ETHICS OF MULTIPLE RELATIONSHIPS IN JUDEO-CHRISTIAN COMMUNITIES

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Multiple role relationships occur when a professional assumes two or more roles with the same person. In faith-based communities, multiple relationships among the clergy and members of their congregations are an inherent and unavoidable aspect of a cleric's responsibilities. The term *congregation* is used here to include actual congregations, chavurot (Hebrew for communities that function like a congregation), synagogues, churches, parishes, assemblies, and other ecclesial bodies. *Clergy* are religious leaders such as priests, rabbis, ministers, and so forth. In Jewish tradition, for example, a religious leader may be a rabbi or hazzan (cantor).

Multiple relationships may take other forms in faith, religious, and spiritual communities when members request the professional services of licensed mental health professionals (MHP) who are fellow congregation members. These MHPs may be sought *because* their fellow congregants know them and trust them. These professionals may share, or at least may be perceived as sharing, many of the same beliefs, values, and practices. A professional's affiliation with the religious community itself may be regarded by some members of the community as a standard of professional competence. For example, developing "a strong link with a local church" is described by Butman (1997, p. 69) as one of 10 guidelines for improving the competence of Christian clinicians. The overlapping relationships of therapists and fellow congregants are not uncommon in some Christian and Jewish communities. In such settings, the therapist and client may co-attend some of the same sermons or small groups in their congregation. They might attend the same religious classes, discussion groups, and other community activities and festivities. Therapists and clients might interact with each other outside the consulting rooms if their children are involved in the congregation's youth activities. Therapists and clients in these communities might even find themselves in each other's homes when religious activities or events groups take place in their homes.

If good fences make good neighbors, as the adage goes, then good boundaries make a firm foundation for a good relationship in counseling and psychotherapy. A *boundary* is the edge, limit, or dividing line of appropriate behavior in a given situation (Gutheil & Brodsky, 2008). Psychotherapists make a distinction between boundary crossings and boundary violations. A *boundary crossing* is a change in role or a departure from a commonly accepted practice that could potentially benefit a client, whereas a *boundary violation* is an ethical breach that harms or exploits the client at some level (Gutheil & Gabbard, 1993). Boundary violations are always unethical, whereas boundary crossings are not necessarily unethical. It is boundary violations that exploit, harm, or take advantage of a client that are unethical. The traditional conservative perspective (e.g., Gutheil & Gabbard, 1993; Pope, 1990) is that boundary crossings erode the edge or dividing line of appropriate behavior, thereby increasing the potential for boundary violations. One way to avoid boundary violations is to avoid the slippery slope of boundary crossings. For example,

many psychotherapists have policies against accepting a client's invitation to a special event such as graduation ceremonies or weddings. On the other hand, the existence of the slippery slope itself has been questioned and it may not be as slippery or as steep as many have feared (Gottlieb & Younggren, 2009).

The counterpoint to the conservative ethical perspective is that some boundary crossings not only cause no harm but in fact may provide some benefit to the client. Zur (2004) provides several examples of potentially beneficial boundary crossings such as if a therapist were to "escort a client to visit a gravesite or a place that held special meaning for the client and their deceased loved one in order to facilitate the grief process" (p. 28). Zur (2007) has argued that some boundary crossings benefit the client by enriching the therapeutic relationship in ways that would not be possible if confined only to the office setting. This idea is articulated in the words of a counselor who had been the former client of a therapist who attended the same church:

> In my case, it worked well, but my therapist was clear from the beginning that things are different when client and therapist are in the same church and both parties are in leadership. However, there was something really beautiful about the dual relationship, because I knew her as a therapist, a leader, a pray-er, and a worshiper. She knew me as a client, a leader, a pray-er, and a worshiper, and she got to see me in the context of my friendships and with my family. So, while I'm sure there are many, many cautions, there was also a multidimensional aspect to our relationship that we wouldn't have experienced any other way (H. Hunnicutt, personal communication, May 07, 2015). [1]

Multiple Relationships Defined

Multiple relationships occur when a professional assumes two or more roles at the same time (concurrently) or at different times (consecutively or sequentially) with a client or with someone who has a significant relationship with a client. The more traditional term *dual relationships* is often preferred over the broader term multiple relationships. In reality, most boundary crossings involve a duality, rather than a multiplicity, of roles. Even when multiple roles are involved, there must be a dual role before there can be multiple roles. In other words, there must be two roles before there can be three or more. *Role blending* is a dual relationship that involves having two or more professional roles with the same person, often at the same time (concurrently) but in some cases at different times (consecutively). Role blending involves two professional roles (e.g. a teacher and a supervisor in a training program), whereas other dual relationships involve one role that is professional and another role that may be non-professional (e.g., social, financial, political). In other words, role blending involves a specific type of dual relationship in which both roles are professional.

