Therapeutic Boundaries and Dual Relationships in Rural Practice

Ethical, Clinical and Standard of Care Considerations

By: Ofer Zur, Ph.D.

This is a 2018 updated version of the original article which was posted by permission of the *Journal of Rural Community Psychology.*

Table Of Contents

ABSTRACT

The nature and meaning of therapeutic boundaries have been debated since the inception of psychotherapy. Still, there is very little agreement among mental health practitioners in regard to boundary issues, such as dual relationships, gifts, bartering or touch in psychotherapy. Rural practice offers a unique setting in which many boundary crossings are unavoidable and, in fact, are a normal and healthy part of rural living and practice. The visibility of therapists, frequent incidental encounters between therapists and clients in the community and unavoidable dual relationships are all part of the standard of care in these communities. This paper differentiates between boundary crossings and boundary violations, dispels the myth that boundary crossings are unethical, disputes the view of rural practice as "ethically-challenged" or compromised and, most importantly, outlines how many of the dominant urban-analytic-risk-management-based practices are often not applicable in rural practices.

INTRODUCTION

The nature and meaning of therapeutic boundaries have been debated since the very beginning of psychotherapy. From Freud onwards there has been no common ground among therapists on the meaning and the application of therapeutic boundaries. While agreements are hard to come by, boundaries are an inherent part of psychotherapy. Whether it is the place or length of therapy, self-disclosure by therapists, issues of confidentiality, gifts, touch or the degree of personal or professional engagement between therapist and client, these boundary issues must be addressed in every clinical situation. The rural practice setting is unique as it illuminates the complexity, richness and challenges around therapeutic boundaries in a way that very few other settings do. Rural settings are often characterized by small, low density and isolated 'frontier' type communities, which are also highly interdependent and interconnected. The U.S. Census Bureau (2010) defines rural as communities with a population of less than 2,500 residents and a population density of less than 1,000 people per square mile. As a result, familiarity between health care providers and their clients is often not only unavoidable but also a prerequisite to the development of trusting, working relationships. Additionally, rural communities very often suffer from a scarcity of medical, mental health and social services and are often economically more distressed compared to most communities in the US. Aside from the considerations of scarcity, economics and accessibility, lack of privacy and the prevalent mental health stigma in rural areas add significant barriers to mental health services.

Low population density, remoteness and isolation have been cited as important characteristics of rural communities. It has been estimated that the rural portion of the United States contains about 80% of the land and about 20% of the people (about 60 million). Economic hard times, the decline in family farming due to corporate agriculture, migration of young people and scarcity of resources have often been cited as major concerns for rural communities (Stamm, 2003). The public mental health system is often the only provider in rural areas and primarily serves persons with serious mental illnesses (Barbopoulos & Clark, 2003; Mulder, Kenkel, Shellenberger, et al., 2000). On the positive side these communities are often cohesive, highly connected and mutually supportive. High visibility and exposure is part of the interdependent nature of many rural communities. However, when it comes to mental health issues, such visibility can act as a deterrent to health-seeking behavior (Mulder & Chang, 1997; Weigel & Baker, 2002; Osborn 2012). Rural Mental Health Research at the NIMH indicates that the 60 million Americans who live in rural America have an equal or even greater likelihood of suffering from mental illness and substance abuse than do their urban counterparts (Thorngren, 2003).

Based on the urban-analytic-solo practice model, traditional approaches to boundaries have taken a firm stance against any form of boundary crossing, such as self-disclosure, gifts or bartering, out-of-office encounters, thus advocating the complete avoidance of any form of dual relationships (Boland-Prom & Anderson, 2013; Brownlee, Halverson, & Chassie 2012; Williams, 1997; Zur, 2000; 2007, 2017). Given the structure of rural living, rural practices simply cannot abide by these guidelines. Psychological training and practice developed primarily as urban, solo practices, which has resulted in many difficulties in applying the urban standards to rural settings. For example, the avoidance of accidental or planned encounters between therapist and client outside the office, which is highly endorsed by urban, solo and analytically oriented therapists, are simply impossible in small, isolated rural communities. Bartering, in some agricultural or poor rural communities, is often expected and even the norm with very few alternatives available. Similarly, the avoidance of dual relationships is unrealistic in such small and isolated communities where interdependence and connectedness are not only the facts of life but also the values that help sustain them. In fact, dual and multiple relationships of many different forms are what help these communities survive the often-difficult economic, weather and other challenges. Along the same lines home visits or joining clients for celebrations or rituals are often the norm within certain cultures within the rural communities. Additionally, mental health services are scarce and, therefore, therapists must practice as generalists, routinely attending to a wide range of mental conditions, often beyond the narrowly defined boundaries of scope of practice as delineated by their education and training. The fact that professional consultations and supportive resources are also scarce makes the rural practice even more challenging. Privacy and confidentiality also have different meanings in rural settings (Werth, Hastings, & Riding-Malon, 2010) where familiarity and interdependence are highly valued and where people know of their friends and neighbors' occupations, relationships and activities, including health-seeking behaviors.

While it is obvious that familiarity between therapists and clients, and the visibility of the therapists are all unavoidable, as they are part of the fabric of rural lives, many "experts" have advocated the impossible. Faulkner and Faulkner (1997), in the their often cited article on multiple relationships in rural communities, advise the unachievable, to "avoid engaging in behaviors with a client that lead to the development of familiarity" (p. 232). Thus, with the stroke of a pen it seems that all mental health services in rural settings are vetoed, or at least deemed unethical. Similar implications derive from widely published psychologist and attorney, Woody, who asserts: "In order to minimize the risk of sexual conduct, policies must prohibit a practitioner from having any contact with the client outside the treatment context and must preclude any type of dual relationships" (1998a p. 188). With the same view of boundaries, widely quoted ethicist-psychiatrist, Simon prescribes: "Ensure no previous, current, or future personal relationships with patients… preserve relative anonymity of the therapist" (1994, p. 514). In an odd twist of logic Simon and co-author, Izben, (1999) uphold these principles as aspirational but admit that

they are not very relevant to rural practices. Even as late as 2003, Campbell and Gordon admit to the inevitability of dual relationships in rural practices but largely ignore the literature on its importance and value and conclude that "…the best practice is to abstain from multiple roles and boundary compromises…" (p. 434).

Rural psychology and its practice have led to the realization that has developed more strongly since the early 1990s that flexible therapeutic boundaries are not only unavoidable and normal in rural (Barnett, 2017; Schank, Helbok, Haldeman & Gallardo, 2010; Schank & Skovholt, 2006) and other settings but also can increase clinical utility. Rural mental health has served as the poster child of flexible boundaries. Largely due to rural mental health practices, which have spearheaded the movement towards more flexible boundaries, after many years of hard fought battles on the 'ethics battlegrounds,' a more flexible, realistic and 'rurally relevant' ethics code has been constructed by some of the largest professional organizations. The American Psychological Association (APA) Code of Ethics of 2002 and American Counseling Association (ACA) Code of Ethics of 2005, have led the way with these changes. The field as a whole has been very gradually and slowly moving beyond the view of rural practices as "ethically-challenged" or "ethically-compromised" in comparison to the dominant urban model.

This paper first reviews the nature and meaning of therapeutic boundaries. Then it describes the six most unique boundary considerations for rural practice: incidental encounters, confidentiality, self-disclosure, dual relationships, scope of practice and telehealth. Next, it reviews additional boundary considerations that are relevant to rural practice, such as bartering, gifts and several out-of-office experiences. Finally, it reviews the standard of care and the codes of ethics as they relate to rural practices, and the paper offers a brief review of risk-benefit analysis and ethical decision-making. An extensive bibliography is provided and can aid the readers who are interested in further exploring the issues of therapeutic boundaries.

Top of Page

BOUNDARIES AND DUAL RELATIONSHIPS IN THERAPY – A REVIEW

A boundary is defined generally as the point at which something ends or the point or line beyond which it becomes something else. Gutheil and Gabbard (1993) regard therapeutic boundaries as the "edge" of appropriate behavior. Many analytically oriented therapists discuss boundaries in terms of a therapeutic frame (Langs, 1982; Smith & Fitzpatrick, 1995). The frame includes structural elements such as time, place, fees and the actual content of psychotherapy. Along these lines it becomes clear that boundaries in therapy, in fact, define the therapeutic environment. In an interesting juxtaposition, rural settings have also been called 'frontiers," which is also defined as a form of boundary or an edge.

*There are two types of boundaries in therapy:*The first one is boundaries that surround the therapeutic relationship and the second is boundaries that are drawn between therapist and client. The first type includes boundaries that are drawn around the therapeutic encounter like borders or frames. These boundaries are articulated in state and federal laws and professional codes of ethics (Zur, 2000, 2005a). They include place of therapy (e.g., office vs. home-based therapy, adventure therapy and intervention taking place outside the office), onset and termination of therapy, form of therapy (e.g., face-to-face, telehealth, etc., web-based therapy), time and length of sessions, confidentiality, incidental encounters outside the office and dual relationships. Boundaries of a second type are drawn between therapist and client and include issues such as fees, physical touch, therapist's self-disclosure, gift exchange, (either from client to therapist, therapist to client or between therapist and a third party), clothing, bartering, language, silence, and physical proximity of therapist and client during sessions.

Different *theoretical orientations*have different interpretations and applications of therapeutic boundaries. While some emphasize the importance of clearly defined and consistently employed boundaries, others stress the therapeutic importance of flexibility and the dismantling of certain rigid boundaries. Additionally, theoretical orientations espoused by therapists are likely to be among the most significant factors determining a therapist's approach to boundaries (Borys & Pope, 1989; Gutheil & Gabbard, 1993, 1998; Lazarus & Zur, 2002, 2007, 2017; Williams, 1997, Zur, 2005b). Family therapists are likely to define the boundaries of psychotherapy, including the limits of confidentiality and who is a patient, in a broader way than most individual therapists (Minuchin, 1974). Psychoanalytically oriented therapists, for clinical-theoretical reasons, are likely to avoid almost all physical touch, self-disclosure and gifts in order to remain emotionally neutral (Langs, 1982). Simon, who has often been the voice of the traditional analytic stance on boundaries, advises therapists to, "Maintain therapist neutrality. Foster psychological separateness of the patient… Ensure no previous, current, or future personal relationships with patients. Minimize physical contact. Preserve relative anonymity of the therapist" (1994, p. 514). At the other end of the spectrum a humanistic therapist is likely to be more flexible in regard to self-disclosure, gifts, physical touch and the beginning and end of sessions. S/he may even leave the office with a client for an out-of-office session (Zur, 2001a, 2007). Jourard, who represents the humanistic psychology point of view on boundaries, states: "In the context of dialogue, I don't hesitate to share any of my experience with existential binds roughly comparable to those in which the seeker finds himself . . . I might teach him such Yoga know-how or tricks for expanding body-awareness as I have mastered or engage in arm wrestling or hold hands or hug him, if that is the response that emerges in the dialogue . . . " (1971a, p. 159). A behavioral therapist may choose to leave the office as part of an in-vivo systematic desensitization of a phobic client (Gutheil & Gabbard, 1993; Lazarus, 1994). A feminist therapist

may make a point of inviting or joining a client for a political rally to exemplify an ideology that espouses the breaking down of boundaries and to emphasize the importance of political involvement (Greenspan, 1986; Hanson, 2003). While humanistic therapists emphasize the importance of self-disclosure for the forming of congruent and authentic therapist-patient relationships (Bugental, 1987; Jourard, 1971b), cognitive-behavioral therapists may reveal significant personal information for the purpose of modeling (Dryden, 1990; Lazarus, 1998). Obviously, a body psychotherapist, such as a Reichian or bioenergetic practitioner, will extensively use touch rather than words in the course of psychotherapy (Reich, 1972; Zur & Nordmarken, 2004). A family or behavioral therapist may choose to join an anorexic client for a family dinner as part of the treatment plan (Fay, 2002; Minuchin, 1974). Culturally sensitive therapy often employs flexible boundaries to accommodate and match the client's specific cultural values (Slama, 2004). Adventure therapy obviously takes place in the outdoors (Gass, 1993), and a spiritually oriented or pastoral counselor often joins a client in prayer and at services (Llewellyn, 2002). It is thus apparent that the therapist's primary theoretical orientation determines her/his view of what constitutes appropriate and helpful practice in regard to boundaries in psychotherapy.

One of the most common misunderstandings in psychotherapeutic ethics is the *lack of differentiation between boundary violations and boundary crossings.*Boundary violations occur when therapists cross the line of decency and integrity and misuse their power to exploit or harm clients. Boundary violations usually involve exploitive business or sexual relationships and are always unethical and are likely to be illegal (Gabbard & Lister, 1995; Gutheil & Gabbard, 1993; Williams, 1997; Zur, 2004a, 2005c). Boundary crossings are very different from boundary violations, are more elusive and thus harder to define. Most broadly, boundary crossings refer to any of the following three concerns: a. deviation from the strictest professional role (Gutheil & Gabbard, 1998; Knapp & Slattery, 2004); b. deviation from traditional, hands off, 'only in the office,' emotionally distant forms of therapy (Zur, 2000); and c. departure from risk management procedures (Lazarus & Zur, 2002). Examples of boundary crossings are: therapist's appropriate self-disclosure, home visit to a dying patient, appropriate non-sexual hug, well-constructed bartering arrangement, home visit, in-vivo desensitization, attending client's wedding, anorexic lunch and adventure therapy. Boundary crossings are often part of well-constructed treatment plans and are often an integral part of behavioral, cognitive-behavioral, humanistic, existential, group, feminist or culturally sensitive therapy.

While maintaining boundaries is the prime responsibility of therapists, clients co-contribute and co-define the nature and development of therapeutic boundaries (Knapp & Slattery, 2004). Clients may violate boundaries when they use physical or verbal violence, or if they act in any other inappropriate manner, such as exposing themselves sexually. The movie, *What About Bob*, demonstrates boundary transgressions initiated and carried out by a client who follows his analyst on the therapist's family vacation. Client may also violate a therapeutic boundary if they threaten the therapist, are invited to the therapist's home or if they stalk their therapist or members of the therapist's family.

The term *out-of-office experience,*as used in this paper, describes any experience that takes place outside the standard boundaries of the therapy office, such as a home visit or accidental encounter at the local market (Zur, 2001a, 2005d; 2017). Out-of-office experiences, which have also been referred to as "boundary extensions" (Jones, Botsko, & Gorman, 2003), are boundary crossings; however, they can also be boundary violations and/or dual relationships. There are several types of out-of-office experiences: home visits; hospitals, jails and other visits; interventions that are only possible outside the office space (e.g., in-vivo desensitization, adventure therapy); attending celebrations or rituals outside the office; walking side-by-side rather than sitting with a client face-to-face; incidental encounters in the community; and encounters outside the office as part of social or other dual relationships.

