I have examined a diverse array of dual relationship and boundary issues. Some issues that arise in the human services are relatively uncomplicated, and some are complex. Some involve practitioners who are motivated primarily by altruism, and some involve practitioners who violate clients’ boundaries because of their own deep-seated pathology, emotional needs, or greed. Some boundary crossings serve a constructive purpose, whereas boundary violations are uniformly destructive.

Despite this remarkable variety, dual relationship and boundary issues share several key features. First, they contain the seeds for potential harm to others. Although serious harm is not inevitable—except in the most egregious violations, such as sexual involvement with a client—it is an ever-present possibility. Human service professionals must be vigilant in their efforts to minimize potential and actual harm to others.

Second, dual relationship and boundary issues pose risks to professionals themselves. At one extreme, practitioners who violate clients’ boundaries and exploit their relationships with them run the very real risk of losing their license and destroying their career. Although some boundary violations occur in and remain in the dark, many eventually come to light. Even less egregious boundary crossings can sometimes trigger lawsuits and ethics complaints filed with licensing boards or other professional bodies, thus disrupting the careers of even the most noble practitioners. Given these possibilities, it behooves human service professionals to understand and follow sound risk-management strategies—primarily to protect clients but also to protect themselves.
Effective risk management concerning dual relationships and boundary issues should provide both conceptual guidance and practical steps that enhance protection of all parties involved. The following is a decision-making model, based on several available frameworks (Corey and Herlihy 1997; Gottlieb 1995; Reamer 2000), that practitioners can use when they encounter potential or actual dual relationships and boundary issues. This model incorporates various factors I highlighted throughout this discussion:

1. Attempt to set unambiguous boundaries at the beginning of all professional relationships.

2. Evaluate potential dual relationships and boundary issues by considering (a) the amount of power the practitioner holds over the client, (b) the duration of the relationship, (c) the clarity of conditions surrounding planned or actual termination, (d) the client's clinical profile (when involved in clinical work), and (e) prevailing ethical standards. How much power does the professional have over the client? How long has the relationship lasted? How likely is it that the client will return for additional services? In clinical relationships, to what extent do the client's clinical needs, issues, vulnerabilities, and symptoms increase the risk that the client will be harmed? To what extent does the dual relationship, boundary crossing, or boundary violation breach prevailing ethical standards? Relationships that entail considerable practitioner power, are long lasting, do not involve clear-cut termination, involve clinical issues that render clients vulnerable, and are not consistent with pertinent ethical standards are especially troubling and risky.

3. Based on these criteria, consider whether a dual relationship in any form is warranted or justifiable. Recognize that gradations exist between the extreme options of a full-fledged dual relationship and no dual relationship. For example, a practitioner may decide that attending a client's graduation from a substance abuse treatment program is permissible but that attending the post-graduation party at the client's home is not. A practitioner may decide to disclose to a particular client that he is a new parent without disclosing intimate details concerning his struggle with infertility. A human service grant administrator may decide to collaborate on a joint project with a private agency headed by her husband but recuse herself from all decisions at her agency concerning funding of her husband's program.

4. Pay special attention to potentially conflicting roles in the relationship or what Kitchener (1988) calls "role incompatibility." For instance, a clinical social worker should not agree to counsel her secretary. An administrator should not supervise her spouse. Of course, sometimes professionals do not
agree about the extent of role incompatibility, which entails divergent expectations and power differentials; among the best examples is the debate among professionals concerning whether practitioners in recovery should attend Alcoholics Anonymous or Narcotics Anonymous meetings at which a client is present and whether community-based mental health programs should hire former clients as staff members.

5. Whenever there is any degree of doubt about dual relationships or boundary issues, consult a thoughtful, principled, and trusted colleague. It is important to consult with colleagues who understand one’s work, particularly in relation to services provided, clientele served, and relevant ethical standards.

6. Discuss the relevant issues with all the parties involved, especially clients. Clients should be actively and deliberately involved in these judgments, in part as a sign of respect and in part to promote informed consent. Fully inform clients of any potential risks.

7. Work under supervision whenever boundary issues are complex and the related risk is high.

8. If necessary, refer the client to another professional in order to minimize risk and prevent harm.

9. Document key aspects of the decision-making process, for example, colleagues consulted, documents reviewed (codes of ethics, agency policies, statutes, regulations), and discussions with clients. As Gutheil and Gabbard (1993) observe in reviewing the findings of Lipton (1977) with regard to clinical contexts, “It is ultimately impossible to codify or prescribe a personal relationship between therapist and patient in a precise manner. Perhaps the best risk management involves careful consideration of any departures from one’s usual practice accompanied by careful documentation of the reasons for the departure” (195–96).

To prevent inappropriate dual relationships and to help practitioners manage complex boundary issues, human service professionals must mount an ambitious education and training agenda. This agenda should include four principal components. First, professional education programs in psychiatry, social work, psychology, marriage and family therapy, psychiatric nursing, and counseling must address these issues vigorously and comprehensively, in the context of both classroom education and internships. Discrete classroom courses devoted to professional ethics, and portions of other courses that include ethics as a key topic (for example, courses on clinical practice, administration, supervision), should incor-
porate readings about and discussions of dual relationships and boundary issues. Supervisors in internship settings should address this issue deliberately as well, with respect to interns’ relationships with clients and with their supervisors and other staff.

Second, continuing education programs should highlight these issues regularly. Annual conferences of professional associations and continuing education seminars should routinely provide participants with workshops and seminars on dual relationships and boundary issues.

Third, human service administrators and supervisors should offer staff members sustained in-service training on these issues. In addition to traditional didactic presentations, the training should include opportunities for staff members to wrestle with complex case scenarios. In-service training facilitators can help staff members apply various guidelines—agency policy, pertinent laws, state regulations, codes of ethics—to this case material to help sharpen the staff’s ethical judgment.

Finally, human service administrators and supervisors should develop and continually refine agency-based policies designed to provide staff with constructive guidance regarding boundary issues. Although formulating crystal-clear, unequivocal guidelines that address all boundary-related permutations is impossible, thoughtful, conceptually mature guidelines can communicate to staff members the core values and concepts they need to consider and help them enhance their critical thinking skills. Smith and Fitzpatrick’s (1995) astute conclusion about the ambiguity of many boundary issues in clinical contexts has broad implications for the human services in general:

In summary, boundary issues regularly pose complex challenges to clinicians. The effects of crossing commonly recognized boundaries range from significant therapeutic progress to serious, indelible harm. The issues are further complicated by the wide range of individual variation that exists in a field where what is normal practice for one clinician may be considered a boundary violation by another. Although setting appropriate boundaries is a professional imperative, flexibility in their maintenance is equally important. Clinicians should avoid setting simplistic standards that may create barriers to therapeutic progress. In the final analysis, ethical practice is governed less by proscriptions than by sound clinical judgment bearing on the therapeutic interventions that will advance the client’s welfare. Given the
individual differences among clients, fine adjustments are required in every case. (505)

In the end, human service professionals who face difficult and challenging boundary issues must draw on their finely honed ethical instincts. Conceptual guidance is fine and important, but practitioners’ handling of daunting circumstances ultimately must depend on their genuine and passionate determination to make ethically sound judgments.