Foreseeable and unforeseeable dual roles. Dual roles can differ in terms of their foreseeability and can be classified as either foreseeable or unforeseeable. *Foreseeable* (or contemplated) dual roles are those that the therapist has time to consider or contemplate before engaging in them. An example of a foreseeable dual role would involve considering whether or not to provide counseling to someone with whom the practitioner has a current or prior relationship in a religious community. *Unforeseeable* (unpredictable or random) dual roles are those that cannot be

reasonably foreseen. An unforeseeable dual role might involve joining a religious community and then later learning that one of the members of this community is a current or former client. Of course, if the practitioner had possessed prior knowledge that his or her psychotherapy client was a member of the religious community, then the subsequent dual role would have been reasonably foreseeable. In the case of unforeseeable dual relationships, APA (2017) Ethical Standard 3.05(b) states, "If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code." Resolving the dilemma of duality may include several options such as discussing the matter with the client, consulting with a colleague, considering termination of the secondary role, considering termination of the primary professional role, and so forth. Regardless of the options, the ultimate ethics question is, "What is in the best interests of the client?"

Concurrent and consecutive dual roles. Dual roles can be conceptualized in terms of temporality and can be classified as either concurrent or consecutive in time. *Concurrent* (or simultaneous) dual roles exist when a therapist has two roles at the same time with the same client or with a person who is in a significant relationship with the client. In other words, it occurs when two roles occur simultaneously. An example of a concurrent or simultaneous dual role might involve a therapist providing family therapy and then learning that one of the members of the family is currently in the therapist's religious discussion group. *Consecutive* (or sequential) dual roles involve a prior relationship that involves either a professional or nonprofessional role followed by the development of a second relationship at a later point in time. Consecutive dual roles can take several forms. Examples of consecutive or sequential dual roles might involve joining a church or synagogue and later learning that one of the congregants is a former client, or having a former client join the congregation in which the therapist has already been an established member. In these scenarios, the professional relationship is primary and then the religious community relationship develops secondarily. In other scenarios, the affiliation in a religious congregation might occur first. For example, a psychologist might be providing psychotherapy to a young adult who begins dating a person with whom the therapist already has a relationship within the same congregation. With respect to these various types of dual roles, it is the concurrent dual role (foreseeable or not) that is the most relevant for the purpose of this discussion.

Professional Ethical Standards

Multiple-role relationships occur when a professional assumes two or more roles, either concurrently or consecutively, with a client or with someone who has a significant relationship with a client. This definition is more inclusive and more stringent than the narrower description provided by the American Psychological Association (APA; 2017) Ethical Standard 3.05 (Multiple Relationships), which states the following:

> (a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated

> with or related to the person with whom they have the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person associated with or related to the person.
>
> A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
>
> Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.
>
> (b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.
>
> (c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

In contrast to the APA's definition of multiple relationships, the American Counseling Association (2014) Ethical Standard A.6.b. (Extending Counseling Boundaries) does not refer to multiple relationships at all. Instead, the ACA uses the term "boundary extensions" to include potentially beneficial boundary crossings. This term replaces the more permissive term "potentially beneficial interactions" (ACA, 2005, p. 5) that was used in an earlier edition of its ethics code. Implicit in these terms is the assumption that boundary extensions may be a part of counseling. Examples include "attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital" (p. 5). Such interactions are not inherently unethical, but rather are described as ethically justifiable extensions of the counseling relationship beyond its traditional boundaries.