The term *dual relationship*in psychotherapy refers to any situation where dual or multiple roles exist between a therapist and a client (Bennett, Bryant, VandenBos, & Greenwood, 1990; Koocher & Keith-Spiegel, 1998; Pope & Vasquez, 1998). This refers to the situations where there is a secondary relationship between therapist and client in addition to the therapeutic one. Dual relationships have often been mistakenly equated with boundary violations and sexual exploitation of clients. While all dual relationships are, at the minimum, boundary crossings, sexual or any other exploitative dual relationships are boundary violations. While all non-exploitative, non-sexual dual relationships are boundary crossings, obviously, not all boundary crossings are dual relationships. There are several types of dual relationships: a social dual relationship is where therapist and client are also friends; a sexual dual relationship is where therapist and client are also involved in a sexual relationship (obviously, sexual dual relationships with current clients are always unethical and illegal in most states); a professional dual relationship is where therapist and client are also professional colleagues in clinics, colleges, staff at training institutions or co-presenters in professional conferences; a business dual relationship is where therapist and client also have employer-employee relationship or are business partners; communal dual relationships are where therapist and client live in the same small community, belong to the same church, play in the same recreational league, or where the therapist shops in a store that is owned by the client; institutional dual relationships take place in the military, prisons, some police department settings and mental hospitals where dual relationships are an inherent and often legally mandated part of the institutional setting. Dual relationships can be avoidable-voluntary, unavoidable or mandated and can be concurrent or sequential. The levels of engagement vary widely with different dual relationships. Schoener (1997) differentiates between "encounters," which are a

low level of engagement; "overlapping relationships," which take place when a client and therapist share occasional encounters; and "multiple relationships," which take place when a client and therapist are very involved and share an ongoing social, professional or business relationship.

One of the biggest concerns with boundaries is the myth of the "*slippery slope*."The term "slippery slope" refers to the idea that failure to adhere to rigid risk management-urban-analytic standards will undeniably lead to harm, exploitation and sexual relationships. This process is described by Gabbard (1994) as follows: "… the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary" (p. 284). Kenneth Pope, a psychologist who has almost single-handedly popularized the notion of the slippery slope, states: "… non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships" (1990, p. 688). Also in agreement are Simon (1991), who decrees, "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself" (p. 614), and Woody (1998a) who asserts: "In order to minimize the risk of sexual conduct, policies must prohibit a practitioner from having any contact with the client outside the treatment context and must preclude any type of dual relationships" (p. 188). Not taking into any consideration the inevitability of incidental encounters, extensive self-disclosure and dual relationships in rural, college, GLBT, military or disabled communities, many authors proscribe the impossible. In fact, following the guidance provided by some renowned authors would simply leave millions of rural, minority, disabled and many other mental health consumers without access to mental health services.

A careful review of the 'slippery slope' argument reveals that it is founded primarily on the paranoid assumption that any boundary crossing, however trivial, inevitably leads to boundary violations and sex (Lazarus & Zur, 2002; Zur, 2005b, 2017). To assert that self-disclosure is likely to lead to a social relationship, that an appropriate hug is most likely to end with intercourse, or accepting a gift is the first step towards an inevitable business relationship, is irrational and illogical. The literature is saturated with articles and books describing therapists' behaviors (e.g. self-disclosure, hugs, home visits, socializing, longer sessions, lunching, exchanging gifts, walks, playing in recreational leagues) that the authors contend are precursors to or on the slippery slope to sexual or other harmful dual relationships (Austin, 1998; Borys & Pope, 1989; Craig, 1991; Kitchener, 1996; Keith-Spiegel & Koocher, 1985; Lakin, 1991; Pope, 1991; Pope & Vasquez, 1998; Rutter, 1989; Sonne, 1994, who reversed her position in a 2006 paper; St. Germaine, 1996). In a critical examination of the slippery slope argument, Zur (2000, 2007) reflects, "to assert that self-disclosure, a home visit, a hug or accepting a gift are actions likely to lead to exploitation, harm and sex is like saying that doctors' visits cause death because most people see a doctor before they die". Lazarus (1994) calls this thinking "an extreme form of syllogistic reasoning" (p. 257). Despite the persistent popularity of the term among ethicists and risk management experts, the 'slippery slope' is a baseless and illogical construct.

The concept of the 'slippery slope,' as used in the professional literature, is especially dangerous when it comes to rural mental health practices. So many rural practices, which are condemned by the urban-analytic-risk management experts, are normal, prevalent and a healthy part of rural living. In fact, they enhance clinical outcomes rather than hurt them. Rural communities have provided the clearest, or what may be considered the poster child or archetypal example of, the importance of flexible boundaries. The reality of rural settings make therapists face the fact that incidental encounters, self-disclosure and dual relationships are simply unavoidable (Barnett, 2011, 2017; Schank, Helbok, Haldeman & Gallardo, 2010; Schank & Skovholt, 2006). In fact, these may be some of the cherished aspects of rural life. Similarly, following the urban-analytic taboo on gifts or bartering may ostracize or even render rural therapists as unemployable. As a result of these realizations, the general field of mental health has been gradually shifting towards an acceptance of a context-based rather than dogmatic approach to boundaries, where flexible applications are accepted when appropriate and/or if inevitable.

Top of Page

UNIQUE BOUNDARY CONSIDERATIONS TO RURAL SETTINGS

This section reviews the most prevalent, complex and challenging ethical and boundary issues for rural settings. These include incidental encounters, confidentiality, self-disclosure, dual relationships, competencies and scope of practice issues.

Incidental Encounters

Incidental encounters have also been referred to as "chance encounters" or "extra therapeutic encounters" and are defined as random, unexpected or unplanned meetings between the therapist and a current client, which take place in the community or anywhere else outside the therapist's office. Such encounters are very common and expected in rural communities simply due to the small size and isolated and remote nature of the communities. Additionally, small rural communities have limited resources and a strong sense of familiarity, which means that therapists and clients are likely to bump into each other regularly in the *only* movie cinema, community pool, gym, market, recreational league or church in town.

One of the early realizations of the unique characteristic of rural practice involved the acknowledgment of the inevitability of incidental encounters in such settings. In the mid 1980s and 1990s, much before the debate on therapeutic boundaries became common and open, Hargrove (1986), Stockman (1990), Sterling (1992), Barnett and Yutrzenka, (1994) and Schank and Skovholt (1997) studied the breadth, clinical meaning and impact of incidental encounters between therapists and clients in rural settings. Borrowing from rural psychology literature, researchers have described and studied similar unavoidable chance encounters in university and college campuses (Sharkin, 1995; Hyman, 2002), in schools (Osborn, 2012), in small enclaves within larger metropolitan areas, such as political, gay and lesbian (Kessler & Waechler, 2005; Schank & Skovholt, 2006; Smith, 1990), disabled and deaf (Guthmann & Sandberg, 2002), ethnic (Schacht, Tafoya, & Mirabla, 1989), military (Johnson, 1995; Johnson, W. B., Ralph, J., & Johnson, S. J. 2005; Zur & Gonzalez, 2002), church (Llewellyn, 2002) communities and in the practice of sports psychology (Moore, 2003) and police psychology (Zelig, 1988).

Concerns with incidental encounters came primarily from two groups, psychoanalytically oriented therapists and risk management experts. Ignoring the fact that chance encounters are a fact of life in rural communities, both groups apply the analytic-urban yardstick to all practices, including rural practice. The earliest investigation into accidental encounters was conducted by Glover (1940), a psychoanalyst who called these encounters "extramural" contact. Like Glover, most other psychoanalytically oriented authors focus on the transference ramifications of such encounters and, in general, view them as negatively effecting the clients and disruptive to the analytic process (Gody, 1996; Strean, 1981; Tarnower, 1966). Simon instructs the impossible: "Ensure no previous, current, or future personal relationships with patients" (1994, p. 514). Diverging from the analytic stance on the disruption of transference analysis caused by chance encounters, Zur (2000, 2001b) asserts that meeting outside the office does not necessarily nullify or negatively effect transference analysis, but instead, the transferencial reaction is more reality-based and provides more 'grist' for the transference mill. What is often missing in the discussion is the simple fact that rural therapists work primarily as part of public agencies with highly disturbed people (Mulder, et. al., 2000) where psychoanalytic treatment generally neither applies nor exists.

Most of the concerns with chance encounters have been around the issue of the impact of the encounter on the therapeutic relationship and, as will be discussed in the next section, the concern with confidentiality and privacy. Obviously, when encountering a client in a public setting, therapists must be respectful of the client's sense of privacy and autonomy and abide by the confidentiality rule. While several surveys have revealed that therapists in general are concerned and unprepared for encounters outside the office, Pulakos' (1994) study of university settings reveals that unlike therapists, students are not as concerned about confidentiality as their therapists are. In fact, students wanted more interaction, not less, when they accidentally encountered their therapists on campus. Sharkin (1995) pointed out that therapists who rigidly avoid interactions might inadvertently expose the therapeutic relationship rather than protect its confidentiality. In dealing with chance encounters, when possible, and in situations where such encounters are expected, talking to clients ahead of time is very important. Respectfully finding out at the very beginning of therapy how they prefer to deal with different types of incidental encounters is very important. Intake material and informed consent can also prepare clients for an inevitable, incidental encounter (Zur, 2000; 2005d). The author's own Office Policies, which are given to clients prior to the first session, state:

> Sonoma is a small town and many clients know Dr. Zur from the community. Some have chosen him because they know him and his activity in the community. Consequently, you may encounter Dr. Zur accidentally or in a planned-expected manner in the community. Unless you instruct Dr. Zur otherwise, Dr. Zur will neither acknowledge his patients in the community first, nor will he acknowledge working with anyone without his/her written permission. Please let Dr. know your wishes in this regard.

In the first unexpected or accidental encounter it is important for the therapist to take cues from the client before choosing to ignore or address the client. Discussing incidental encounters with clients in subsequent therapy sessions can be beneficial; however, routine or brief encounters, most often, may not merit any lengthy discussion. The nature and importance of such discussions *depends* on the type of community where the encounter takes place, the nature of the therapeutic relationship, the type of client and the frequency, predictability, type, length, quality and significance of such encounters.

Confidentiality, Privacy and Visibility

Rural communities have been likened to "fishbowls." They are often the type of community where everybody knows everybody (Barbopoulos & Clark, 2003; Faulkner & Faulkner, 1997; Osborn, 2012; Schank, Helbok, Haldeman & Gallardo, 2010; Schank & Skovholt, 2006). As a result, privacy and anonymity standards and expectations of the urban setting are easily applied to rural settings. While confidentiality is extremely important for therapeutic success, its applications are very complex in rural settings (Roberts, Battaglia & Epstein, 1999). Shah (1970) defined confidentiality as "an ethic that protects the client from unauthorized disclosure of information about the client by the therapist without the client's permission, except in unusual circumstances" (p. 159). The ability to protect the privacy of clients in regard to mental health services in rural communities is one of the biggest challenges of clinicians and agencies in such settings.

There are a number of reasons why confidentiality is difficult to maintain in rural settings. The small size, low density, limited resources, and familiarity and interconnectedness all contribute to the challenge of maintaining the confidentiality and privacy of psychotherapy clients. Because of the limited number of professional persons in most rural areas, office space is at a premium and limited. As a result, clients who walk into a certain dwelling that is being associated with mental health services are likely not only to be recognized but are also often stigmatized as mental health clients. Due to limited resources, agencies and psychotherapists' offices are often located in the same building or right next to other non-medical professional offices. This can increase the direct exposure of mental health consumers to the community. Visibility is a major obstacle to the maintenance of confidentiality and ultimately to the accessibility to mental health services. Comings and goings at the mental health clinic are noticed, observed and, at times, discussed and shared among members of the small community. Therefore, the chances of loss of privacy with significant consequence for personal, family and professional relationships are intensified (Solomon, Hiesbergr, & Winer, 1981). Also, rural communities are often highly connected in several ways, including a quick spread of communication, word of mouth and gossip as ways of carrying communications. As a result of such high visibility, confidentiality is often compromised.

Due to the small size of the community, rural residents have a fear of being identified and labeled as mentally ill. This is because the stigma of being a "mental patient" in a rural area is a difficult one (Barbopoulos & Clark, 2003; Findlay & Sheeham, 2004; Mulder & Chang, 1997; Solomon, et al., 1981; Osborn, 2012; Weigel & Baker, 2002). In contrast to urban clients, who usually have the "luxury" of anonymity and at times much less stigma, rural clients often face the problem of being visible, exposed and often labeled and stigmatized (Morrison, 1979; Osborn 2012).

Disclosing confidential information, as required by law, often has different ramifications in rural settings. Child or elder abuse reporting, involuntary hospitalization of patients who are in danger to themselves or others, suicide prevention interventions or reporting illnesses or diseases to local public health officials are all more complex and carry the risk of exposure in rural communities. This is due to the small and interconnected nature of the communities, which can easily expose clients to community wide awareness of their problems and challenges (Weigel & Baker, 2002). Even simple communication between two practitioners and their staff can, unwittingly, expose a client to a wider audience. Small communities often have one small newspaper that reports extensively on local news, big or small, significant or insignificant. Police reports and other community occurrences that may have revolved around mental health patients can easily find their way into the local newspaper columns. Needless to say, such risk of rather shameful exposure of one's mental health, emotional or relational problems can also lead to a major inhibition of seeking help.

The risk of exposure not only effects help-seeking behavior among rural dwellers but also have been reported to effect ethical and clinical decision-making by mental health practitioners who, understandably, seek to protect the privacy of their clients from shameful, humiliating and damaging exposure (Barbopoulos & Clark, 2003; Osborn 2012; Ullom-Minnich & Kallail, 1993). Mental health caregivers must take into account the exposure risk when they conduct their risk-benefit analysis and consult with ethical and legal experts, where they face significant conflict among clinical, ethical and legal mandates (Roberts, et al., 1999). Such conflicts are often between protecting the welfare of the community from a potentially dangerous client, protecting the client's privacy, reputation or dignity and reducing people and other potential clients' reluctance and fear of seeking mental health services. A thorough risk-benefit analysis should include communal and personal considerations along with the clinical, ethical and legal ones.

Due to the way information flows in rural communities, confidential information that is authorized for release by the patient may be carelessly or accidentally leaked and disseminated. For example, diagnostic and treatment information released locally for insurance purposes may be seen by individuals who know the patient (Simon & Williams, 1999). Even worse, for example, the client, who is diagnosed with a major disorder, may be dating the insurance person's daughter. Small communities often present inherent and inescapable confidentiality and privacy problems not common in urban settings.

It is incumbent on all psychotherapists and mental health staff to be aware of the challenges to confidentiality and privacy in rural settings. They must provide clients with truly informed consent prior to the onset of treatment, discuss it in the beginning of therapy and do their best to honor clients' privacy and dignity. Consultation and brainstorming with experts and colleagues in person, via phone, email, chat rooms, listserves, etc., may also be helpful in handling complex situations in the best way possible. Prior to any release of information the patient must be informed of and understand the potential or known risks. Also, the patient should be allowed to review and approve any information before it is released.

