others who are desperate and need care and support from professional like us. We make unnervingly difficult decisions about boundaries "on the spot" due to clients and colleague's unforeseen statement or actions. As a result of this, we cannot run away from ethical challenges, as they are part of our professional call.

8. Last but not the least, as a psychologist; consultation is crucial and paramount in our day -to-day dealing with clients. We sometimes cover by our own personal issues. Thus, turning to other trusted colleagues, particular those who are not involved in our situation helps in building ethical decision-making. Similarly, valuable ideas that are not well-thought-out and unknown biases can be pointed out by colleagues. Furthermore, as we take hard decisions under pressure, we may inadvertently but reasonably become more worried about how the action might affect our duties, for instance, we tend to think that can our action cause us a misconduct suit or accrediting complaint, can estrange us with our dependable referral sources, will it cause us losing our clients or client's provider. Therefore, engaging in consultation help us to reflect our decision's outcomes consequences for those who affected.

9.

### **A Decision-Making Model**

For us as a psychologist to continue to emphasise the significant implication of dual relationship and boundary crossing in clinical practice, a variety of ethical issues must be considered if professional standard is to be maintained. Simon and Shuman (2007) in their contribution to ethical decision making, maintain that a psychologist should always form the habit of upholding applicable boundaries even in the face of working with tough clients and boundary-testing. They continue by argue that in a therapeutic practice, there is neither faultless therapists nor perfect treatment. This statement alone ought to inspire psychologist to be acquainted with their boundaries, as this will make their work easier. This paper used a decision making model to analyse potential dual relationships and the boundary issue in clinical psychology. This model has three advantages that make it appropriate for analysing ethical issues in clinical practice. The first advantage recognised in most literature is that, the model is specifically designed to solve potential dual relationship ethical problems that we confront daily in clinical practice. Secondly, the model is too broad, i.e., provided limited direction for professional and narrow, i.e., explained how clinician should behave. Lastly the model contains all possible dual relationship issues that might happen, irrespective of the situational context.

### **Assumptions**

The decision making model is purposely designed to help professional colleagues to manage their relationships effectively and efficiently, if they realised that they cannot avoid it. The model uses seven assumptions to analyse relationship and boundaries in clinical psychology. As a model that focuses on ethical decision making, it embraces all professional relationships that we undertake in clinical practice. This model is not only limited to interactions with service users, learners, or supervises, it is also applicable to anyone who uses psychological services, irrespective of the kind of support provided. The model believes that as a psychologist, our social role should be professionally oriented, irrespective of our situation and relationship with clients. The model also assumes that, our aspiration as a professional is to avoid any act of dual relationships in all our dealings (APA, 1990). This remains impossible in most situations as we all confronted with multifaceted problems and challenges. This view is supported by Kieth-Spiegel and Koocher (1985) and Haas and Malouf (1989), when they concluded that such interactions is not totally avoidable. Similarly, this supposition is related to the APA Ethical Principles (APA, 1992) and the concept of

overlapping interactions presented by the Feminist Therapy Institute's Code of Ethics (1987).

Thirdly the model assumes that, because of the high inherent risk that clinical psychologist experience daily with client, any interactions with service users must be assessed critically in order to evaluate possible harm. The model assumes that all dual relationships in clinical practice are oppressive by deducing that mostly, engaging in dual relationships come with little or no risk and may be helpful. The act must always be circumvented, if we realise that it might lead to harm. Fifthly, the model also educate on how to manage pertinent issues, and make recommendations for action. The model assumes that professional's problem arises when psychologist anticipate of adding additional relationship to the current one. The model is not planned for circumstances where many relationships exist. Lastly, the model proposes that dimension of any relationship must be measured from the service user's viewpoint, and, not the professionals. As psychologist, we do not have access to the client's feelings in these circumstances, therefore, our decisions must be conservatively done in order to ensure that client welfare are protected.