Whereas ACA (2014) Ethical Standard A.6.b. (Extending Counseling Boundaries) addresses foreseeable concurrent dual relationships, ACA Ethical Standard A.6.a. (Previous Relationships) addresses foreseeable consecutive dual relationships. In both cases, such dual relationships can be contemplated before entering into them. ACA Ethical Standard A.6.a (Previous Relationships) states the following:

> Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a professional association, organization, or community. When counselors accept these clients, they take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs. (2014, p. 5)

The American Association of Christian Counselors (AACC; 2014) uses the traditional term *dual relationships*, which are defined as

relationships involving "the breakdown of proper professional or ministerial boundaries" (p. 17). Contained in Ethical Standard 1-140 (Dual and Multiple Relationships) is an underlying implication that dual relationships are improper because they can increase the potential for exploitation. The implied unethicality of dual relationships is made more explicit by reference to a breakdown of proper boundaries:

> Dual relationships involve the breakdown of proper professional or ministerial boundaries. A dual relationship exists when two or more roles are mixed in a manner that can harm the counseling relationship and/or the therapeutic process. This includes counseling, as well as personal, fraternal, business, financial, or sexual and romantic relationships. Not all dual relationships are necessarily unethical—it is *client exploitation* that is wrong, not the dual relationship in and of itself. However, it remains the responsibility of the counselor to monitor and evaluate any potential harm to clients. (AACC, 2014, p. 17)

The AACC code of ethics contains an explicit prohibition against counseling fellow congregants when there is a close relationship. Ethical Standard 1-140-f (Counseling with Fellow Church Members) also contains a burden of proof on the part of the counselor to justify dual relationships with church members:

> Christian counselors do not provide counseling to fellow church members with whom they have close personal, business, or shared ministry relations. Dual relationships with any other church members who are clients are potentially troublesome and best avoided, otherwise requiring justification. Pastors and church staff helpers should take all reasonable precautions to limit the adverse impact of any dual relationships. (AACC, 2014, p. 18)

McMinn and Meek (1996, pp. 28-35) reported results of a survey of members of the AACC. Of the 498 AACC members who responded to the McMinn and Meek survey, 77 were also members of the Christian Association for Psychological Studies (CAPS). McMinn, Meek, and McRay (1997) reported a comparison of responses to the 88-item survey between the total sample and the CAPS members. The reported behavior patterns were very similar to the patterns previously reported from the landmark survey of professional psychologists (Pope, Tabachnick, & Keith-Spiegel, 1987). Gibson and Pope (1993) reported results of a national survey similar to the Pope et al. (1987) survey but with data from a sample of 579 counselors certified by the National Board for Certified Counselors (NBCC). A limitation of the study was that the participants were questioned only about the perceived ethicality of the behavior and confidence of their judgment, but they were not questioned about the frequency of occurrence of the behavior in their actual practices. As Gibson and Pope (1993) emphasize, "Beliefs are not necessarily indicative of behavior" (p. 335). Neukrug and Milliken's (2011) survey of ACA counselors indicated that "attending a client's wedding, graduation, or other formal ceremony" was described as ethical by 72.1% of the respondents. However, there were no survey items related to dual relationships between MHPs and fellow congregants. None of these surveys specifically addresses the questions of how therapists view the ethicality of providing professional services to fellow congregants or how often therapists engage in these practices. There appears to be a paucity of evidenced-based literature on which therapists can base

decisions regarding dual relationships among therapists and their fellow congregants.

Sanders (1996, 2013) delineates a number of variables that should be considered when dual relationships arise in religious communities. Although Sanders specifically addresses Christian counselors and therapists, his model may have utility to practitioners from other faith traditions. These variables include the divergence of the obligations of each role, the locale and availability of other practitioners, the nature of the presenting problem, the type of treatment needed to resolve the problem, the power-prestige differential, potential confidentiality problems, and the ability of each party to define and maintain appropriate boundaries. These variables provide some considerations for practitioners who desire a systematic model for ethical decision making.

Lazarus and Zur (2002) emphasize that duality in relationships should not be confused with exploitation. Dual relationships are not necessarily unethical; it is client *exploitation* that is unethical. Exploitation occurs when a professional, who is in a fiduciary relationship with a client, takes advantage of the client in order to benefit the professional. Yet as Tomm (1993) has pointed out, "It is not the power itself that corrupts; it is the disposition to corruption (or lack of personal responsibility) that is amplified by the power" (p. 11). Nevertheless, the potential for exploitation, loss of objectivity, or loss of effectiveness can increase when therapists blend their professional relationship with other kinds of relationships.