Self-Disclosure

Self-disclosure by a therapist is the revelation of personal rather than professional information about the therapist to the client. There are several types of self-disclosures: The first type is deliberate self-disclosure, which refers to the therapist's intentional communication of personal information. It applies to verbal and also to other deliberate non-verbal actions, such as placing a family photo in the office, certain office décor or an empathic gesture (Barnett, 1998; Gutheil & Gabbard, 1998;

Mahalik, Van Ormer & Simi, 2000). There are two kinds of deliberate self-disclosures. The first is self-revealing, which refers to the disclosure of information by therapists about themselves, and the second is self-involving, which refers to the therapist's personal reactions (e.g., anger, compassion) to clients and to occurrences that take place during sessions (Knox, Hess, Petersen, & Hill, 1997). The second kind is unavoidable self-disclosure, which includes an extremely wide range of unavoidable disclosures, such as therapist's gender, age and physique, place of practice, tone of voice, pregnancy, accent, visible tattoos or apparent disability. Therapists reveal themselves also by their manner of dress, hairstyle, use of make-up, jewelry, perfume, facial hair, wedding or engagement rings, or the wearing of a cross, star of David or any other symbol (Barnett, 1998; Tillman, 1998). Therapists' visibility in rural communities is highly relevant to this type of self-disclosure (Barnett, 2011). When the therapy office is located at the therapist's home, it always involves extensive self-disclosures, such as economic status, information about the family and pet, and at times it also involves information about sexual orientation, hobbies, habits, neighbors, community and much more. Third is accidental self-disclosure, which occurs when there are incidental encounters that, as discussed above, are rather frequent and normal in rural communities. Another type of accidental self-disclosure is through therapists' spontaneous verbal or non-verbal reactions (i.e., expression of shock, spontaneous expression of appreciation or anger) or other planned and unplanned occurrences that happen to reveal therapists' personal information to their clients (Stricker & Fisher, 1990). The fourth type of self-disclosure takes place when clients deliberately seek information about their therapists without their therapist's consent or knowledge. Clients can initiate inquiries about their therapist by conducting a simple Web search or stalking their therapist.

Generally, the attitude towards therapeutic self-disclosure is closely related to the therapist's primary theoretical orientation. On one extreme are traditional analysts who focus on neutrality and anonymity for clinical and transferencial reasons. More recently, focus on the interpersonal by several modern psychodynamic psychotherapies has emphasized the importance of self-disclosure in relational and intersubjective perspectives (Aron, 1991; Barnett, 2011; Bridges, 2001; Burke, 1992; Cooper, 1998; Stricker & Fisher, 1990). In contrast to the traditional analytic approach, humanistic, existential, group, family, behavioral, cognitive, feminist and narrative psychotherapist all see clinical value in self-disclosure, however, for different reasons.

Regardless of one's orientation, self-disclosure is prevalent and normal in rural communities. Obviously, the second type of self-disclosure, where therapists are known in their communities, has the greatest relevance to therapists who practice in rural communities and must contend with extensive and ongoing self-disclosure. Due to the nature of rural communities, therapists' personal lives are highly visible, and as a result, a therapist's marital status, family details, economic status, religion or political affiliation, sexual orientation, hobbies and even temper and other personal information may be readily available to past, current and future clients (Barnett, 2011; Brown, 1984; Campbell & Gordon, 2003; Hargrove, 1986; Lazarus & Zur, 2002; Nickel, 2004; Osborn 2012; Schank, Helbok, Haldeman & Gallardo, 2010; Schank & Skovholt, 1997, 2006; Stockman, 1990).

Rural therapists must learn to live with a significant level of self-disclosure that derives from the inherent nature of rural living. I, the author of this article, live in a town of 8,000 people, which is considered neither very small nor rural. Still, almost every time I emerge from my home to play basketball, shop at the local market, attend a movie in our local one screen theater, I bump into a current or past client and, probably unwittingly, into some future clients. How I dress, the car I drive and my interactions with my family members are often observed by clients.

Within the therapy encounter, where self-disclosure is optional, therapists must make sure that the disclosure is done for clinical-therapeutic purposes or for the client's benefit rather than for the therapist's. Thus, the intent of the therapist is extremely important as it should be focused firmly on the client's welfare and should not be fueled by the gratification of the therapist's needs or desires (Barnett, 1998; Bridges, 2001; Mallow, 1998). Several writers have raised the concern that the therapist's intentional self-disclosure should neither burden the client nor be excessive nor create a situation where the client needs to care for the therapist.

The importance of familiarity and its relationship to trust plays an extremely important role in rural communities. As with the data from minority communities (Barbopoulos & Clark, 2003; Sue & Sue, 2003), many clients in rural communities will enter into therapeutic relationships only if they are familiar with the caregiver's values, life style and attitudes towards certain issues. Due to the interdependent nature of rural communities, trust is derived from familiarity rather than from credentials and professional status alone (Zur, 2000, 2005d). Therapists who try to drastically reduce their visibility and involvement in their communities (i.e., buying a car in a far away town only to avoid buying it from the only dealership in town owned by their client) are likely to elicit distrust and suspicion in small communities. Clients' inquiry from friends, neighbors and other fellow residents in rural communities about their therapists can easily yield extensive and detailed data. At times a client's awareness of their therapist may give rise to concern for the client and may affect the clinical encounter. For example, a pro-life client may realize that his therapist is pro-choice. Similarly, different religious or political affiliations may cause distrust or other feelings in regard to their therapist. When possible and appropriate, therapists should try to identify such tensions and discuss them with their clients. At times differences may interfere with the therapeutic progress, and termination and referral, if even possible, may be the correct path of action.

Graduate schools and profession training, which often base their ethics and practice teaching on the urban, analytic or risk management principles, rarely prepare new therapists to deal with this important aspect of rural mental health (Barbopoulos & Clark, 2003; Keller, Murray, Hargrove, & Tangerine, 1983; Murray & Keller, 1991). As a result, these therapists are unprepared, uninformed and often uncomfortable, even trying to avoid inevitable social encounters in their communities in order to avoid self-disclosure.

Dual Relationships

Dual relationships in psychotherapy, also referred to as multiple or overlapping relationships, refer to the existence of an additional role or roles between therapist and client in addition to the clinical relationship (Boland-Prom & Anderson 2013; Brownlee, Halverson, & Chassie 2012; Zur & Lazarus, 2002; Zur 2007, 2017). Examples of dual relationships are when a psychotherapy client is also a community member, fellow congregation member, friend or business associate of the therapist. As with incidental encounters and self-disclosure, dual relationships are the hallmark of the interconnected, rural settings. While often controversial, dual relationships, especially social and business, are an unavoidable part of interdependent rural settings (Schank, Helbok, Haldeman & Gallardo, 2010).

There are many types of dual relationships in rural communities. Most often they are social dual relationships, where a client and therapist also socialize in the community or meet on Sunday in the only church in town. They are often professional, where a client is also a colleague of the therapist in the only mental health center in town. They can be business dual relationships, where the therapist is a patron in the only shoe store in town owned by the client. They can be professional, when client and therapist are involved in an artistic or creative partnership or are involved in a fund raising effort. Dual relationships can be avoidable, as is the case in most large urban areas, unavoidable, as in small rural towns, or voluntary, when the therapist has a choice in the matter.

As was noted above and as was demonstrated by the rural practice, not all dual relationships are unethical (Burgard, 2013; Koocher & Keith-Spiegel, 2016). Section 3.05 of the 2016 APA code of ethics clearly states: “Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.” Dual relationships are very common in rural settings (Barbopoulos & Clark, 2003; Barnett, 1999; Barnett, & Yutrzenka, 1994; Burgard, 2013; Campbell & Gordon, 2003; Osborn, 2012; Schank, Helbok, Haldeman & Gallardo, 2010; Schank & Skovholt, 1997, 2006; Zur, 2000, 2007). Borys and Pope (1989) found that nonsexual relationships were more acceptable to rural than urban psychologists. Due to the nature of rural settings, therapists and clients are very often engaged in social dual relationships when they are members of the same congregation, belong to the same gym, when they chaperone their children on a school trip, serve on the same PTA committee, play in the same recreational league, attend a concert in the only theater in town or when therapists and clients join in fund raising for a local cause. Therapists and clients are often engaged in business dual relationships when the therapist makes copies at the only copy store in town that is owned and operated by a client, or when a therapist shops in an establishment where the client is working. Professional dual relationships are as relevant and manifest themselves when therapist and client are both members of the local Rotary club, chamber of commerce, community agency board or local professional organization etc. Another type of professional dual relationship frequently occurs in rural communities due to the very limited number of professionals. This is when a therapist sees friends, acquaintances or colleagues in therapy. Besides the availability issue, rural communities rely more heavily on word of mouth, first hand information recommendation and referrals when seeking services rather than on advertisements or Yellow Page type listings.

Publications on mental health practice and ethics during the 1980s and early 1990s focused primarily on the risks of dual relationships and their association with sexual boundary violations (e.g., Borys & Pope, 1989; Epstein, Simon, & Kay, 1992; Gutheil & Gabbard, 1993; Kitchener, 1988; Pope, 1989, 1990; Pope, Sonnet, & Holroyd, 1993; Simon, 1991, 1992; Sonne & Pope, 1991; Strasburg, Jorgenson, & Sutherland, 1992). Blatantly ignoring the reality of rural communities, many of them proscribe the impossible, the complete avoidance of dual relationships. Starting in the mid 1990s, a shift took place. Using the rural mental health as the poster child or case study, more publications have reviewed the inevitability of dual relationships in rural and other settings (e.g., Barnett, 1999; Barnett, & Yutrzenka, 1994; Burgard, 2013; Campbell & Gordon, 2003; Ebert, 1997; Hedges, Hilton, Hilton, & Caudill, 1977; Kessler & Waehler, 2005; Knapp & Vandecreek, 2006; Lazarus, 1994, 1998; Lazarus & Zur, 2002; Schank & Skovholt, 1997, 2006; Schank, Helbok, Haldeman & Gallardo, 2010; Tomm, 1993; Williams, 1997; Younggren & Gottlieb, 2004; Zur, 2000, 2004a). A few publications have gone beyond the acknowledgment that dual relationships are sometimes inevitable and unavoidable. Referring often to rural settings, they discuss the fact that dual relationships are often a normal and healthy part of communal living and, in fact, can also be beneficial, increase trust, speed up therapy and enhance clinical outcome (Barnett, 1999, 2017; Boland-Prom & Anderson, 2013; Brownlee, Halverson, & Chassie 2012; Campbell & Gordon, 2003; Herlihy & Corey, 2006; Kessler & Waehler, 2005; Lazarus & Zur, 2002; Osborn, 2012; Schank & Skovholt, 2006; Williams, 1997; Younggren & Gottlieb, 2004; Zur, 2001a, 2005b).

The codes of ethics of some of the most prominent professional organizations have mirrored the changes in attitude towards dual relationships by the general field. The 2016 American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* simply and clearly states: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Section 3.05, para. 3). In contrast to many ethical teachings and publications, almost all codes of ethics of professional psychotherapist associations (e.g., ACA, AAMFT, NASW) do not prohibit non-sexual dual relationships. They generally state: a. non-sexual dual relationships are not always avoidable; b. non-sexual dual relationships are not always unethical; c. therapists must avoid only the dual relationships that might impair their judgment and objectivity, interfere with performing therapy or supervision effectively or harm or exploit patients. For direct quotes from the code of ethics on dual relationships, see section below on Codes of Ethics on Rural Related Boundaries.

The author's own Office Policies, which are given to clients prior to the first session, state:

DUAL RELATIONSHIPS & INCIDENTAL ENCOUNTERS: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Zur's objectivity, clinical judgment or therapeutic effectiveness or can be exploitative in nature. Dr. Zur will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Sonoma is a small town, and dual relationships may not always be avoided. Many clients choose Dr. Zur as their therapist because they know him socially or work with him before they enter into therapy with him. Nevertheless, Dr. Zur will discuss with you, his client/s, the often-existing complexities, potential benefits and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to Dr. Zur if the dual relationship become s uncomfortable for you in any way. Dr. Zur will always listen carefully, and respond accordingly, to your feedback and will discontinue the dual relationship or therapy if he finds it interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time.

Navigating dual relationships in rural communities can be an enriching and rewarding experience, but it can also be challenging. Therapists must evaluate each dual relationship and determined its risks and benefits. A very engaged social or professional dual relationship with a borderline or paranoid client may not be clinically or ethically advised. However, the same relationship may be enriching with a well functioning client. Therapists who are the only mental health professionals in their communities may encounter situations where, for clinical reasons, they would prefer not having certain business or social dual relationships with certain clients. However, being the only one available for face-to-face therapy, they may face unavoidable dual relationship situations where they must conduct and document a thorough analysis of the risks and benefits of not treating the client vs. the risks and benefits of treating the client while engaging in an unavoidable dual relationship. Thorough documentation and consulting with an expert via the phone or email is of extreme importance in such situations. In many cases discussing the complexities involved in any dual relationship with clients and getting their opinions and perceptions is very important from a clinical and ethical point of view. Needless to say, the sexual dual relationship with current or recently terminated clients is always clinically and ethically ill advised and illegal in most states.

In summary, rural communities present psychotherapists, who practice there, with a wide range of unavoidable dual relationship situations, which are embedded in the social structure and, therefore, become normal, accepted and expected. People in such communities are familiar with most of their fellow citizens, including the local therapists. These communities often offer only a limited pool of therapists from which to choose As a result, therapists and clients often know each other prior to the start of therapy and interact with each other in a number of non-clinical capacities before, during and after therapy. Practitioners in such small communities often cannot avoid interacting with their clients at the local market, community events, business clubs and school functions. Avoiding all contacts would require the therapist to lead the life of a hermit. If therapists choose to isolate themselves, they will be looked upon with suspicion by members of such communities who rely on familiarity for the development of trust. Rural therapists are presented with a wide spectrum of dual relationships, some are likely to enrich the clinical work and others may be more challenging. Therapists, therefore, must carefully and attentively consider the potential impact of the dual relationship on the therapeutic exchange and conduct a risk-benefit analysis of the dual relationship situation in order to know how best to proceed. At times, consultation with an expert is an important part of the ethical decision-making process.

Competencies and Scope of Practice

One of the main characteristics of rural communities is the limited availability of resources in general and mental health resources in particular (Stamm, 2003). There are fewer practitioners, resources, consultants and supervisors in rural areas compared to most urban ones (Hastings & Cohn, 2013). As a result, rural clinicians commonly perform their professional work as generalists. They must assume broad responsibilities with more independence and attend to medical conditions that do not

necessarily fall within their scope of practice as defined by their education, training and experience. Additionally, there are fewer training opportunities available in rural areas compared to large urban settings (Barbopoulos & Clark, 2003; Roberts, et. al., 1999; Hastings & Cohn, 2013).

