Multiple Relationships and Therapy: When 6 degrees of separation is not possible

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Case Study

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Abstract

Dual relationships pose a unique problem for mental health practitioners in rural areas. They are often unavoidable and require special considerations to effectively and ethically navigate. The case studies presented explore the complications that are often presented within these contexts, and provides clinical implications for therapist practicing in rural and/or small communities.

Keywords: Dual Relationships, Multiple Relationships, Ethics, Rural

Introduction

The Ethics Code

The American Psychological Association ethics code defines multiple relationships as…when a psychologist is in a professional role with a person and at the same time is in another role with the same person, at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or promises to enter into another relationship in the future with the person or a person closely associated with or related to the person [1-3]. 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. 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. 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 [1].

Though these dual relationships are generally frowned upon in the ethics code, there is a grace allowed for situations in which multiple relationships are inevitable as long as confidentiality and transparency with the patient are upheld. Based on the aforementioned standard, the crux of multiple relationships is the risk of harm to the client and the impairment in the objectivity of the practitioner. However, the determination of these factors can be multilayered and nuanced when providers practice in areas in which the personal and professional often collide; such as rural areas and small communities. By definition, rural areas are less populous; there are fewer people to engage and fill specific roles. As such, both professional roles and personal roles often. In rural areas, mental health professionals are weighted with the needs of their patients as well as their relationship with community at-large due to both the intimacy of rural communities and shortage of providers in these areas. Therefore, the potential of multiple relationships between mental health providers and their clients is increased [2].

The Rural Area Shortage and High Need

Health Professional Shortage Areas (HPSA) are specific designations that indicate locations and populations in which there is a lack of health care professionals. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. . . For mental health, the population to provider ratio must be at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community) [3]. As Table 1 demonstrates, as of 2018 there was a shortage of approximately 1,886 mental health professionals in rural areas across the Unites States. Of the 5,124 HPSA designations, 2,721 (53.1%) are in rural areas.

	Number of Designations[1]	Population of Designated HPSAs[2]	Percent of Need Met[3]	Practitioners Needed to Remove Designations
Mental Health HPSA Totals	5,124		115,383,074	6,894
Rural	2,721	53.10%	26,145,246	1,886
Geographic Area	625	12.20%	22,770,815	1,227
Population Group	108	2.11%	2,396,760	184

This severe lack of providers indicates that the mental health practitioners within these rural areas provide services to a broad swath of their communities, and treat an array of disorders; due to the fact that rural communities are disproportionately impacted by behavioral issues with mental health implications and some mental health issues [4]. To evidence this significant need, The Substance Abuse and Mental Health Administration (SAMHSA) conducted a survey of mental health and substance use across the United States. SAMHSA's 2017 National Survey on Drug Use and Health examines the impact of mental health on populations comparatively by categorizing areas as "large metro", "small metro", and "nonmetro". Nonmetro areas are subdivided to "urbanized", "less urbanized", and "completely rural" [5].

According to SAMHSA (2018), 16.8% of residents of rural areas got into a serious fight at school or work in 2016 and 18.7% did in 2017 (both years rural areas were ranked amongst the highest of all population types), 2.5% sold illegal drugs in 2016 and 3.0% did in 2017 (again, holding the highest of all population types both years), 5.8 % stole or tried to steal items worth more than $50 and this percentage was 1.8 in 2017 (highest of all areas for that year), and amongst grade school students 5.5% had a grade average last complete period of a D or lower in 2016 (the second highest) and 4.6 % did in 2017. Also, in 2016 only 69.9% of students heard or saw a drug or alcohol prevention messages in school (the second to lowest of all percentages) and 68% received these messages in 2017 [5].

With regard to mental health populations, in 2016 13.9% of individuals residing in rural areas were diagnosed with a mental illness excluding serious mental illness; this number rose to and 15.2% in 2017 (the higher than any other area). The 2017 breakdown of this group for persons aged 26 or older is as follows: (1) aged 26+ were 19%, (2) aged 26-49 were 24.8%, and (3) aged 50+ were 15.7%. The percentages of mental health diagnoses amongst persons aged 26 and over, were the highest across all geographic types. This indicates that rural areas have the highest percentages of mental health diagnoses in the nation.