**The Model**

The decision model is based on three dimensions (Gottlieb, 1986) and they are vital to the ethical decision-making process in clinical practice. The first

dimension observed in this model is power. This is explained as the amount of power that a psychologist wielded in their relationship with the client. Although this is widely varied, the psychologist who gives a talk during community practice has relatively little control over those in the gathering, compare to those that work with clients over a long-term period. Secondly, the time of the relationship, coupled with the aspect of power is relevant. This is because in a psychologist-client relationship, power rises over time. The intensity of power is limited in a brief relationship, i.e., a single assessment session for referral, and increases as the interactions progress, i.e., student and teacher. Thirdly, the clarity of termination means that the client and the clinician might engage in a further professional contact. For instance a psychological assessment with a job seeker involves a clear-cut termination, with little or no additional contact. Conversely, a clinical psychologist working with family, sometime beliefs they have a long-term obligation to their client. The question is how can we terminate a professional relation in clinical practice? This model indicates that, a professional relationship with clients continues until the client thinks otherwise, irrespective of the time or contact in the interim. As soon as the psychologist realise he/she does not understand how the clients feel, the ethical choice is to accept that the client has the right to recommence the professional connection in the future.

<b>Table 1 - Dimensions for Ethical Decision-Making</b>		
Low Power	Mid-Range Power	High Power
Little or no personal relationship Or Persons consider each other peers (may include elements of influence).	Clear power differential present, but the relationship is circumscribed.	Clear power differential with profound personal influence.
Brief Duration	Intermediate Duration	Long Duration
Single or few contacts over short period of time.	Regular contact over a limited period of time.	Continuous or episodic contact over a long period of time.
Specific Termination	Uncertain Termination	Indefinite Termination
Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again.	Professional function is completed but further contact is not ruled out.	No agreement regarding when or if termination is to take place.

### Application of Decision-Making Model

Decision making model can be applied to clinical practice, particularly, when a psychologist is considering on having an additional relationship. This can be achieved through the following process:

1. The psychologist needs to appraise the present relationship by using the following dimensions. i.e., from the client's angle, where do the relationship lies on each? How pronounced is the power difference, for how long is the relationship, and has it evidently over? If the relationship takes the right side on two or three of the scopes (i.e., upper power, lengthier period and no end), the probability of danger is higher, therefore, the clinician should not attempt to create any other relationship on the existing one. However, for family, group or individual psychologist, the circumstances are clear. For them, the power differential is boundless, the therapy session can be extensive, and ending such session is not explicit. Besides, the client might believe it is their right to come back for treatment any time they want in the future. For instance, some families may perceive a psychologist the way they see a family physician by thinking that he/ she will always be accessible anytime they need a service. In such circumstances, the general belief that a professional-client relationship does not ends is correct. On the other hand, if the relationship lies on the left flank of the three dimensions (i.e., less power, less period, and clearly ended), one can shift or move down to the subsequent level. But, in a situation where a relationship lies in the middle of the three dimensions, some kinds of extra relationships are allowed, so, the psychologist can possibly move down to the subsequent level.

2. The Psychologist must observe the anticipated relationship base on the three dimensions analysed in the present interaction with clients. If the expected relationship cascades to the right side of the scopes (i.e., leading to long and indeterminate end), then such relationship must not be jettisoned, particularly, in a situation where the present relationship also cascades to the right. On the other hand, if the projected relationship falls in between the middle and the left side of the scopes, the rapport can be allowed and the psychologist can proceed to step three. For instance, a psychologist might ponder about going into a relationship with a family 'client she has worked with before that need no further engagement. In this situation, the clinician has enormous power that is short-lived and last for a definite period, and thus makes closing the professional rapport more explicit. The new rapport, though, having unstated and unclear length and termination, comprise little or no power difference. In contrast, if the first relationship falls to the left part of the dimensions, and the anticipated relationship fall to the right side, the relationship can

be promoted and allowed, i.e., a psychologist could ponder about assessing a child that he or she has previously engaged with the parents

3. The Psychologist must look at the relationship for any role incongruity if they fall in-between the middle or the left side of the dimensions. According to Kitchener (1988) role incongruity arises as a result of the following: higher differences in anticipations of the two roles, greater divergence of the duties of the two roles, and last but not the least an upsurge in the power disparity. However, whenever the two diverse roles look highly unsuited, the clinician should endeavour to reject or abandoned the expected relationship. For instance, a clinical psychologist must not take member of staff as a transitory psychotherapy client. But, if the relationships fall in the middle, or left side of the sizes, and the level of unsuitability is small, the clinician can continue with the relationship. For example, a psychologist might consider one of his employees as a participant in an assessment process he or she is supervising. A psychologist, who worked with a drug addicted man before, might consider working again with him and his spouse for conjugal problems.