Psychotherapists, like most health care providers, in remote and isolated communities must attend to a very broad range of mental health issues. These can range from birth and pediatric to end of life and grief issues, from trauma to marriage therapy and from acute emergencies to existential and spiritual issues. As the only practitioners available in the area, they must deal with depression, anxiety, schizophrenia, PTSD, postpartum depression, suicidality and every other mental disorder in the book. Their obviously great need for specialist support conflicts with the reality of fewer resources, less supervision and fewer available specialist-consultants than are available to their urban counterparts.

These generalist issues have clinical, ethical and, potentially, legal ramifications, because it often means that rural psychotherapists routinely are working outside their scope of practice as traditionally defined by their education, training and experience.

Most professional association codes of ethics attend to the issue of competency. Following is the section in the American Psychological Association's (APA) most recent code of 2016 on the issue of limited resources, such as in rural areas.

> When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study. (Section 2, Competence, para d.)

The code seems to attend well to the challenges and complexities that are faced by rural practitioners. As in the section on dual relationships, cited above, the section on competency takes into account that rural and other practitioners in isolated areas where resources are limited (e.g., aircraft carrier, remote military base) may need to conduct interventions for which they do not have training or education.

Recent technological developments have the potential to aid rural practitioners in their diverse and broad practices. First and foremost, the Internet is a rich resource that can provide therapists with updated information and guidelines on different conditions and disorders. Professional listserve, chat-rooms and poster-boards can also help therapists navigate new and difficult territories and gain necessary information to attend to the many mental conditions needing their attention. While phone consultation has been available for many years, email, Instant Messaging, Video-Conferencing and other methods of communication have increased the ease of utilizing clinical, ethical and legal consultations. Along the same lines, continuing education programs are now available online or via home study courses and are no longer limited to actual classroom format. Therefore, the rural therapist is not burdened with expensive training and driving long distances. While some states have allowed clinicians to obtain most or all of their continuing education credits via online courses, some other states are still lagging behind and dragging their feet into the technological era.

Telemedicine

The use of the telephone as an adjunct to traditional verbal psychotherapy has been common for several decades in rural and in urban settings. The telephone has primarily been used in emergencies, crisis interventions, follow ups, rescheduling of appointments and other basic necessary communications between office sessions. The technological explosion towards the end of the 20th century, with its widespread use of cell phones, email and, more recently, Instant Messaging (IM), chat, video teleconferencing (VTC), audioconferencing, text messaging, blogging and photo-cell technology, have changed the way that billions of people communicate, learn and get informed. This has special meaning for rural medical care where resources are limited and density is low. In some rural areas traveling to a therapy appointment can take a whole day. Many clients have neither the time nor the means or capacity to make such effort. Similarly, therapists who conduct home visits may spend long hours to reach a single home, which means that they can see a very limited number of people on such travel days.

Telemedicine is a boundary issue that transcends the traditional boundaries of the office and brings a new format to the boundary between therapists and patients who are not engaged in a face-to-face exchange when they participate in telemedicine. Telemedicine (also called e-medicine or web-based medicine) has proliferated primarily with patients who either cannot access traditional medical services or have no medical services in their locale. This is particularly true in remote and rural areas and among the bedridden, homebound and those who cannot access medical services for mental (e.g., phobias), physical (e.g., handicaps, hospice) or other reasons (e.g., lack of transportation). Psychological online resources

(cyberpsychology) are purported to present low-cost, convenient and supportive services to the online population (Maheu, Whitten, & Allen, 2001; Grohol, 1999). Some knowledgeable people believe that the e-technologies will overcome the current electronic divide due to local (i.e., rural areas), economic and cultural barriers (Stamm, 2003).

Telemedicine has a huge potential in rural areas, as was recognized by the Surgeon General's 1999 report (U.S. Department of Health and Human Services) on mental health along with other reports (Barbopoulos & Clark, 2003). The report raised several concerns regarding rural and other unique settings and approximates that two-thirds of people who need mental health care never receive it because they cannot access it for a variety of reasons. This can be that they are too embarrassed or shy to make in-person contact with a psychotherapist. The report goes on to suggest that online therapy is a possible solution because it can be highly accessible, relatively inexpensive, it uses non-direct visual environment and offers these clients a sense of security and a way to express themselves with less sense of shame or intimidation.

For various reasons, including economic (i.e., poverty), cultural (technical or lack of orientation), technological (i.e., access to Internet) and age (generally, young people are more comfortable with the new technologies), rural clients are often less likely to utilize telemedicine at the present time. However, with the increased focus on the benefits of tele-technologies in rural areas there is slow and consistent progress in technological utilities in mental health. There are a number of reasons that telemedicine can be very helpful in increasing accessibility and utility of mental health services in rural areas.

Following are a few examples of the potential benefits of online therapy compared to traditional face-to-face therapy in an office:

- A young man in a small rural town who wants to explore his newly discovered homosexuality. He would not dare to consult face-to-face with any local psychotherapist but would sign up for online therapy with a therapist in another part of the state.
- A poor client who does not have reliable transportation to reach a mental health practitioner who practices 100 miles away.
- An agoraphobic or home bound client who lives far from a local mental health center, where the therapists cannot schedule a home visit more than once every few months.
- Latino, Chinese or Indian patients who live in rural areas and would like to communicate with their therapists in their native tongue but have no psychotherapists in their area who speak their language.
- A prominent public figure in a small rural town who wants to discuss online sex addiction but would not seek help from any local therapist.
- A deaf client who resides in a small isolated town and cannot benefit from talk therapy, cannot find a compatible signing therapist and does not want to use a translator.
- A disorganized and poor family that is scattered around the rural area would like to have family therapy via phone, chat or teleconferencing.

There are several concerns with the delivery of mental health services online. Accordingly, online therapy advantages are also accompanied by a number of ethical, legal and clinical challenges and dilemmas. These include concerns with valid identification of the client, valid informed consent, confidentiality of electronic communication, technological competencies, electronic divide and economic and cultural barriers, states' licensure requirements and practicing across state lines, legal issues around mandatory reporting requirements and effectively responding to mental crises and emergencies, such as danger to self or others.

One of the most problematic aspects of telehealth is that some states' laws and licensing board regulations prohibit practicing psychotherapy across state lines. In an era where surgeons perform remote surgery on clients half way around the world, nurses take vital signs remotely via modems, expert physicians fly to different states to provide consultations and treatment, where online support groups and chat rooms bring people with similar disorders together from all over the world, the injunction against practicing across state lines seems archaic. Consider a consultation case involving a psychologist who conducted psychotherapy with a high functioning executive-client for 15 years in intermittent-long-term therapy. Therapy was very effective in helping the client deal with his intermittent, acute panic attacks. When the client had to relocate to a rural area, he wanted to continue the well-established and highly successful therapeutic relationship with his long-term therapist via phone and email. Very few therapists were available in the new locale, where most of them were primarily involved in public agency work and none was an expert in panic disorders. The client did not want to seek out another therapist as was suggested by his long time therapist, who offered to help him find one and help with the transition. The client trusted, was comfortable with, had an excellent history with his therapist and saw no reason to seek a new relationship with a new therapist. However, the state where the client was relocating has a law where the treating therapist must be licensed in the

state where the client resides. Due to this current state law and the licensing board regulations against practicing across state lines, the therapist had to terminate therapy. The client resented having to "shop" for a new therapist while being required by this situation to expend the clinically unnecessary time, energy and money required to familiarize himself with a new therapist. He was even more upset when he learned about the low availability of therapists in his new, rural area. The disappointed client viewed the situation as a "legally mandated professional abandonment." The therapist viewed the termination as clearly counter-indicated as it did not enhance the client's welfare. As telehealth is proliferating and is used more widely in medicine, state licensing laws are likely to catch up with our technological advancements.

Some of the suggestions for ways that therapists can attend to boundary and clinical, ethical and legal concerns regarding telehealth are:

- Provide client, prior to beginning of therapy, with a clear Informed Consent detailing the limitations of telehealth, in general, and confidentiality and privacy, in particular.
- Detail the vulnerability of privacy and concern with confidentiality on any telephone, cell-phone or web-based communication.
- Inform the client of potential limitations of telehealth when it comes to crisis intervention and dealing with dangerous situations.
- Identify the importance of securing correct identification of client.
- Keep on file hard copies of client's informed consent for treatment, biographical background, etc.
- Practice within your limits of clinical and technological competence.
- Have a crisis intervention plan in place, including ways to reach local emergency services, and make referrals to local psychotherapists, psychiatrists and psychiatric hospitals.
- Verify the legality of practicing across state lines in the states where you and the client reside.
- Provide thorough screening and be aware of the growing research on telehealth when considering which clients may not be suited to this kind of medium.
- Have a clear agreement in regard to the fee that is being charged, how is it being charged and, of course, the rates and method of payment.
- Follow your state laws, your licensing board rules and your state and national professional association guidelines.

In summary, telehealth or e-therapy are new and rapidly evolving means of conducting psychotherapy, which have a potential to significantly increase accessibility and quality of rural mental health services. Telehealth can help clients who are poor and/or lack transportation, who live far from mental health services, who cannot locate a suitable or appropriately matched mental health practitioner or who are shy or reluctant to obtain face-to-fact traditional services. The potential benefit of telehealth to rural areas is enormous, but economic, technological, cultural, and other barriers still need to be overcome.

Top of Page

ADDITIONAL BOUNDARY CONSIDERATIONS RELEVANT TO RURAL PRACTICE

This section reviews additional boundary considerations, such as bartering, gifts and several types of out-of-office experiences. The latter include therapists attending clients' ceremonies and rituals, making a home visit, conducting outdoor or adventure therapy or getting and giving a ride from/to a client. This section concludes with a brief summary of additional boundary considerations, which are not necessarily unique to rural settings. These include the issues of physical touch, home office, silence, clothing, sharing food and lending money or objects to clients.

Bartering

Bartering, in general, is the exchange of goods and services. It has surely been a part of human interaction since the dawn of our species, many thousands of years before gold, silver or paper money was introduced. It is more common in agricultural or farming and poor rural communities (Barnett, 2017; Canter, Bennett, Jones, & Nagy, 1996; Koocher & Keith-Spiegel, 1998). People have bartered or traded in almost all areas of their lives. Today, in psychotherapy or counseling, bartering is the acceptance of services (automobile or plumbing repair, house cleaning, secretarial work, etc.), goods (chickens, cabinetry, produce, sculpture, etc.) or other non-monetary payments from clients in return for mental health services. Generally, bartering is more common with poor clients who seek or need therapy but do not have the money to pay for it. It is more common with those who are cash poor but more readily can exchange services for agricultural produce. Artists are often cash-poor but art rich and are often more than happy to barter with their art. It is also part of the norm in certain non-European

cultures and alternative communities. It is also more common in times of economic depression, when clients and/or therapists are in financial straits. On the therapist's side the dominance of managed care in the last couple of decades has contributed to their financial woes, which in turn has induced them to incorporate lower fees and bartering into their payment policies (Pedersen, 1996; Woody, 1998b; Zur, 2004b). As with fee-for-service services, the employment of bartering arrangements in place of insurance billing increases patient privacy and circumvents the hassles of pre-authorization, audits, and delay and denial of claims (Hill, 1999).

There are many ways to structure bartering arrangements. One common way is an exchange of the fair market value of the exchanged goods or services. For example, if the therapist's fee were $140 per session, a client's sculpture with a fair market value of $1,400 would buy the client-sculptor ten sessions. Some poor agriculture communities often have more flexibility in bartering, where the arrangement is something like one chicken for one session (Zur, 2004b). Other bartering of services agreements are based on an hour for hour trade, that is, an hour of client's work, regardless of its fair market value, is provided in exchange for one "therapy hour."

Bartering in therapy is clearly a boundary issue as it alters the usual, agreed parameters of the therapeutic relationship vis-à-vis remuneration, and it presents an alternative to the customary method of payment or insurance reimbursement (Barnett, 2017; Gutheil & Gabbard, 1993, 1998; Williams, 1997; Zur, 2004b). All bartering arrangements are, at the very least, boundary crossings. While bartering of goods is more likely to constitute a boundary crossing but not usually a dual relationship, bartering of services always creates dual relationships. For example, when a client barters a chicken in exchange for therapy, this does not generate another relationship besides the therapeutic one; it is merely a boundary crossing. The chicken just replaces the cash, check or credit card payment. Bartering of services clearly creates a dual relationship wherein barter introduces a secondary connection, most often a business relationship, into the therapeutic one. For example, a client who cleans the office or baby-sits in exchange for therapy is involved in a dual relationship, as the client is simultaneously an employee and a client. The concerns with bartering usually focus on the complications that arise from determining the financial value of goods and services that are bartered for therapy or if therapy has to stop and the product has been delivered or services have been provided (Woody, 1998a). Another concern is when therapists are discontent with the product or service they exchange for the therapy.

The APA code of ethics has been evolving consistently over the last several decades in the direction of wider acceptance of bartering. The most recent code of ethics (2016) simply defines, but does not denounce, bartering anymore. Section 6.05, Barter with Clients/Patients, states: "Barter is the acceptance of goods, services, or other non-monetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative." The codes of ethics of almost all other large professional associations, such as AAMFT (2015), ACA (2014) and NASW (2017), give mixed messages about bartering. On the one hand they discourage their membership from engaging in bartering, but on the other hand they permit it if it is not exploitative, not clinically contraindicated and is an accepted practice in the community. No doubt, bartering is accepted in many agricultural and poor rural communities.

Gifts

Giving a gift is an ancient and universal way to express gratitude, appreciation, altruism and love (Saad & Gill, 2003). Gifts have been defined as "something that is bestowed voluntarily and without compensation (Dictionary.com, 2005). Therapists, in general, receive gifts from clients (Borys & Pope, 1989; Pope, Keith-Spiegel, & Tabachnick, 1986). The gift giving exchange is even more prevalent in smaller communities and certain cultures. There are several types of gifts in therapy. The first type, and the most common, is gifts to therapists by clients. These are often small, symbolic gifts given during the holidays, towards the end of therapy or after a difficult period of therapy. The second, and quite common, are gifts from therapists to clients, often given at the end of therapy, during the holidays, for birthdays or as a transitional object to help clients deal with anxiety or separation (Zur, 2005e).