For those aged 18 or older with co-occurring substance use disorder and any mental illness, excluding serious mental illness, the percentages are: (1) aged 18-25 were 5.2% in 2016 (the highest ranking of geographic types) and 3.7% in 2017, (2) aged 26+ were 1.5% in 2016 and 2% in 2017 (the second highest), (3) aged 26-49 3.9% in 2016 (highest) and 3.7% in 2017 (highest; SAMSA, 2018). Moreover, in 2016, 4.5% of rural residents aged 18 years or older experienced a major depressive episode with severe impairment and in 2017, the percentage was five (which was tied for highest). The percentages of persons 18 years or older who had serious thoughts of suicide within past year were: (1) aged 18-25 9% in 2016 (second highest) and 10.8% in 2017, (2) aged 26+ 3.4% in 2016 and 4% 2017 (highest ranking), and (3) aged 50+ 2.3% in 2016 and 4% in 2017 [5].

Though the numbers of individuals in need of mental health services are amongst the highest of those within the country, the delivery of these services rank as the lowest in both 2016 and 2017; 16.5% and 15.3% respectively. This amounts to the highest percentage of unmet mental health need across all area types within the United States. The reasons for not receiving mental health services in the past year among persons aged 18 or older are as follows: (1) 28.1% in 2016 and 29.2% in 2017 thought could handle the problem without treatment, (2) 20.8% in 2016 and 24.6% in 2017 stated that they did not know where receive services, (3) 37.5% in 2016 and 40.8% in 2017 could not afford cost, and (4) 20.4% in 2016 and 21.1% in 2017 stated that they did not have the time to participate in treatment.

Arising ethical issues in rural areas

As demonstrated in the SAMHSA (2018) data, the severity of mental health issues in rural areas is quite significant. However, for mental health practitioners in these areas, these numbers do not represent just "clients"; they are their child's teacher, their housekeeper, their pastor, their family doctor. Social interactions can range from casual exchange with a former patient as they bag your groceries to being a parishioner at the church of a current client. This makes multiple relationships in rural area practices virtual unavoidable to some degree. The nuance and inevitability of these multiple relationships call to question the manner in which the factors of risk to patient and threatened objectivity of the practitioner are determined. How many degrees of separation is sufficient and how does a therapist determine risk when there are few other options? The case studies hereafter examine just that.

Case Study 1

Jason was a 16-year-old African American patient. His treatment consisted of in-person talk therapy for psychological concerns. He resided in the same rural community as his mental health therapist, and shared a neighborhood and attended school with several of the therapist's relatives. Due to these overlapping relationships, the provider had personal relationships with of several of Jason's family members, teachers, and community members. Further complicating the duality of this client/therapist relationship, he could only participate in in-home treatment due to extenuating circumstances. The therapist knew this would be a challenging case due to the dual relationships, and discussed their concerns with the client and his mother. After informing them of confidentiality and the potential risks given the small, closed nature of their community, both agreed to continue treatment. Initially, Jason appeared to have a difficulty trusting, building rapport, and opening up to the therapist. He voiced concerns about others finding out about his treatment, and frequently inquired as to what rumors about him the therapist may be were aware of.

Keeping confidentiality in mind, the therapist attempted to practice discretion. They would park away from client's house. Also, in an effort to hold the space within the therapeutic sessions, the practitioner addressed his concerns by questioning what he would like to be known about him, discussing the emotional impact of stigmatizing rumors, and addressing internalized stigma. Approaching treatment in this manner allowed Jason to become comfortable with the therapist, differentiate between the therapist's professional role and their role in the community, and to finally feel heard and understood by someone in the community. In an effort to remain objective with this patient, the therapist also sought professional consultation. With this foundation laid, Jason began to build rapport and actively engage in the therapeutic process. Later in the course of treatment, the he became available to be seen by the therapist in a private setting, and treatment was moved to an office expeditiously.