4. Clinical psychologist must be ready to engage professional colleague in consultation. In line with the seventh assumption, the new relationship must be measured from client viewpoint, and judgements must be done in a conservative manner. Meeting with a professional colleague must be seen as normal, when making such judgements. A colleague who is used to such situations, i.e., the service user, and the decision-maker is the perfect choice for professional consultation. For instance, an associate might view it ill-advised that a recently divorced, troubled, male medical training supervisor agrees a date from one of his female interns.

5. It is also imperative to state that as a psychologist, we must engage clients in decision making, if he or she decided to continue with the extra relationship. The Psychologist must assess the following factors, the importance of the decision-making model, its justification, the relevant ethical questions, obtainable options, and lastly, likely adverse implications as an element of informed consent. For Instance, if the client is capable, and decide to involve in an additional relationship, the clinician can continue, once the service user is given ample time to think about the other options. If the service user /client fails to aware of the quandary or are reluctant to ruminate on the matters before making a choice, he or she is seen as at risk, and the anticipated relationship should be forbidden.



**Case Study 1**

Dr Badmus is a clinical psychologist working in a private psychotherapy clinic. A young lady in her middle twenty was referred to her for relationship issues. After working with her for 3 months, the client thinks that her problems are over and after discussing with the psychologist, they both agreed to end the therapy. Three years later the client and the psychologist, coincidentally, met again at a get together party. They both had a lengthy discussion and at the end of the day, they exchange address and the client asked the psychologist if they can meet again. The clinician responded and quickly pointed out that he would have loved to take her out, but due to their past professional contact, he would not be able to do so. To buttress his point, he told her that such relationship would affect any future professional consultation she might need from him. She agreed with him, and suggested that if there is any need for future consultation, she would not mind him referring her to a professional colleague. Though, they went out together for quite some time, the relationship did not last long. Two years after ending their social relationship, she called the psychologist and requested for service. The clinician declined the consultation by mentioning their last discussion at the party and offered to refer her to a professional colleague. She immediately gets annoyed with the suggestion and bangs the phone. Since then, there has been no contact between them.

**Case Analysis**

Many people would contend that Dr. Badmus took a good decision the way he handle the situation. He was conscious of the danger that may follow his friendship with a former client. Besides, he was even aware of the informed consent processes in the hub of a social event. But, if all his action is right, then, what is the problem? By using the model to analysis the scenario, it shows that Dr Banda had a rapport with high power of intermediate period and a seemingly exact termination. The model also disclose the effect of great role unsuitability when counsellors get involved in a social relationship with former clients. Moreover, Dr. Banda should have considered the client's need in these circumstances. Though, agreed with her, the clinician failed to observe and analyse the intended relationship from the client's perspective. Additionally, the model recommends a waiting period and discussion with a professional colleague. Supposing Dr. Banda, followed the principle of the model to the end, he might have re-evaluate the situation.

**Case Study 2**

Dr. Titus is a private clinical psychologist practitioner; one day he was having a psychotherapy session with a young lady who was having a relationship problem. During the therapy session, the young lady told the clinician about her problem in keeping a long term relationship with the opposite sex. She told the psychologist that since the death of her husband, she has not been able to hold a relationship for a long period. Some week later the client called Dr Titus and reminded him of their conversation and asks if he can recommend somebody for her. As a result of their conversation, Dr Titus decided to consult a trusted professional colleague for advice. After his consultation with a professional colleague, Dr Titus called the client and decline further consultation with her.