Gifts can be symbolic (e.g., a poem) or concrete (e.g., a book), and they can be modest — homemade cookies or bread, a music CD, flowers, homegrown fruits or a framed picture — or more extravagant and expensive or truly excessive items or a large sum of money (Knox, Hess, Williams, & Hill, 2003). Gifts can be appropriate or inappropriate in their type, monetary value, timing, content, frequency, intent of the giver, perception of the receiver and their effect on the giver, receiver or anyone else that may be touched by the gift-giving (Knox, et. al., 2003; Spandler, Burman, Goldberg, Margison, & Amos, 2000; Welfel, 2002). Even small gifts can be inappropriate if, for example, they include violent or sexual or romantic themes (Koocher & Keth-Speigle, 1998). Some scholars describe an overlap between gifts, favors and bartering and view most gifts as a form of unspoken quid pro quo (Gabbard & Nadelson, 1995). At times, especially in child therapy, therapists may be given gifts by the clients' parents or other family members. Other types of gifts in therapy are sample medications and gifts by pharmaceutical

companies, often as part of their multibillion-dollar annual marketing efforts and gifts that are made in response to referrals of new clients. The latter can be viewed as a kickback, which has been deemed unethical and even illegal in many similar situations.

Rural and small communities and certain cultures, such as Native American, have a long tradition that appreciates gift exchange. As a result, gifts are likely to be a more prevalent and accepted practice in such communities. While clinicians must pay close attention to cultural and communal factors that influence gift giving, they must also pay attention to clinical issues, make sure that they understand the meaning that clients give to their gifts and notice whether clients try to buy love through their gifts (Corey, Corey, & Callahan, 2003; Hahn, 1998; Spandler, et al., 2000; Zur, 2005e).

Besides the clinical-psychological aspects, gift giving in psychotherapy must always be considered within its cultural context. More often than not, the meaning of gift-giving behavior derived from specific cultures can only be understood within this cultural context (Corey, et al., 2003; Koocher & Keth-Speigle, 1998; Trimble, 2002). Regardless of the therapist's clinical or ethical stance on the subject of gifts, s/he must be aware that turning down a small gift may mean rejection or disrespect to an individual who comes from a culture which stresses hospitality, reciprocity or the importance of gift-giving rituals (Barnett & Bivings, 2002; Nathan, 1994; Spandler, et al., 2000). A standard, pre-existing "no gift policy" is often meaningless and does not mitigate the sense of insult or humiliation for a non-Western client whose culture emphasizes the significance of gift giving. While in many Western cultures the verbal expression of gratitude seems appropriate and sufficient, in many non-Western cultures actual gifts and attendant rituals are the primary means of expressing gratitude, affirmation and an emotional bond (Otnes & Beltramini, 1996). In order for a therapist to successfully work with a client from a non-Western culture it is necessary to comprehend the specific meaning of the gift ritual for the culture in question (Saad & Gill, 2003). In the Indian, Cambodian and many other Far Eastern cultures, there is greater focus on the meaning and rituals of gift giving. In some of these cultures the gift is not given to the person but to the spirit in the person. In others the gifts are perceived to be able to cure ailments or mental illness if they appease the spirit of the ancestors carried by the sick person. According to this tradition if the gift is not given, the sickness may return (Refugee Mental Health In The United States, 2004). Japanese, Indian and many other cultures generally have very proscribed rituals regarding what should be given, when, to whom and how. Native American clients may give their therapist tobacco when asking for healing or, consistent with the rituals of giving gifts to healers, they may give some other kind of gift at the very first session (American Indian Mental Health Advisory Council, 2004).

The act of gift giving is the act of crossing the traditionally drawn professional-interpersonal line. Clinically appropriate gift giving, either by clients, by therapists or by a third party, are considered boundary crossings (Gutheil & Gabbard, 1993; Lazarus & Zur, 2002; Williams, 1997). Inappropriate gifts by clients, therapists or third parties and gifts with inappropriate or offensive themes or gifts that create indebtedness are boundary violations (Gutheil & Gabbard, 1998; Koocher & Keith-Spiegel, 1998; Zur, 2005e).

Most major professional organizations' codes of ethics, except AAMFT and ACA, do not address the issue of gifts directly. The AAMFT Code of Ethics states, " Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship." (2015, Standard III, 3.9). The American Counseling Association (ACA) revised code of 2014 takes a similar flexible stance on gift giving. The APA Code of Ethics (2016), like several other codes, does not mention gifts directly but has an injunction against gifts for referrals and other forms of kickbacks. Like any other ethical decision regarding boundary crossing, the decision whether to accept or give gifts should be based first and foremost on the welfare of the client and must be made under the general moral and ethical principles of Beneficence and Nonmaleficence. For example, therapists intervene in ways that endeavor to benefit their clients and avoid harm. Applying these principles to gift giving means that the decision should be clinically driven and must take into consideration the client's presenting problem, culture, history, age and any other relevant client factors. As with any boundary crossing, when making the decision to accept or give a gift, the therapist should balance the risks against the benefits of accepting or not accepting a gift and, similarly, conduct a risk-benefit analysis for giving or not giving gifts to clients. From a risk management point of view gift exchange, like self-disclosure, home visits and non-sexual touch, has been cited as an area of concern (Gutheil & Gabbard, 1993; Williams, 1997; Zur, 2005e). As with any risk management concern, therapists must document any gifts whether given by clients, therapists or a third party and articulate the rationale for their intervention in the context of the client, the setting and, when appropriate, their therapeutic modality.

Out-Of-Office Experiences

There are a number of situations where therapists leave the office for clinical reasons. A prime example is therapists conducting an in-vivo desensitization session with a phobic patient in the outdoors. Other examples are when therapists join clients in rituals and ceremonies, make home visits, or conduct therapy in the outdoors as part of adventure therapy. Other out-of-office experiences may involve therapists giving or getting a ride from a client before or after a session. There has been

ongoing confusion in the field of ethics where these kinds of out-of-office activities were confused with dual relationships (Sonne, 2006; Zur, 2001a, 2005d, 2007). The above-mentioned interventions are clinically driven interventions that do not add a secondary relationship to the therapist-client relationship. They are all boundary crossings but not dual relationships.

Following are brief descriptions of out-of-office activities that are most relevant and unique to rural mental health services.

Ceremonies, Rituals and Life Transitions

Therapists who work in rural, small or ethnic communities may accept invitations to attend significant life transitions and rituals or celebrations in clients' lives. Examples are: attending the wedding of a couple who finally decides to get married after many tumultuous years of pre-marital therapy; attending the graduation of a patient who never thought he would complete his studies and got the help and support to do so from his therapist; accepting invitations to the funeral or memorial service of a client's spouse or child; joining clients to celebrate christenings, confirmations, sweat lodge ceremonies, bar mitzvahs and similar events; attending the first performance in a school play of an adolescent girl who, with the help of therapy, overcame her fear of public speaking; viewing the solo show of a client-sculptor who finally overcame a severe artist's block; and going with a landscape architect, who has overcome drug addiction and depression, to view the prize-winning garden he designed. Rejecting such invitations can easily result in significant or even irreversible rupture of the therapeutic alliance. Such special efforts and openness on the part of the therapist have been reported to significantly increase therapeutic alliance and therapeutic effectiveness (Lazarus & Zur, 2002). There are other events that warrant leaving the office. Therapists who work with different cultures inevitably join their Native American clients in some of their sacred rituals, their Latino clients in weddings, their Catholic clients at confirmations, or their Jewish clients for bar or bat mitzvahs (Kertész, 2002; Zur, 2001a, 2005d). Refusing to do so, in certain cultures, is likely to cause irreparable damage to the therapeutic alliance, to nullify trust and is likely to render therapy ineffective. Unlike the commonly held believe, there are no laws or ethical guidelines that prohibit therapists from attending such events. As with any other clinical intervention, therapists must make sure that the client's welfare is being considered first. As with any intervention, therapists must take into consideration the client, the context of therapy, the therapeutic relationships and the therapist's factors in determining the clinical and ethical appropriateness of attending clients' ceremonies or rituals outside the office.

Home Visits

The home visit used to be the most common way for the family doctor to attend to their patients. Still, there are many reasons for therapists to make a home visit, especially in rural settings where the population density is low, people are spread over large areas and poverty is prevalent. Some clients cannot make it to the therapy office because they are too ill or too old, are bedridden, homebound or disabled or do not have the transportation or other means to get to the office (Zur, 2001a, 2005d). Some clients are suffering from debilitating depression, agoraphobic, paranoia or are too OCD to leave the house (Christensen, 1995; Morris, 2003; Rabin, et al., 1982; Zur, 2001a, 2005d). Some families are too disorganized, too scattered emotionally and/or physically, do not have the means of getting to the office or live too far away to bring all family members together for an office visit. Other families might derive special benefit from a home visit where the therapist can observe the complexities and hardships of their lives and become familiar with the context of their family life, support system (or lack thereof) and neighborhood. In some cultures, such as that of certain Native American tribes, the home is a much more acceptable venue for mental health interventions than the medical office. Most of the literature on home-based therapy has focused on interventions that were either part of family therapy (Bass, 1988; Berg, 1994; Boyd-Franklin & Bry, 2000; Christensen, 1995; Halvorson, 1992; Kanter. 1977; Washburn, 1994) or some type of case management regarding abuse, neglect or foster child concerns (Morris, 2003). It was not until the passage of Public Law 96-272, also known as the Adoption and Child Welfare Act of 1980, that home-based family therapy became significantly more common (Morris, 2003). The law was enacted partly in an attempt to avoid out-of-home placement of foster children and also to increase their safety through case management and home-based family therapy. The proliferation of case management primarily conducted by social workers as part of their assessments of child abuse, child neglect and domestic abuse, as well as the increased use of interventions since the early '80s, have made home visits a normal part of case management assessment and intervention. The close-knit cultures that often characterize rural communities often expect home visits as part of the flow of social exchange in these communities. Additionally, the office or place of service is often located very far from residences, which may be scattered over a very large geographical area. The fact that a large percentage of the rural communities are also poor and often part of diverse non-Anglo cultures may also provide more incentive for clinicians to conduct home visits, especially because they can learn more about their clients' lives and the economic, physical, communal and spiritual aspects of their lives through home visits. While there are neither laws nor ethical guidelines that prohibit home visits there are, in fact, laws, such as mentioned above, that strongly encourage it. In addition to attending to the client, setting, therapy and therapist factors, safety issues must be addressed as well during home visits and at times special training can be highly beneficial, (Schacht, et al., 1989).

Outdoor or Adventure Therapy

The proliferation of remotely located alternative boarding high schools and drug rehabilitation inpatient programs in the last couple of decades has resulted in a huge rise in utilization of outdoor or adventure therapy (Zur, 2005d). This therapeutic approach is known by various names. It has been called Adventure Therapy (Gass, 1993), Wilderness Therapy (Davis-Berman & Berman, 1994), Outdoor Therapy (Orchin, 2004), Camping Therapy (Lowry, 1974), Outdoor Pursuits, and Risk Education (Ewert, 1987). For clinical and economic reasons these programs are often located in rural and remote areas. However, they also can be located in urban settings where there are indoor facilities for rock climbing or trapeze structures and rope courses (Levine, 1978). The clients examine their beliefs in both their limitations and abilities and learn to rely on themselves and the group in order to carry out a variety of tasks assigned them. What unifies these programs is that they are conducted in the outdoors where patients are physically and emotionally challenged to overcome their fears and reassess their self-perceptions. Adventure therapy or Wilderness Programs are mostly conducted in remote settings, outdoors. They mostly include activities such as backpacking, hiking, biking, camping, canoeing, rope courses, navigating, vision quests, rock-climbing and repelling down cliffs. These forms of therapy are usually highly structured and are composed of individual and group challenges with a corresponding mix of individual risk taking, overcoming fears and group cooperation (Schoel, Prouty & Radcliffe, 1988). These programs have been used extensively with high-risk adolescents in boarding schools and drug rehabilitation programs (e.g., Herbert, 1966), as an adjunct to therapy with long-term mental illness (Banaka & Young, 1985; Berman & Anton, 1988; McClung, 1984; Stich & Senior, 1984), with intellectual disability (Dillenschneider, 1983), substance abuse (Gass & McPhee, 1990), fearful, withdrawn or avoidance clients (Orchin, 2004) and rehabilitation of juvenile delinquents (Herbert, 1996).

Giving or Getting a Ride

Due to lack of public transportation and other resources, rural therapists are likely to encounter situations where clients who are either poor and/or have difficulty with transportation may need a ride back home after a session. For the same reason lack of readily available resources and low population density, therapists may also be in need of a ride to pick up or drop their car in a local garage (Zur, 2005d). While rarely discussed in the professional literature, apparently over a third of the therapists surveyed, reported very occasionally asking their clients for favors, such as a ride home (Fay, 2002; Lazarus, 1994; Pope, Tabachnick, & Keith-Spiegel, 1987). Therapists who ask their clients for such favors must make sure that clients are neither pressured to comply nor that the favor result in a significant burden.

Additional Boundary Considerations Not Specific to Rural Settings

There are several additional boundary considerations that go beyond the scope of this paper. These include non-sexual touch (Field, 1998; Hunter & Struve 1998; Smith, Clance & Imes, 1998; Zur & Nordmarken, 2004), home office (Nordmarken & Zur, 1995; Pepper, 2003; Woody, 1999) and language, clothing and sharing food. (Gutheil & Gabbard, 1993)

Top of Page

STANDARD OF CARE

Understanding the meaning of the standard of care is extremely important for rural practitioners because of the false, yet prevalent, perception that the urban-analytic-solo practice standard is the ultimate or correct one. This is very important in rural or frontier settings where the public mental health system, rather than solo practices, is often the only provider and primarily serves persons with serious mental illnesses who almost never engage in psychodynamic or psychoanalytic psychotherapy.

The Standard of Care is one of the most important constructs in medicine and mental health. Most broadly, the standard of care has been defined as the usual and customary professional standard of practice in the community. It has been described as the qualities and conditions that prevail, or should prevail, in a particular mental health service and that a reasonable and prudent practitioner follows. What is most important in rural mental health practice is that the standard is based on community and professional standards. The importance of this is that rural mental health professionals are held to a rural standard rather than to an urban one. In other words professionals are held to the same standard as others of the same profession or discipline with comparable qualification in similar localities (Caudill, 2004; Doverspike, 1999; Woody, 1998a, b; Zur, 2005c).

There is no one textbook or set of rules that define the standard of care. Instead, the standard of care is primarily determined in courts and licensing board hearings by testimonies from expert witnesses. Attorneys on both sides often present conflicting expert testimonies about the standard of care. The fact that there are many types of communities, cultures, settings and hundreds of different psychotherapeutic orientations make the concept of the standard of care extremely complex, elusive and controversial. Aside from the agreement never to harm or exploit clients, to treat them with respect and dignity and to

protect their privacy and autonomy, there is little agreement among practitioners in the field about what constitutes proper care. A New York City psychoanalyst's treatment of anxiety is likely to be very different than the treatment of the same condition by a local counselor on a Native American reservation in Arizona.

Following are the six elements from which the standard of care is derived. Several of these elements, have also been described by Caudill (2004), Doverspike (1999), Reid (1998), Williams (1997, 2003), and Zur (2005c), among others.