Case Study 2

Jane was a 32-year-old military member on active duty who engaged in individual psychological therapy on a small military base. Due to the base being overseas, she was unable to access care outside of her small military community. In addition, the small, tight-knit community nature of the military base meant that the therapist also interacted with the patient during all on-base military social events. Moreover, the client was a part of the therapist's husbands' squadron.

Initially, Jane expressed a valid concern in with working with the therapist based on the aforementioned issues and the worry that others may become aware of her struggles. The therapist offered to refer the patient to another practitioner; however, due to limited resources client would be waitlisted for a calendar year at the only other clinic on the base. The severity of Jane's diagnosis would not permit her to wait a year for treatment. Therefore, the client agreed to continue to work with the counselor. The therapist informed Jane of the limits of confidentiality and that the professional relationship would only occur within the office setting. Further, the therapist agreed to not engage with Jane outside of the office. Over the course of Jane's therapy, she gradually eased into a comfortable rapport with the practitioner. In the counselors work with Jane, the dual relationship did not hinder the therapeutic relationship. In fact, at termination Jane shared that being able to see the counselor in other settings allowed her to be more honest due to possible shared experiences.

Case Study 3

A mental health practitioner was a guest speaker at a domestic violence conference for professionals that took place within their small, rural community. Specifically, they were invited to speak about their personal experience with domestic violence; as opposed to providing psychoeducation on the topic. Though this event took place within the community, the therapist did not anticipate crossing paths with patients, as this conference was for professionals providing services for domestic violence survivors.

Upon arriving at the event, the practitioner greeted other guest speakers at which point they became aware that the mother of a current client was a guest speaker as well. Moreover, when the therapist looked to the back of the audience, they observed the client in attendance. As panic set in, they thought, "How will I pull this off? What would I say? How can I possibly share my story?" "What do I do?" The therapist ultimately decided that they would not share the details of their personal story as agreed upon with the conference organizers. They opted to speak in generalizations and provide psychoeducation on domestic violence due to the potential impact it may have on the therapeutic relationship.

Discussion

As previously stated, the shortage of mental health providers in rural areas and small community settings complicates the client-practitioner relationship; specifically, with regard to dual relationships. Moreover, the severity of mental health diagnoses often means that practitioners may have to compromise this ethical aspiration to meet immediate patient needs. Across the aforementioned case studies, several common threads have implications for practitioners in rural/closed community. The first of which is the decision to take a client when one has prior knowledge of a possible dual relationship. According to Gottlieb (1986) as cited in Afolabi, there are three categories of relationships, based on the power differential between clinician and patient [6]. Gottlieb goes on to state that these should factor into ethical decision making in clinical practice [6]. The first of which is "Low Power". Within this dimension, the practitioner has little or no personal relationship, treatment is brief with a few sessions over a short period of time, there is a specific date set for the termination of services, and the likelihood of the parties having future contact is miniscule. "Mid-Range Power" is a dynamic where there is a clear but limited power differential. In a "Mid-Range Power" therapeutic relationship the length of treatment is intermediate with regular contact, no specific termination date is known at the outset of treatment, and there is an increased possibility of continued contact. Lastly, "High Power" applies to relationships with a clear power differential with the therapist holding significant personal influence. The duration of a "High Power" relationship is long term, there is continuous contact or episodic contact over

a long period, and there is a high likelihood of contact outside of the therapeutic setting during treatment and upon termination [6].