Conflicts Checklist

In plain English, dual roles, multiple relationships, and boundary extensions involve concepts that prospective clients understand as *conflicts of interest*. This term is often more easily used when discussing the potential problems of engaging in multiple roles with clients. APA (2017) Ethical Standard 3.06 (Conflict of Interest) states, "Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation." A conflicts check may improve one's ethical vision by assessing whether a contemplated role change will pass the ethical test. Based on APA (2017) Ethical Standard 3.06, a conflicts check includes five basic questions, listed in order from the most sensitive to the least sensitive screening criteria:

- Is there a chance of *loss of effectiveness* of the professional? If yes, then stop. If no, then proceed to the next step.
- Is there a chance of *loss of objectivity* of the professional? If yes, then stop. If no, then proceed to the next step.
- Is there a chance of *loss of competence* of the professional? If yes, then stop. If no, then proceed to the next step.
- Is there a chance of *risk of exploitation* of the client? If yes, then stop. If no, then proceed to the next step.
- Is there a chance of *risk of harm* of the client? If yes, then stop. If no, then proceed with caution after consulting with a colleague to determine the client's best interests and to identify any ethical blind spots on the part of the professional. (Doverspike, 2015, p. 194)

Decision Making Model

Some professionals believe that flexibility in managing boundaries can provide benefits to some clients when reasonable standards are applied ethically and on a case-by-case basis (Knapp & VandeCreek, 2012; Herlihy & Corey, 2015). When considering whether to become involved in a concurrent dual relationship, there are several questions that practitioners should be able to answer before proceeding with a secondary role. With respect to foreseeable dual roles, this model operates on the assumption that the primary relationship is within the faith community (i.e., fellow congregants) and that the contemplated secondary relationship is a professional one (i.e., therapist-client).

- **Institutional prohibitions:** Does the religious institution itself have a policy regarding the provision of professional services to fellow congregants? If the religious institutional policy prohibits such provision of services, then a practitioner who is a member of that congregation should not enter into the secondary professional role with that congregant or that congregant's significant others.

- **Activity of practitioner:** How active, devout, or observant is the practitioner within his or her religious affiliation? Professionals who attend services only at religious holidays will be less likely to have extra-therapeutic encounters than practitioners who attend weekly or daily. Similarly, professionals who hold leadership positions within their congregations may have actual or perceived influence and power over the congregants. Some leadership roles involve more perceived power than others. Lay leaders are also more likely to have regular encounters with fellow congregants, which can complicate considerations of therapeutic involvement.

- **Activity of client:** How active, devout, or observant is the congregant (i.e., the former, current, or prospective client) within his or her religious affiliation? Prospective clients who attend religious services only at holidays may be less likely to have extra-therapeutic encounters, whereas those who regularly attend services or small discussion groups will be more likely to have such encounters outside counseling sessions.

- **Publicity of observance:** Where does the primary role occur on the continuum between publicity and privacy? Attending a large religious ceremony open to the public would not be considered controversial, whereas attending private religious events within the home of a client might create an appearance of impropriety. For example, attending an occasional Bar Mitzvah at a synagogue places a Jewish marriage and family therapist at less risk of client contact (i.e., with a member of the congregation) than attending a weekly Torah study group or an annual Passover Seder (e.g., in the home of the congregant).

- **Formality of observance:** Where does the primary role occur on the continuum between formality and informality? Formal religious ceremonies have more structure and therefore may be less problematic in terms of boundary management, whereas informal gatherings have less structure and therefore less clearly defined role expectations. For example, attending weekly Mass in a large Roman Catholic parish places a Catholic social worker at less risk of client contact (i.e., with a member of the parish) than attending a daily or even weekly Rosary in the same parish. Similarly, occasional attendance at a Sunday morning worship service of a megachurch would be different than attending a weekly Bible Study Group with four other couples.

- **Orientation of therapist:** Is the possibility of entering into a secondary psychotherapeutic role consistent with the practitioner's theoretical orientation? If not, then consider avoiding the secondary role. For example, engaging in a dual role would be incompatible with a traditional psychodynamic framework, whereas the same dual relationship might be more justifiable for a school psychologist working from an educational perspective.

- **Boundaries of therapist:** How well is the practitioner managing clear boundaries and maintaining therapeutic neutrality in his or her personal and professional life? If the practitioner is already having trouble managing boundaries in his or her own life, then consider avoiding the secondary role. For example, a professional counselor struggling with a personal addiction and a recent drug-related legal problem might have more difficulty working with an adolescent substance user than would an experienced certified addiction counselor (CAC) who has two decades of sobriety.