- **Statutes:** Each state has many statutes, such as Child Abuse, Elder Abuse, Domestic Violence Reporting and other laws.
- **Licensing board regulations:** In most states there are extensive licensing board regulations governing many aspects of psychotherapy practices, such as mandated continuing education for licensed psychotherapists and many others.
- **Case law:** Case law is one of the cornerstones of the standard of care. No case is more famous for having created a duty for psychotherapists than the Tarasoff decision of the California Supreme Court in Tarasoff v. Regents of the University California. Along the same line of thought, several experts have predicted that HIPAA regulations will become the standard of care through case law (Newman, 2003; Zur, 2005c). While HIPAA is a federal law that applies across the board, only case laws that are directly related or are applied to rural mental health practice will be relevant to the standard of care for rural practice.
- **Ethical Codes and Guidelines of professional associations:** The professional association codes of ethics are an important but also controversial part of the standard of care. These codes are applied to all professionals regardless of whether they are members of these organizations or not. For example, American Psychological Association (APA, 2016) ethical principles apply to APA members, but in most situations they are also applied to non-member licensed psychologists. Additionally, many states have officially adopted APA or NASW codes of ethics as the licensing board standards for psychologists and social workers, respectively. Practitioners who present themselves as specialists or practice in a more specialized area are likely to be held to the ethical standard articulated by a more specialized professional association.
- **Consensus of the professionals:** In a field that is practiced in many settings and cultures and is comprised of hundreds of therapeutic orientations, consensus is hard to come by. This aspect of the standard of care is primarily derived from professional publications, such as this article; guidelines and presentations, such as in *The Journal of Rural Community Psychology* or summary-review articles, such as by Murray and Keller (1991) or Barbopoulos and Clark (2003); or by reports and recommendations, such as *The Behavioral Health Care Needs of Rural Women* by The Rural Women's Work Group of the Rural Task Force of the American Psychological Association and the American Psychological Association Committee on Rural Health (Mulder, et al., 2000). It may be based on official guidelines published by professional associations, such as APA, ApA, NASW, AAMFT, and ACA, or derived from specific population guidelines.
- **Consensus in the community:** Perhaps the most important aspect of the standard of care is that it is also bound by community norms. Consequently, different communities, which abide by different cultural customs and values, have different standards. Obviously, rural communities differ from urban ones. As this article articulates, issues of self-disclosure, dual relationships, confidentiality, bartering, etc. have very different meaning in rural settings then in urban ones. Consequently, the standard of care for rural mental health differs from that for urban mental health. Similarly, gifts, touch and attending ceremonies and rituals are normal and expected in Hispanic, Jewish or Native American communities (Lazarus & Zur, 2002; Zur, 2001a).

The standard of care has often been viewed in inaccurate ways. Following is a non-exhaustive list of what the standard of care is not.

- It is not a standard of perfection. It is the standard based on the average practitioner and on reasonable actions.
- The standard is neither based on urban practices nor on analytic guidelines.
- It is not guided by risk management principles. This is a deep concern for rural practitioners who very often are unable to follow strict and rigid risk management guidelines, which consist of do not disclose, do not engage in any dual relationships, avoid out-of-office experiences, etc.
- The standard is neither determined by outcome nor by cost. It is determined by practices and their rationale or intentionality.
- The standard is not permanent or fixed. It is continuously evolving and changing.

In summary, the standard of care has been defined by some as the usual and customary professional standard of practice in the community. There is no one textbook or set of rules that define the standard of care, and some suggest it is nothing more than a perception. One of the biggest problems with risk management practices is that they have often been confused with the standard of care. Attorneys and expert witnesses often treat the two as the same. As a result, prudent and competent

therapists are unjustly accused of practicing below the standard of care when they adhere to professional principles, follow the precepts of their orientation and community standards but do not follow strict analytic guidelines or fear-based risk management practices (knapp et al., 2013).

Top of Page

CODES OF ETHICS ON RURAL RELATED BOUNDARIES

Professional association codes of ethics, in general, do not deal directly with boundary crossing concerns except in the case of dual relationships, bartering, gifts and non-sexual touch. Of course, all the codes forbid boundary violations, such as sexual relationships with current clients or exploitative business relationships. The codes make no reference to whether therapy should take place at the office, home office, on a hiking trail or client's home nor articulate any guidelines in regard to self-disclosure or whether therapists should leave the office with their clients or not. All the codes clearly mandate that therapists treat clients with respect and dignity and avoid behaviors that are exploitative and harmful or may reasonably result in harm to clients.

Following are direct quotes from the codes of ethics of the largest professional associations on the issues of dual relationships, bartering and gifts.

In regard to ***dual relationships,*** as was cited above, the 2016 American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* simply and clearly states: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Section 3.05, para. 5). The 2014 American Counseling Association (ACA) *Code of Ethics and Standards for Practice* states: " Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. 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. In extending these boundaries, counselors take appropriate professional precau- tions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs. " (Section A.6.b). The National Association of Social Workers (NASW) *Code of Ethics* (2017), Standard 1.06.c, states: "In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries." (Conflict of Interest Section, para 3). The American Association of Marriage and Family Therapists (AAMFT) *Code of Ethics* (2015), Section 1.3, states: "Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.". Almost all codes of ethics of other professional psychotherapist associations do not prohibit non-sexual dual relationships. They generally state, a. Non-sexual dual relationships are not always avoidable; b. Non-sexual dual relationships are not always unethical; c. Therapists must avoid only the dual relationships that might impair their judgment and objectivity, interfere with performing therapy or supervision effectively or harm or exploit patients.

When it comes to ***bartering,*** also as cited above, the APA codes of ethics have been evolving consistently over the last several decades in the direction of wider acceptance of bartering. The most recent code of ethics of 2016 simply defines bartering but does not denounce it anymore. Section 6.05, Barter with Clients/Patients, states: "Barter is the acceptance of goods, services, or other no monetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative." The National Association of Social Workers (NASW) 2017 Code of Ethics in section 1.13.b, Payment for Services, provides the following lengthy paragraph about bartering:

> "Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship" (Section 1.13, para 2).

The American Counseling Association (ACA) Code of Ethics of 2014 dropped the 1996 statement, "Bartering Discouraged." Instead it introduces a more reasonable and flexible guideline, which states in section A.10.e. Bartering: " Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract." The American Association for Marriage and Family Therapy (AAMFT) 2015 Code of Ethics states in Standard VIII of Financial Arrangements: "Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established." (section 8.5). NASW (2017) in particular, and some other codes as well, give mixed messages about bartering: On the one hand they discourage their membership from engaging in bartering, but on the other hand they permit it if it is not exploitative, not clinically contraindicated and is an accepted practice in the community. There is no doubt that bartering is a rather accepted practice in many rural communities

With regard to ***gifts,*** most professional organization codes of ethics, except AAMFT and ACA, do not address the issue of gifts directly. The AAMFT Code of Ethics states: " Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship.." (2015, Standard III, 3.9). The American Counseling Association (ACA) revised code of 2014 takes a flexible stance on gifts and states, Receiving Gifts: "Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and the counselor's motivation for wanting or declining the gift" (Section A.10.f). The APA Code of Ethics (2016), like several other codes, does not mention gifts directly but has an injunction against gifts for referrals and other forms of kickbacks.

Top of Page

ETHICAL DECISION-MAKING

Ethical decision-making in psychotherapy has received much attention. Many authors have focused on the principles of ethics in psychology (e.g., Beauchamp & Childress, 1983; Kitchener, 1996) and are consistent with the APA Code of Ethics view of the following five moral principles as the foundation of ethical decision-making: 1) autonomy – the concept wherewith the client's freedom of choice is respected and encouraged and the responsibility for actions and how they effect the self and others is stressed; 2) nonmaleficence – the principle of "do no harm," which involves not intentionally inflicting pain on others and refraining from actions that risk harm to others; 3) beneficence – the counselor's responsibility to contribute to the client's well-being by preventing harm and being proactive in attempting to benefit the client; 4) justice – the principle of providing equal treatment for all clients; and 5) fidelity – honoring commitments and guarding the client's trust and the therapeutic relationship.

Ethical Decision-Making Models

Several texts broadly outline ethical decision-making for psychotherapists and cover general ethical decision-making including concerns with therapeutic boundaries (e.g., Canter, et al., 1996; Corey, et al., 2003; Haas & Malouf, 1989; Herlihy & Corey, 2006; Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 1998; Welfel, 2002). Most of the ethical decision-making models identify the following basic steps that comprise the ethical decision-making process: Identifying and naming the ethical conflicts involved; identifying the relevant section of the professional code of ethics; development of alternative courses of action; conducting a risk-benefit analysis of the likely short and long-term consequences of each course of action on the individual(s) and/or group(s) involved or likely to be effected; making an informed choice of course of action applying the relevant ethical principles; evaluating the results of the course of action; and modifying the course of action as required or re-engaging in the decision-making process, if necessary. Most of the models also emphasize the importance of documentation, informed consent, consultation and involving the client in the decision-making process.

A few texts focus on ethical decision-making and guidelines specifically for boundary crossings and dual relationships. These include Gutheil and Gabbard (1993), Herlihy and Corey (2006), Lazarus and Zur (2002), Schank and Skovholt (2006), Schank, Helbok, Haldeman & Gallardo (2010), and Smith & Fitzpatrick (1995), among others. Several other texts have provided more specific models and guidelines for handling dual relationship situations. They include Anderson & Kitchener (1998), Ebert (1997), Gottlieb (1993), Kitchener (1988), Lazarus and Zur (2002), Sonne (2006), Younggren & Gottlieb (2004), and Zur (2004c).

Risk-Benefit Analysis

Many experts, scholars, consultants and practitioners have put their attention on risk management and its focus on "do no harm" by avoiding certain actions, such as touch, leaving the office, dual relationships or bartering. What is often missing in this approach is the harm that results from inaction. For example, mental health practitioners rarely ask questions such as, What is the risk if I do not give this client a supportive hug? What is the risk of not letting the client barter a sculpture for therapy? Or what is the risk of not attending the sweat lodge with a certain client? Instead of narrowly looking at the codes of ethics and limiting the decision-making process, therapists should conduct a thorough risk benefit analysis of the situation. They should ask questions such as, What are the risks *and* benefits of carrying out or not carrying out the proposed action? Or more specifically, What are the potential risks and benefits of either accepting or rejecting the gift? An example of risk benefit may look like that: The risk of accepting a gift from a particular client involves affirming her belief that she is not lovable, interferes with the transference analysis, and may give her the impression that the therapist is greedy. On the other hand, accepting the gift from the same client is likely to enhance the therapeutic alliance and allow the client to experience the therapist's expression of gratitude. The risk of *not* accepting the gift is that the client may experience shame, rejection and an irrevocable rupture of the therapeutic alliance, especially if the client's cultural background is such that refusing a gift is likely to be perceived as an insult. Rejection of the gift may result in the client dropping out of therapy. The potential benefit of not accepting the gift is that it may enable the client to become conscious of and to verbally articulate her desire to be accepted and loved rather than 'acting it out' by buying love through gift giving.

Context of Therapy

The process of ethical decision-making often includes risk-benefit analysis of actions or inactions. Either process cannot be done in a vacuum and must be anchored in the context of therapy. As this paper emphasizes, the context of rural mental health is very different from urban and other contexts where psychotherapy may take place. Generally, the *context* of therapy involves setting, therapy, and client and therapist factors:

Client factors include the following:

- Culture, age, gender, social-economical class, finances, living conditions and transportation, sexual orientation.
- History, including history of trauma, sexual and/or physical abuse.
- Presenting problem, mental state and type and severity of mental disturbances, personality type and/or personality disorder.
- Social support, religious and/or spiritual beliefs and practices.
- Physical health condition and level of physical mobility.
- Prior experience with therapy and therapists.

Setting factors include the following aspects:

- Rural vs. urban, town vs. village, high density vs. low density, outpatient vs. inpatient vs. day program.
- Public agency vs. solo practice vs. group practice.
- Office in county, public or medical building vs. private setting vs. home office.
- Locality: affluent, suburban setting vs. poor neighborhood; large university counseling center vs. small college counseling center; major urban setting vs. remote military base or prison.
- Forensic settings and legal mandates: elective vs. mandated: elective therapy vs. court mandated evaluation, therapy, sanity evaluation or fitness for duty evaluation.
- Hospitalization: voluntary admission vs. involuntary hold.
- Mandated reporting: child, elder or mentally ill person abuse reports or reports due to client posing imminent danger to self or others.

Therapy factors include the following:

- Therapeutic factors: modality (individual vs. couple vs. family vs. group therapy) or (short term vs. long term vs. intermittent long-term therapy); intensity of therapy; population; and theoretical orientation.
- Therapeutic relationship factors: quality and nature of therapeutic alliance; length; familiarity and interactivity in the community; presence or absence of dual relationships and type of dual relationships, if applicable.

Therapist factors include culture, age, gender, sexual orientation, experience and training.

Ethical Decision-Making

Following is a brief description of a seven-step decision-making process that utilizes the codes of ethics to augment critical thinking and to emphasize flexibility and clinical effectiveness. Based partly on the above-mentioned ethical decision-making models and incorporating moral and critical-thinking principles, among others, following is the progression for ethical decision-making for boundaries in psychotherapy.

The ***first*** step is identifying the issue. The ***second***step is identifying the relevant moral, ethical, clinical, communal, legal, professional and other issues and conflicts involved. These may include concern with the client's welfare, the client's family and community. Issues of nonmaleficence, beneficence, fidelity, responsibility, justice, respect and integrity are all of great consequence to this step. The codes of ethics are especially pertinent to this stage, but the inquiry may include additional moral, philosophical, spiritual and community values, as well as other germane considerations. The entire context of therapy, which includes setting, therapy and client and therapist factors should be considered at this early stage of the decision-making process. This stage is aimed at brainstorming or mapping, as broadly as possible, the ethical, professional and other relevant complexities, not resolving them. Prematurely narrowing the scope of the questioning and inquiry due to risk management, or any other concerns, risks ruling out potentially valid options and may lead to an unsubstantiated, unethical or even harmful decision. The ***third***step is to develop a series of alternative courses of action. As with the second step, this step invites the therapist to think broadly and consider as many options as possible. Reducing the options prematurely may distort the process and create an undesirable course of action. The ***fourth***step is conducting an analysis of the likely short-term, ongoing and long-term risks and benefits of each course of action or inaction for anyone or anything involved or likely to be effected. The ***fifth*** step involves, first, separately weighing the risks against the benefits within each option, then comparing them and choosing a course of action. Therapists facing complex ethical, clinical or legal cases would assuredly benefit from consultation with appropriate experts. The ***sixth*** step involves implementing the course of action chosen through the risk-benefit analysis. This involves articulating a treatment plan, which includes short, and when necessary, intermediate and long term goals; interventions employed with the aim of achieving these goals; outlining a clinical rationale and/or empirical support for the proposed interventions; and establishing ways to evaluate the effectiveness of the interventions. The ***seventh*** step involves developing ways to assess the success or effectiveness of the plan and respond to the results of the assessment by either continuing with it if it has proven successful or modifying or discontinuing it if it has failed to accomplish some or all of its objectives.