The aforementioned lack of providers, prevalence of high need and chronic mental health concerns, and intimacy of community members within sequestered or rural communities contest this decision-making model. Dual relationships in this setting are often complex and blur the lines across various types of power dynamics [7]. Based on Gottlieb's model, and other similar models, many providers in these environments range from mid-range to high power with the vast majority of their clients; which is defined by this model as boundary crossing and presents an ethical risk. A more viable alternative is for practitioners to integrate this model with Principle A of the APA ethics code, Beneficence and Nonmaleficence [1]. Under this integrated model, clinicians can examine the aspects of the power dynamics delineated by Gottlieb (1986) with regard to risk and weigh the potential harm of each factor for each individual client. This model, proposed by Kitchener (1988) as cited in Bugard, permits flexibility while maintaining one's ethical responsibility [2]. For example, a "High Power" relationship with a client diagnosed with Schizoaffective Disorder may hold a higher level of clinical necessity than a "Mid-Range Power" relationship with an individual with mild anxiety symptoms; as with the former a lack of treatment may cause more harm to the patient than the duality of the relationship with in treatment. Applying this decision-making model may also have positive implications for the treatment of individuals grappling with severe or chronic mental health issues in rural areas because many of therapist in these areas report a reluctancy to engage high-risk patients [7].

The second common thread in the case studies is transparency of the dual relationship during the informed consent process. A common understanding of the therapeutic relationship and the boundaries thereof is developed at the start of treatment. When providing services to individuals with whom one has a multiple relationship it is imperative to create mutual boundaries to contain the therapy considering the implications of the dual relationship. These boundaries should be constructed in a manner that is befitting the cultural norms of the community, protect the patient, and permit the practitioner to place distance between their personal and professional lives. With regard to cultural norms and traditions, the closeness of a small community generally breeds familiarity and a family-like social environment. Residents often casually greet one another and attend at-larger community events tinged with a socially intimate ease. As such, it may draw more attention for a therapist to not casually speak or to actively avoid a client outside of the office [2]. Alternatively, the responsibility of effectively maintaining multiple roles as provider and co-community member can increase the chances of practitioner burnout [8]. Therapists may set boundaries such as not engaging in extended conversation with the client outside of therapy, and/or not discussing out of office interactions within therapy. No matter the terms, a plan for navigating the norms of the community while maintaining the container of therapy should be created at the out-set of therapy, stringently upheld by the provider, and revisited and revised as needed throughout the treatment; as exemplified in Case Study 2. The case studies also discussed the theme of a patients' awareness of self within the treatment and the perceived views of the community at-large [9-11]. Slama states ". . . despite the isolation involved in rural living, there is also what I shall call a goldfish bowl effect, in which ruralites [sic] are aware that other people are very interested in their lives and talking about them" (p. 10). This "goldfish bowl effect" often becomes a deterrent to treatment or initial hesitancy to fully engage in the therapeutic process due to fears or anxieties surrounding the dual relationship. As demonstrated in the case studies, this barrier may be reduced over time with the establishment of clear boundaries during the intake process and the client building trust by observing the provider reinforce those boundaries.

Another commonality between the case studies is flexibility. Practicing in a close-knit community requires a limberness that is often not necessary in other settings. This flexibility also encompasses a level of vigilance and self-awareness on the part of the practitioner. On your feet, thinking and self-awareness enable them to quickly and effectively navigate the various social and professional situations inherent to multiple relationships. The compass for navigating this adaptability is the reduction of the dual relationship. Decisions, such as the last-minute decision to withhold personal information as demonstrated in Case Study 3, allow mental health providers to uphold the boundaries necessary for effective clinical treatment.

Conclusion

Rural areas and small communities experience a shortage of providers while simultaneously ranking amongst the highest in the nation with some critical mental health concerns. This results in few practitioners providing services to a broad swath of their small communities. Also, the inherent nature of rural communities is a small population, which lends to clinicians having multiple relationships with their patients.

Though multiple relationships are frowned upon by the ethics code and considered risky for both clinicians and clients, these case studies demonstrate that they can be handled effectively. The keys to navigating dual relationships in rural areas are utilizing an appropriate decision-making model, transparency and the setting of boundaries during the informed consent process, and flexibility. If properly managed, a dual relationship may not hinder therapeutic outcomes. On the contrary, this relationship may serve to benefit the client in unexpected ways.

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