- **Boundaries of client:** How intact are the client's boundaries, reality testing abilities, and levels of functioning? Are there any clinical contraindications regarding entering into a secondary role? Are there any indications that the client might feel exploited or otherwise misinterpret the therapist's secondary role? For example, a failing college student with obvious emotional, dramatic, and erratic personality traits might require more intensive boundary management than would a more stable college graduate seeking a few sessions related to career guidance or choice of job offers.

- **Availability of practitioners:** What is the availability of other practitioners in the local geographic area? As a general rule, the greater the availability of other qualified practitioners in the community, the greater the burden on the therapist to provide a rationale for becoming involved in a dual relationship. Conversely, in sparsely populated areas where there may be few or no practitioners, such as some rural communities, a therapist may have a stronger argument for maintaining multiple relationships within the

geographic community. Regardless of location, therapists who are isolated often make the mistake of thinking of themselves as "the only game in town."

- **Prevailing practices:** What is the prevailing practice within the local professional community? In general, the more prevalent the practice of dual relationships, the less likely the secondary role will be perceived as inappropriate. However, an important caveat is that prevailing professional practices within a community do not determine the *ethicality* of such practices. Instead, prevailing practices reflect the *prevalence* of such practices.

- **Professional opinions:** How well can the practitioner defend his or her actions if these were to be disclosed to the practitioner's most respected professional peers? Reading one's written description of the actions that are being contemplated can assist a practitioner in making an appropriate decision. An even better strategy would involve reading one's licensing board's description of a practitioner's actions. A therapist can imagine how he or she would feel if reading the proverbial front page headline describing an action taken with a client.

- **Best interests of the client:** What is in the best interests of the client? Remember that the best interests of the client are the cornerstone ethical principles that underlie all of these guidelines.

Case Scenarios

For purposes of illustration, the following case scenarios highlight the need for a conflicts checklist and decision making model when considering fellow congregants as prospective clients. These cases reflect various combinations of the dimensions of foreseeability and temporality. These case examples represent fictitious cases, known as *composite cases*, which are based in part on compilations of trends observed in actual cases. Background information, demographic data, and names have been changed to ensure anonymity.

New Neuropsychologist in Town. Dr. Ruth is a recently licensed psychologist who has just completed her second year of post-doctoral training in geriatric neuropsychology. She moved back to the city where her parents have been living for many years. Dr. Ruth's grandfather was a founding member of a local Reform Jewish congregation where Dr. Ruth's parents are regarded as prominent leaders. Her father is a former president of their congregation. Dr. Ruth herself is not observant, although she occasionally attends services with her parents. She was recently approached by Esther, an age-peer congregant who had heard about Dr. Ruth's recent relocation. Esther asked whether it would be possible for Dr. Ruth to provide a neuropsychological assessment of her grandmother. Esther's grandmother has shown some signs of cognitive decline and her personal physician had recommended a neuropsychological evaluation. As Dr. Ruth began her diagnostic interview, she noticed several bruises on her patient's face and arms. Upon further inquiry, the patient described several recent incidents in which her daughter-

in-law (i.e., Esther's mother) had reportedly become angry and had pulled her arms and slapped her while assisting with dressing. Dr. Ruth suddenly felt the hair on the back of her neck rise as she realized that she might have a mandated reporting duty in response to her patient's allegations. She asked herself how this unforeseen development might affect her relationship with her age-peer, Esther. As Dr. Ruth thought about it further, she began wondering how a mandated report of suspected physical abuse of an elder person might affect her parents, her parents' relationship with the other congregants and, most importantly, her patient's welfare within their community.

> **Comment:** Although Dr. Ruth did not foresee this ethical dilemma, the regularity of activity and the prominence of her parents within a close knit community might have suggested that there may not have been sufficient degrees of separation to insulate her patient from being placed in an awkward position with respect to Dr. Ruth's relationship to her parents and others in the community.