**Analysis**

In analysing this scenario, some might think Dr Titus action is conservative. The client is a mature lady who has a right to make a decision. The model demonstrates that the power differential was in the middle, of unknown closure and perhaps of long period. Dr. Titus recognized that as long as the power differential is sustained, the inharmoniousness in the role would continue. The discussion had shown additional information critical to his decision. Dr Titus understood that if he went ahead and introduce someone to the client and they start a relationship, she might feel indebted to him and susceptible to potential manipulation. Had the relationship failed, the client might displace or have hostile feelings towards him, and this may have an impact on their future professional conduct together. Moreover, Dr Titus followed the model recommendation for a waiting period and discussion with a professional colleague and this go a long way to help him make a positive decision which eventually useful in his decision making.

**Discussion and conclusion**

Though the American Psychological Association (APA) came out with elaborate ethical values and principles that guide the professional conduct of its members, there still a lack of comprehensive, systematically gathered data about the degree to which members believe in or comply with these guidelines. Research has long identifies lack of broad and scientifically generated data on psychologists' beliefs and compliance with ethical principles as the bane of the profession. Such information, as important as they are, are not available to guide individual clinical psychologist in their decision making or the APA in their efforts to review, improve, and spread the code of practice. For instance, evidence till date, still shows

that little is known about the valuable experience needed in regulating appropriate conduct in clinical practice. As mentioned in most of the ethical literature, the practicability of boundary issues remains unsolved in clinical practice. Although the ethical principle offered common guidelines for clinical psychologist, little or no guideline is offered when comes to decision making. This paper describes the relevant steps that psychologist must followed in the course of making a professional decision, and defines a decision- making model that helps psychologist making professional judgement. Though the model is relevant to psychologist, there still some issues that need to be solved if professionalism is to be sustained.

The question is, should we engage former psychotherapy clients in social relationship? Even with clear evidence that shows that the service has ended. Studies prove that in such situation, power differential remains, particularly when the client's belief he /she can come back for further service. If this arises, make relationship with such client untenable and unwise. However, other social interaction may be less challenging. For instance, one may positively consider honouring an invitation from a former teenage psychotherapy client to the pub, if the matters were deliberated in the way labelled above. Psychologist faces similar nettlesome conditions when they had middle to long-term personal contact with clients and interns. For instance, in the beginning, the power differential is pronounced, and contacts may go on for ages, and then develop into peer, friendly, companionable or passionate ones. In this case, it is advisable that psychologists must be aware of the statement illustrated earlier, that the scope of the relationship must be viewed from the client's perspectives. Thus, it is not sufficient to conclude that the approved professional rapport is reaching termination. Finally, as good as a decision making model is to clinical practice, it still lacks empirical validation. So, for it to be properly applied in clinical practice, it required a subtle professional judgement as well as careful and thorough reflection from a clinical psychologist. It is also worth mentioning that consultation is an important ingredient in the decision-making process. There is still no alternative to professional consultation of trusted colleagues.

### Recommendation

As the decision whether or not to cross a borderline threaten us every day, they often subtle and influences the progress recorded in the therapy. Although dual relationships sometimes enhanced therapy, aids the treatment strategy, and promotes the clinician-client working relationship; it also weakens the treatment process, hampers the clinician-client

cooperation, and brings instant or lasting damage to the service user. At the individual level, psychologists must take cognisance of their individual and professional needs and be self-care. They must endeavour to achieve those needs without allowing it having bearing on their relationships with clients. Based on these analyses, this paper recommends that: 1) professionals should position themselves and make sound choices by coming up with a strategy on boundary crossings that focus on their general attitude to ethics. 2) Efforts must be directed toward staying up-to-date with the evolving law, ethical values, research, concept, and practice procedures. 3) Before taking any decision, a psychologist must take into consideration the situational context of each client. 4) Clinical psychologist must involve in critical thinking devoid of common cognitive blunder that can affect clinical duties. 5) Efforts should be directed toward avoiding personal responsibility for our decisions and we should justify our choices and conduct. When we realise our mistake or notice that our boundary choices have led to woe, we should apply accessible means to come up with the best solution to solve the problem

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