Top of Page

SUMMARY

Rural settings are primarily defined by remoteness and low density of populations. In small towns where everybody knows everybody, there are limited resources; often low economic status also characterizes rural communities. Rural mental health has been the poster child when it comes to flexible therapeutic boundaries. Boundaries in therapy refer to issues, such as self-disclosure, gifts, bartering, home visits, touch, and dual relationships. While boundary violations are always unethical and can be illegal, boundary crossings are often part of a well-structured clinical intervention, such as a home visit or in-vivo desensitization or attending a funeral or wedding. Rural settings present psychotherapists with a number of therapeutically unavoidable boundary challenges. These include the high visibility of therapists to clients and the extensive self-disclosure that accompanies it, unavoidable multiple relationships between therapists and clients which are aspects of rural or frontier living, compromised privacy and confidentiality due to the "fish bowl" aspect of rural living. The urban-analytic-solo practice-risk management model has dominated the professional attitudes, training and ethics for mental health services. This model, which emphasizes anonymity, emotional distance, only in the office approach to psychotherapy, has low applicability and utility to rural settings.

Since the early 1990s there has been a growing realization that the urban-analytic model is not highly relevant to rural settings, where the fabric of the community is woven by interdependence and interconnectedness. As a result, some of the largest professional associations have adjusted their codes of ethics to acknowledge that dual relationships are not necessarily unethical and bartering or gifts are also normal parts of human exchanges, including therapeutic ones.

There are a number of popular myths or faulty beliefs held by many psychotherapists. There are no ethical injunctions against making home visits, attending a client's wedding or school play, conducting interventions outside the office or carrying out adventure therapy on a rope course or a challenging trail. Unlike the prevailing myth of the "slippery slope," non-sexual touch does not necessarily lead to a sexual relationship, simple gift exchange does not necessary end up as a business relationship and accidental encounters do not lead to a complex and involved dual relationship. What all the professional ethics codes and guidelines have in common is the emphasis on the welfare of the client and the preservation of the client's dignity, respect and

privacy. Unlike the analytic myth, familiarity and multiple relationships do not nullify therapeutic effectiveness. Finally, unlike the proscription of rigid risk management guidelines, self-disclosure, leaving the office for clinical reasons, or dual relationships do not necessarily result in therapists' higher vulnerability to lawsuits and licensing boards sanctions.

What is important is that as a profession, we do not view rural settings as "ethically-challenged" in comparison to urban settings. Visibility, familiarity, dependence, fluidity and connection are important values that ought to be cherished and celebrated, not tolerated. My hope is that the professional trend, which is moving toward acknowledging the reality of rural living, will broaden to include the realization that the urban model of isolation and individual concerns, rather than social concerns, is not necessarily a healthy way of living, surviving and thriving. Finally, I hope that graduate schools and professional trainings broaden their perspective on what is truly ethical, diverse and healthy.

Top of Page

REFERENCES

American Association for Marriage and Family Therapists. (2015). *AAMFT code of ethics.* Washington, DC: Author. Retrieved from https://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/code_of_ethics.aspx

American Counseling Association. (2014). *ACA code of ethics: As approved by the ACA Governing Council, 2014.* American Counseling Association. Retrieved from https://www.counseling.org/Resources/aca-code-of-ethics.pdf

American Indian Mental Health Advisory Council. (2004). *Cultural competency guidelines for the provision of clinical mental health services to American Indians in the state of Minnesota.* Retrieved from http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4086-ENG.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.

American Psychological Association (APA). (2016). *Ethical principles of psychologists and code of conduct.* Retrieved from http://www.apa.org/ethics/code/ethics-code-2017.pdf

Anderson, S. K., & Kitchener, K. S. (1998). Nonsexual post-therapy relationships: A conceptual framework to assess ethical risks. *Professional Psychology: Research and Practice*, 29, 91-99.

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues,* 1, 29-51.

Austin, K. M. (1998). *Dangers for therapists.* Redlands: California Selected Books.

Banaka, W. H., & Young, D. W. (1985). Community coping skills enhanced by an adventure camp for adult chronic psychiatric patients. *Hospital and Community Psychiatry*, 36, 746-748.

Barbopoulos, A. and Clark, J. M (2003). Practicing psychology in rural settings: Issues and guidelines. *Canadian Psychology*, 44/4, 410-424.

Barnett, J. E. (2017). Unavoidable Incidental Contacts and Multiple Relationships in Rural Practice. In O. Zur (Ed.), Multiple relationships in psychotherapy and counseling. New York, NY: Routledge.

Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. Psychotherapy, 48, 315-321.

Barnett, J. E. (1999). Multiple relationships: Ethical dilemmas and practical solutions. In L. VandeCreek, S. Knapp, & T. Jackson. (Eds.). *Innovations in clinical practice: A source book, Vol. 17* (pp. 225-267). Sarasota, FL: Professional Resource Press.

Barnett, J. E. (1998). Should psychotherapists self-disclose? Clinical and ethical considerations. In L. VandeCreek, S. Knapp, & T. Jackson. (Eds.). *Innovations in clinical practice: A source book, Vol. 16* (pp. 419-428). Sarasota, FL: Professional Resource Exchange.

Barnett, J. E. & Bivings, N. D. (2002). Culturally sensitive treatment and ethical practice. *The Maryland Psychologist*, 48(2), 8, 25.

Barnett, J. E., & Yutrzenka, B. A. (1994). Nonsexual dual relationships in professional practice, with special applications to rural and military communities. *The Independent Practitioner*, 14(5), 243-248.

Bass, M. (1988). Intervention in the home: A case study. *Journal of Child and Youth Care*, 3(5), 31-35.

Beauchamp, T. L., & Childress, J. F. (1983). Principles of biomedical ethics (2nd Ed.). New York: Oxford University.

Bennett, B. E., Bryant, B. K., VandenBos, G. R., & Greenwood, A. (1990). *Professional liability and risk management*. Washington, DC: American Psychological Association.

Berg, I. K. (1994). *Family-based services: A solution-focused approach.* New York: W.W. Norton.

Berman, D. S. and Anton, M. T. (1988). A wilderness therapy program as an alternative to adolescent psychiatric hospitalization. *Residential Treatment for Children and Youth*, 5(3), 41-53.

Boland-Prom, K & Anderson, S. C (2013). Teaching ethical deciion making using dual relationships principles as a case example. *Journal of Social Work Education*, 495-510.

Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20, 283-293.

Boyd-Franklin, N., & Bry, B. H. (2000). *Reaching out in family therapy: Home-based, school, and community interventions.* New York: The Guilford Press.

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy*, 38, 21-30.

Brown, L. S. (1984). The lesbian therapist in private practice and her community. *Psychotherapy in Private Practice*, 2(4), 9-16.

Brownlee, K., Halverson, Glenn and Chassie, A. (2012.). The development of dual and multiple relationships for social workers in rural communities. *Journal of Comparative Social Work 2*(1).

Bugental, J. F. (1987). *The Art of the psychotherapist.* New York: W. W. Norton.

Burgard, E.,L.. (2013). Ethical Concerns about Dual Relationships in Small and Rural Communities – A review. *Journal of European Psychology Students*, *4*(1), 69-77.

Burke, W. (1992). Countertransference, disclosure and the asymmetry/mutuality dilemma. *Psychoanalytic Dialogue*, 2, 241-271.

Campbell, C. D., & Gordon, M. C. (2003). Acknowledging the inevitable: Understanding multiple relationships in rural practice. *Professional Psychology: Research and Practice*, 34(4), 430-434.

Canter, M., Bennett, B., Jones, S., & Nagy, T. (1996). *Ethics for psychologists.* Washington, DC: American Psychological Association.

Caudill, C. O. (2004). *Therapists under fire.* Retrieved from https://www.cphins.com/DesktopDefault.aspx?tabid=39

Christensen, L. L. (1995). Therapists' perspectives on home-based family therapy. *The American Journal of Family Therapy*, 23, 306-314.

Cooper, S. (1998). Countertransference disclosure and the conceptualization of analytic technique. *Psychoanalytic Quarterly.* LXVII, 128-154.

Corey, G., Corey, M. S., & Callahan, P. (2003). *Issues and ethics in the helping professions.* (6th Ed.). Pacific Grove, CA: Brooks/Cole.

Craig, J. D. (1991). Preventing dual relationships in pastoral counseling. *Counseling and Values*, 36, 49-55.

Davis-Berman, J., & Berman, D. S. (1994). *Wilderness therapy: Foundations, theory & research.* Dubuque, IA: Kendall/Hunt.

Dictionary.com (2005). Retrieved from http://dictionary.reference.com/search?q=gift&r=67.

Dillenschneider, C. A. (1983). Wilderness adventure programming for the mentally retarded: A rationale and therapeutic basis for program development. (ERIC Document Reproduction Service, ED238216).

Doverspike, W. F. (1999). *Ethical risk management: Guidelines for practice, a practical ethics handbook.* Sarasota, FL: Professional Resource Press.

Dryden, W. (1990). Self-disclosure in rational emotive therapy. In G. Stricker & M. Fisher. (Eds.). *Self-disclosure in the therapeutic relationship* (pp. 61-74). New York: Plenum.

Ebert, B. W. (1997). Dual-relationship prohibitions: A concept whose time never should have come. *Applied & Preventative Psychology*, 6, 137-156.

Epstein, R. S., Simon, R. I., & Kay, G. G. (1992). Assessing boundary violations in psychotherapy: Survey results with the exploitation index. *Bulletin of the Menninger Clinic*, 56, 150-166.

Ewert, A. (1987). Research in experiential education: An overview. *The Journal of Experiential Education*, 10(2), 4-7.

Faulkner, K. K., & Faulkner, T. A. (1997). Managing multiple relationships in rural communities: Neutrality and boundary violations. *Clinical Psychology: Science and Practice* 4(3), 225-234.

Fay, A. (2002). The case against boundaries in psychotherapy. In A. A. Lazarus & O. Zur. (Eds.). *Dual relationships and psychotherapy* (pp. 146-166). New York: Springer.

Field, T. (1998) Massage therapy effects. *American Psychologist*, 53(12), 1270-1281.

Findlay, R. A. and Sheeham, M. C. (2004). Utilisation of mental health services in rural and remote communities. *Journal of Rural Community Psychology*, E7/ 1. http://www.marshall.edu/jrcp/e62_findlay.htm

Gabbard, G. (1994). Teetering on the precipice: A commentary on Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics and Behavior*, 4, 283-286.

Gabbard, G. O., & Lester, E. P. (1995). *Boundaries & boundary violations in psychoanalysis.* New York: Basic Books.

Gabbard, G. O., & Nadelson, C. (1995). Professional boundaries in the physician-patient relationship. *Journal of the American Medical Association*, 273(18), 1445-1449.

Gass, M. A. (1993). *Adventure therapy: Therapeutic applications of adventure programming.* Dubuque, IA: Kendall/Hunt.

Gass, M. A., & McPhee, P. J. (1990). Emerging for recovery: A descriptive data analysis of adventure therapy for substance abusers. *The Journal of Experiential Education*, 13(2), 29-35.

Glover, E. (1940). *An investigation of the technique of psychoanalysis.* Baltimore: Williams & Wilkins.

Gody, D. S. (1996). Chance encounters: Unintentional therapist disclosure. *Psychoanalytic Psychology*, 13(4), 495-511.

Gottlieb, M. C. (1993). Avoiding exploitative dual relationships: A decision-making model. *Psychotherapy*, 30(1), 41-48.

Greenspan, M. (1986). Should therapists be personal? Self-disclosure and therapeutic distance in feminist therapy. In D. Howard (Ed.). *The Dynamics of Feminist Therapy* (pp. 5-17). New York: The Haworth Press.

Grohol, J. M. (1999). *Best practices in e-therapy: Definition & scope of e-therapy.* Retrieved from http://psychcentral.com/best/best3.htm.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, 150, 188-196.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, 155(3), 409-414.

Guthmann, D., & Sandberg, K. A. (2002). Dual relationships in the deaf community: When dual relationships are unavoidable and essential. In A. A. Lazarus & O. Zur. (Eds.). *Dual relationships and psychotherapy* (pp. 287-297). New York: Springer.

Haas, L. J., & Malouf, J. L. (1989). *Keeping up the good work: A practitioner's guide to mental health ethics.* Sarasota, FL: Professional Resource Exchange.

Hahn, W. K. (1998). Gifts in psychotherapy: An intersubjective approach to patient gifts. *Psychotherapy: Theory/Research/Practice/Training*, 35(1), 78-86.

Halvorson, V. M. (1992). A home-based family intervention program. *Hospital and Community Psychiatry*, 43, 395-397.

Hanson, J. E. (2003). Coming out: Therapist self-disclosure as a therapeutic technique, with specific application to sexual minority populations. [Online paper.]

Hargrove, D. S. (1986). Ethical issues in rural mental health practice. *Professional Psychology: Research and Practice*, 17, 20-23.

Hastings, S. L, & Cohn, T. J. (2013). Challenges and opportunities associated with rural mental health practice. *Journal of Rural Mental Health*, *37*, 37-49.

Hedges, L. E., Hilton, R., Hilton, V. W., & Caudill, O. B. (1997). *Therapists at risk: Perils of the intimacy of the therapeutic relationships.* New Jersey: Jason Aronson.

Herbert, J. T. (1996). Use of adventure-based counseling programs for persons with disabilities. *Journal of Rehabilitation*, 62, 3-9.

Herlihy, B. and Corey, G. (2006). *Boundary issues in counseling: Multiple roles and responsibilities.* (2nd Ed.). Alexandria, VA: American Association for Counseling and Development.

Hill, M. (1999). Barter: Ethical considerations in psychotherapy. *Women and Therapy*, 22(3), 81-91.

Hunter, M., & Struve, J. (1998). *The ethical use of touch in psychotherapy.* Thousand Oaks, CA: Sage Publications.

Hyman, S. M. (2002). The shirtless jock therapist and the bikini-clad client: An exploration of chance extra-therapeutic encounters. In A. A. Lazarus, & O. Zur. (Eds.). *Dual relationships and psychotherapy.* (pp. 348-359). New York: Springer.

Johnson, W. B. (1995). Perennial ethical quandaries in military psychology: Toward American Psychological Association and Department of Defense collaboration. *Professional Psychology: Research and Practice*, 26, 281-287.

Johnson, W. B., Ralph, J., & Johnson, S. J. (2005). Managing multiple roles in embedded environments: The case of aircraft carrier psychology. *Professional Psychology: Research and Practice*, 36(1), 73-81.

Jones, M., Botsko, M., & Gorman, B. S. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training.* 40(4), 289-301.

Jourard, S. M. (1971a) *The transparent self.* New York: Van Nostrand Reinhold.