Helpful Hannah. Hannah is a clinical social worker employed in the pediatric section of a local hospital. She also maintains a lay leadership position as an Elder in an ecumenical Christian denomination. She was recently approached by her pastor, who asked whether she could provide transportation to one of the congregation's members, Mary, who was scheduled to undergo outpatient transcranial magnetic stimulation (TMS) at the same hospital. Always willing to serve others, and after consulting with her pastor who discerned no conflict of interest for Hannah, she agreed to provide transportation. During the first week, the daily one-hour commute seemed to work well. At the end of the second week, the commute seemed a little too close for comfort. By the third week, the relationship seemed to morph into a hybrid relationship that was "partly friendship and partly professional" (Goldin, 2002, p. 414), with Mary doing most of the talking and Hannah doing most of the listening. At the end of the third week, Hannah received a text message that Mary wanted to kill herself because things were not getting better as she had hoped. Hannah quickly responded with a text message (i.e., "call 911") as she drove to Mary's house, only to find that Mary was reportedly "out on the town with friends." The next morning, Hannah was startled to find an email from Mary exclaiming, "You're no counselor. Get out of my life." Hannah became even more concerned when she learned from her pastor that Mary had sent the email blast to a listserv of church members.

> **Comment:** Although Hannah's secondary role may have been clearly a non-professional one within the defined boundaries of her role as a lay minister, her identification as an MHP may have made it easier for a fellow congregant to misinterpret the service she was providing. Hannah may have contributed to this perception through her own interactions with the congregant. Hannah may also have contributed to her own confirmation bias of no conflict of interest by "consulting" with someone who was neither a neutral party nor a mental health professional. Hannah may have had a blind spot that would have come into clearer focus had she sought a more objective consultation with a peer. With respect to her willingness to always serve others, perhaps another MHP in the same faith tradition could have reminded Hannah that even Jesus did not heal every person in Nazareth (see Mark 6:5).

Mindful Mandy. Dr. Mandy is a psychologist who is a member of a non-denominational Christian church. One Sunday, she attended a

Sunday School class where the guest speaker was discussing meditation and mindfulness from a Christian perspective. Knowing Dr. Mandy as a casual acquaintance, one of the members of the class scheduled an appointment at Dr. Mandy's office the following week. Discovering this development only when she met her prospective client in the waiting room, Dr. Mandy was at first taken aback but she decided to at least determine why the person had scheduled. The woman said that she was not seeking any counseling, but rather she only wanted to meet a few times to learn about some meditation and mindfulness techniques. She said that she understood that these services would not be covered by her insurance and she was willing to pay for "some lessons in mindfulness."

> **Comment:** The casual acquaintance's specific request regarding "lessons" rather than "counseling" may allow the psychologist to create and manage realistic expectations within a time-limited framework. However, only an initial interview, which would thereby create a professional relationship, can reveal whether or not the client's request is the proverbial tip of the iceberg with respect to deeper concerns.

Torah Study Group. Dr. Naamah and her husband have been members of a Torah Study Group for two years. The group meets weekly at their synagogue and consists of six middle-aged married couples who read the weekly Parsha. They are currently studying Shemot (the Book of Exodus) and its application for living in today's world. Each month, one couple in the group also hosts a "supper for six" at their home, where the dialogue often diverges into discussions ranging from politics to raising their teenage children. Unexpectedly, a former client shows up at the weekly meeting at the synagogue. Dr. Naamah is surprised but maintains her usual composure and does not verbally acknowledge the new couple who are visiting the class. Dr. Naamah does not say anything to her husband, Solomon, but instead she silently struggles with what to do about this new couple who she had seen in marriage counseling six months earlier. She seems to recollect that they had dropped out prematurely after two sessions with some unresolved matters in their relationship. The following week, she receives a phone call from the wife of the couple, who reassures Dr. Naamah that there is no problem, that their marriage is fine now, and that they have been looking for a new study group and believe they have found it this past week. During the next week, Dr. Naamah finds herself struggling with whether to withdraw from the group.

> **Comment:** Dr. Naamah's struggle is not only with whether to remain in the class. Her real dilemma involves how to protect the privacy of her former clients, regardless of whether she remains in the group. If she remains, she faces the task of monitoring her self-disclosures to some of her closest friends. If she withdraws, she faces the dilemma of how to withdraw without drawing attention to her former client and while protecting her client's privacy. Either way, she still faces the uncertainty of how to respond if her former clients should want to continue with their unfinished business of marriage counseling.

The Pastor's Wife. Paul is the only licensed professional counselor in a small rural town. There are a few other therapists within a 50 mile radius but none of them are on managed care panels. Paul is also active in his local Baptist church. The minister's wife, Lydia, called him and asked for an appointment because of a recent panic attack in the absence

of any history of emotional problems. Knowing Lydia as a strong woman whose emotional stability was obvious to the whole community, Paul did not hesitate to schedule an appointment for her. During the initial interview, Lydia's description of a few limited symptom anxiety attacks appeared to be without any precipitants. She responded well to some simple cognitive behavioral coping skills that seemed more like an educational approach than a psychotherapeutic one. One Monday morning, however, Lydia arrived in a somewhat distraught mood and disclosed that she and her husband had been having increasingly frequent arguments at home. She wanted some reassurance from Paul that this information would be kept strictly confidential, which prompted Paul to say, "What you say here will stay here." Lydia then disclosed that she and her husband had been experiencing a great deal of conflict regarding money. Unexpectedly, Lydia revealed that last year her husband had taken money from the church funds that are dedicated to mission work. She said she thought Paul should know because he is the new chair of the Mission Committee.

> **Comment:** Paul mentally kicked himself when he realized that his client's disclosure did not rise to the level of any ethically or legally justifiable report to any third party. As a licensed professional counselor, Paul realized that he was also a guardian of the protected information that his client had shared with him. At the same time, Paul was aware of his fiduciary responsibility as the chair of the church committee that had been impacted by the pastor's alleged activities during the past year. As a steward of the church's mission funds, Paul felt a tug to carry the message of this new information to others on the committee.

The Bar Mitzah. Susan is a middle-aged clinical social worker who is an active member of her Roman Catholic parish. She is known throughout the archdiocese in a large metropolitan city, where she was previously employed as a social worker and where she now maintains an independent practice working with adults. Recently, when attending the Bar Mitzvah service of one of her child's friends, she is approached by Beth, a current client who Beth remembers is a Conservative Jew. Coincidentally, it was the day before the Bar Mitzvah that Susan found herself trying to remember the name of the congregation where Beth said she was a member. Suddenly, Susan remembers. The two greet each other discretely, exchange some social pleasantries, and Susan excuses herself as her client is approached by another attendee.

> **Comment:** Susan finds herself in an unforeseeable concurrent dual relationship, which in this instance could be called a "chance extratherapeutic encounter" (Hyman, 2002, p. 351). According to Hyman, "the common stance, whether intentional or not, seems to be avoidance of full human contact (i.e., not approaching the client, not initiating a conversation) during the encounters and detailed analysis of the interaction during subsequent therapy sessions" (p. 351). In other words, incidental encounters with current clients can provide grist for the therapeutic mill in the client's next psychotherapy session.

Summary

Dual roles and multiple relationships can take many other forms in faith, religious, and spiritual communities when their members request the professional services of MHPs who are fellow congregants. Although multiple role relationships should be avoided when there are

close personal, business, or shared ministry relations, there remain other types of dual relationships in which there may be a benefit to a client without the risk of harm, exploitation, or loss of effectiveness. Dual roles and boundary extensions in religious communities are not inherently unethical and are not specifically prohibited by the codes of ethics of mental health and counseling associations. At the same time, extending the boundaries of counseling and psychotherapy must be approached in a caring, cautious, and conscientious manner. For clinicians and counselors who believe that some flexibility in managing boundaries can provide benefits to carefully selected clients, the use of peer consultation and a systematic approach to decision making can be useful. Reasonable decisions that are in the best interests of the client can be made on a case-by-case basis.

Notes

The example on page 2 of this document was used by permission of the Rev. Dr. Heather Hunnicutt. Before her ordination and prior to earning her doctoral degree, Heather earned a graduate degree in mental health counseling.

Heather Hunnicutt was ordained in the Christian Church (Disciples of Christ) in 2018. Before earning her doctorate, she served as associate pastor at First Christian Church of Marietta, Georgia. She became an authorized minister in the Penn Northeast Conference of the United Church of Christ in 2019. In August 2019, she became pastor of Salem United Church of Christ in Pocono Pines, Pennsylvania. She is an ordained clergy in the Christian Church (Disciples of Christ) serving a United Church of Christ parish, in addition to being a Licensed Professional Counselor in Pennsylvania. She works at Evergreen Counseling and Consulting in Blakeslee, Pennsylvania. In addition to pastoring the church and maintaining her practice, she serves on the Top of the Mountain Ecumenical Council, and Penn Northeast's Mental Health Ministry Team. Dr. Hunnicutt is also an adjunct professor of theology at the University of Scranton.

For additional information about Heather Hunnicutt, see this article: Christian Counselors - 2018

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