Jourard, S. M. (1971b). *Self-disclosure: An experimental analysis of the transparent self.* New York: Wiley-Interscience.

Kanter, R. M. (1977). *Work and family in the United States: A critical review and agenda for research and policy.* New York: Russell Foundation.

Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology: Professional standards and cases.* New York: Random House.

Keller, P. A., Murray, J. D., Hargrove, D. S., & Dengerink, H. A. (1983). Issues in training psychologists for rural settings. *Journal of Rural Community Psychology*, 4(1), 11-23. Retrieved from http://www.marshall.edu/jrcp/j41-4Keller.pdf .

Kertész, R. (2002). Dual relationships in psychotherapy in Latin America. In A. A. Lazarus, & O. Zur. (Eds.). *Dual relationships and psychotherapy* (pp. 329-334). New York: Springer.

Kessler, L .E., & Waehler, C.A. (2005). Ethical issues in professional practice: Addressing multiple relationships between clients and therapists in lesbian, gay, bisexual, and transgender communities. *Professional Psychology: Research and Practice* , 36(1), 66-72.

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

Kitchener, K. S. (1996). Professional codes of ethics and ongoing moral problems in psychology. In W. O'Donohue & R. F. Kitchener. (Eds.). *The philosophy of psychology* (pp. 361-370). London: Sage Publications.

Knapp, S., & Slattery, J. M. (2004). Professional boundaries in nontraditional settings. *Professional Psychology: Research and Practice*, 14(5), 553-558.

Knapp, S. J. and VandeCreek, L. D. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

Knapp, S., Younggren, J. N., Vandecreek, L., Harris, E., & Matrin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized Approach (2nd ed.).* Washington, DC: American Psychological Association Insurance Trust.

Knox, S., Hess, S. A., Williams, E. N., & Hill, C. E. (2003). Here's a little something for you: How therapists respond to clients' gifts. *Journal of Counseling* Psychology, 50, 199-210.

Knox, S., Hess, S.A., Pedersen, D.A., & Hill, C.E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counselling Psychology,* 44, 274-283.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional standards and cases.* (2nd Ed.). New York: Oxford University Press.

Koocher, G. P., & Keith-Spiegel, P. (2016). *Ethics in psychology and the mental health professions (4th ed)*. New York, NY: Oxford University Press.

Lakin, M. (1991). *Coping with ethical dilemmas in psychotherapy.* New York: Pergamon Press.

Langs, R. (1982). *Psychotherapy: A basic text.* New York: Aronson.

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics and Behavior,* 4, 255-261.

Lazarus, A. A. (1998). How do you like these boundaries? *The Clinical Psychologist,* 51, 22-25.

Lazarus, A. A., & Zur, O. (Eds.). (2002). *Dual relationships and psychotherapy.* New York: Springer.

Levine, D. U. (1978). Experiencing the city. *The Journal of Experiential Education,* 1(2), 13-19.

Llewellyn, R. (2002). Sanity and sanctity: The counselor and multiple relationships in the church. In A. A. Lazarus & O. Zur. (Eds.). *Dual relationships and psychotherapy* (pp. 298-314). New York: Springer.

Lowry, T. (1974). *Camping therapy: Its uses in psychiatry and rehabilitation.* Springfield, IL: Charles C. Thomas.

Mahalik, J. R., van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck. (Ed.). *Practicing feminist ethics in psychology.* Washington: American Psychological Association.

Maheu, M., Whitten, P., & Allen, A. (2001). *E-health, telehealth, and telemedicine: A guide to startup and success.* New York: Jossey-Bass.

Mallow, A. J. (1998). Self-disclosure: Reconciling psychoanalytic psychotherapy and Alcoholics Anonymous philosophy. *Journal of Substance Abuse Treatment* 15, 493–498.

McClung, S. B. (1984). A rock climbing program as therapy for the chronically mentally ill. *Dissertation Abstracts International,* 45(04B), 1292. (University Microfilms, AAD8416170).

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Moore, Z. E. (2003). Ethical dilemmas in sport psychology: Discussion and recommendation for practice. *Professional Psychology: Research and Practice,* 34(6), 601-610.

Morris, J. (2003). The home visit in family therapy. *Journal of Family Psychotherapy* , 14(3), 95-99.

Morrison, J. (1979). Confidentiality and rural mental health. *Rural Community Mental Health Newsletter,* 6(1), 17-18.

Mulder, P. L., & Chang, A. F. (1997). Domestic violence in rural communities: A literature review and discussion. Retrieved from *Journal of Rural Community Psychology,* E1/1. http://www.marshall.edu/jrcp/vole1/vol_e1_1/Mulder_Chang.html.

Mulder, P. L., Kenkel, M. B., Shellenberger, S., Constantine, M.G., Streiegel, R., Sears, Jr., F.S., et al. (2000). *The behavioral health care needs of rural women,* American Psychological Association, © American Psychological. Association. Retrieved from http://www.apa.org/rural/ruralwomen.pdf.

Murray, I. D. & Keller, P. A. (1991). Psychology and rural America: Current status and future directions. *American Psychologist,* 46, 220-231.

Nathan, T. (1994). *The Healing Influence.* Paris: Odile Jacob.

National Association of Social Workers. (2018). *Code of Ethics.* Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English.

Newman R. (2003). The whys of HIPAA compliance. *APA Monitor,* February, 29.

Nickel, M. (2004). Professional boundaries: The dilemma of dual and multiple relationships in rural clinical practice. *Consulting and Clinical Psychology Journal,* 1(1), 17-22.

Nordmarken, N., & Zur, O. (2005). Home office: Ethical and clinical considerations. Retrieved from https://www.zurinstitute.com/homeoffice.html.

Orchin, I. (2004). Taking therapy outdoors: How to use nature to get rough cases unstuck. *Psychotherapy Networker, November/December,* 27-28.

Osborn, L. (2012). Juggling personal life and professionalism: Ethical implications for rural school psychologists. *Psychology in the Schools, 49*, 876-882.

Otnes, C., & Beltramini, R. F. (1996). Gift-giving: A research anthology. Bowling Green, OH: Bowling Green State University Popular Press.

Pedersen, C. (1996). Common problem areas and their causes resulting in disciplinary action. In L. J. Bass, S. T., DeMers, J. R. P., Ogloff, C., Peterson, J. L., Pettifor, R. P., Reaves, T., et al. (Eds.). *Professional conduct and discipline in psychology,* (pp. 71–89). Washington, DC: American Psychological Association.

Pepper, R. S. (2003). Be it ever so humble: The controversial issue of psychotherapy groups in the home office setting. *Groups*, 27(1), 41-52.

Pope, K. S. (1989). Therapist-patient sex syndrome: A guide to assessing damage. In G. O. Gabbard. (Ed.). *Sexual exploitation in professional relationships* (pp. 39-55). Washington, DC: American Psychiatric Press.

Pope, K. S. (1990). Therapist-patient sex as sex abuse: Six scientific, professional, and practical dilemmas in addressing victimization and rehabilitation. *Professional Psychology: Research and Practice,* 21, 227-239.

Pope, K. S. (1991). Dual roles and sexual intimacy in psychotherapy. *Ethics and Behavior,* 1(1), 21-34.

Pope, K. S., Keith-Spiegel, P., & Tabachnick, B. G. (1986). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. *American Psychologist*, 41(2), 147-15.

Pope, K. S., Sonne, J., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists in training.* Washington, DC: American Psychological Association.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, K. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist*, 42(1), 993-1006.

Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling: A practical guide.* (2nd Ed.). San Francisco: Jossey-Bass.

Pulakos, J. (1994). Incidental encounters between therapists and clients: The client's perspective. *Professional Psychology,* 25, 300-303.

Rabin, C., Rosenbaum, H., & Sens, M. (1982). Home-based marital therapy for multiproblem families. *Journal of Marital and Family Therapy,* 8, 451-461.

Refugee Mental Health In The United States (2004). A cry for help. Retrieved from http://www.refugees.org/world/articles/mentalhlth_rr97_9.htm.

Reich, W. (1972). *Character analysis.* New York: Simon & Schuster.

Reid, W. H. (1998). Standard of care and patient need. *The Journal of Psychiatric Practice, May.* Retrieved from www.reidpsychiatry.com/columns/Reid05-98.pdf.

Roberts, L. W., Battaglia, J., & Epstein, R. S. (1999). Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services,* 50(4), 497-503.

Rutter, P. (1989). *Sex in the forbidden zone: When men in power–therapists, doctors, clergy, teachers, and others–betray women's trust.* New York: Fawcett Crest. Retrieved from http://intl-ps.psychiatryonline.org/cgi/content/full/50/4/497.

Rogers, C. (1970). *Carl Rogers on encounter groups.* New York: Harper & Row.

Rutter, P. (1989). *Sex in the forbidden zone: When men in power betray women's trust.* New York: *Psychiatric Annals,* 21, 614-619.

Saad, G., & Gill, T. (2003). An evolutionary psychology perspective on gift-giving among young adults. *Psychology & Marketing*, 20(9), 765–784.

Schacht, A. J., Tafoya, N., & Mirabla, K. (1989). Home-based therapy with American Indian families. *American Indian and Alaska Native Mental Health Research,* 3(2), 27-42.

Schank, J. A., Helbok, C. M., Haldeman, D. C., & Gallardo, M. E. (2010). Challenges and benefits of ethica small-community practice. *Professional Psychology: Research and Practice, 41,* 502-510.

Schank, J. A., & Skovholt, T. M. (1997). Dual relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice,* 28, 44-49.

Schank, A. J., & Skovholt, T. M. (2006). Ethical Practice in Small Communities: Challenges and Rewards for Psychologist. Washington DC: APA Books.

Schoel, J., Prouty, D., & Radcliffe, P. (1988). *Islands of healing: A guide to adventure based counseling.* Hamilton, MA: Project Adventure.

Schoener, G. R. (1997 September). *Boundaries in professional relationships.* Paper presented at the Norwegian Psychological Association, Oslo, Norway.

Shah, S. A. (1970). Privileged communication, confidentiality, and privacy: Confidentiality. *Professional Psychology,* 1, 159-164.

Sharkin, B. (1995). Strains on confidentiality in college-student psychotherapy: Entangled therapeutic relationships, incidental encounters, and third-party inquiries. *Professional Psychology: Research and Practice,* 26, 184–189.

Simon, R. I. (1991). Psychological injury caused by boundary violation precursors to therapist-patient sex. *Psychiatric Annals,* 21, 614-619.

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Bulletin of the American Academy of Psychiatry and Law,* 20, 269-287.

Simon, R. I. (1994). Transference in therapist-patient sex: The illusion of patient improvement and consent part 1. *Psychiatric Annals,* 24, 509-515.

Simon R. I., & Williams, I. C. (1999). Maintaining treatment boundaries in small communities and rural areas. *Psychiatric Services,* 50, 1440-1446.

Simon, R. I., & Izben, C. W. (1999), Maintaining Treatment Boundaries in Small Communities and Rural Areas. *Psychiatric Services,* 50,1440-1446. © 1999 American Psychiatric Association.

Slama, K. (2004). Rural culture is a diversity issue. *Minnesota Psychologist,* 9-13. Retrieved from http://www.apa.org/rural/Rural_Culture_is_a_Diversity_Issue.pdf.

Smith, A. J. (1990). Working within the lesbian community: The dilemma of overlapping relationships. In H. Lerman, & N. Porter. (Eds.). *Feminist Ethics in Psychotherapy.* (pp. 92-96). New York: Springer.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice,* 25(5), 499-506.

Smith, E., Clance, P .R., & Imes, S. (Eds.). (1998). *Touch in Psychotherapy: Theory, Research and Practice.* New York: Guilford Press.

Solomon, G., Hiesbergr, J., & Winer, J. L. (1981). Confidentiality issues in rural community mental health. *Journal of Rural Community Psychology,* 2(1), 17-37. Retrieved from http://www.marshall.edu/jrcp/archives/Vol21/v21Solomon.htm.

Sonne, J. L. (2006). Nonsexual multiple relationships: A practical decision-making model for clinicians. Retrieved from http://kspope.com/site/multiple-relationships.php.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions? *Professional Psychology: Research and Practice,* 25(4), 331-343.

Sonne, J. L., & Pope, K. S. (1991). Treating victims of therapist-patient involvement. *Psychotherapy,* 28, 174-187.

Spandler, H., Burman, E., Goldberg, B., Margison, F., & Amos, T. (2000). A double edged sword: Understanding gifts in psychotherapy. *European Journal of Psychotherapy, Counseling and Health* 3(1), 77-101.

St. Germaine, J. (1996). Dual relationships and certified alcohol and drug counselors: A national study of ethical beliefs and behaviors. *Alcoholism Treatment Quarterly,* 14(2), 29-45.

Stamm, B. H. (Ed.). (2003). *Rural Behavioral Health Care.* Washington, DC: APA Books.

Stich, T. F. & Senior, N. (1984). Adventure therapy: An innovative treatment for psychiatric patients. *New Directions for Mental Health Services,* 21, 103-108.

Sterling, D. L. (1992). Practicing rural psychotherapy: Complexity of role and boundary. *Psychotherapy in Private Practice*, 10(3), 105-127.

Stockman, A. F. (1990). Dual relationships in rural mental health practice: An ethical dilemma. *Journal of Rural Community Psychology*, 11, 31-45.

Strasburger, L. H., Jorgenson, L., & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. *American Journal of Psychotherapy*, 46(4), 544-555.

Strean, H. S. (1981). Extra-analytic contacts: Theoretical and clinical considerations. *Psychoanalytic Quarterly*, 56, 238-257.

Stricker, G. & Fisher, M. (Eds.). (1990). *Self-disclosure in the therapeutic relationship.* New York: Plenum.

Sue, D., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice.* (4th Ed.). New York: John Wiley and Sons.

Tarnower, W. (1966). Extra-analytic contacts between the psychoanalyst and the patient. *Psychoanalytic Quarterly*, 35, 399-413.

Thorngren, J. M. (2003). Rural mental health: A qualitative inquiry. *Journal of Rural Community Psychology*, E6(2). Retrieved from http://www.marshall.edu/jrcp/JRCP_E6_2_Thorngren.htm.

Tillman, J. G. (1998). Psychodynamic psychotherapy, religious beliefs, and self-disclosure. *Journal of Psychotherapy*, 52(3), 273-286.

Tomm, K. (1993). The ethics of dual relationships. *California Therapist*, 5(1), 7-19.

Trimble, J. E. (2002). *Counseling across cultures.* Thousand Oaks, CA: Sage.

Ullom-Minnich, P. D., & Kallail K. J. (1993). Physicians' strategies for safeguarding confidentiality: The influence of community and practice characteristics. *Journal of Family Practice* 37, 445-448.

U.S. Census Bureau. (2010). Frequently asked questions. Retrieved from https://ask.census.gov/faq.php?id=5000&faqId=5971

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general-executive summary.* Rockville, MD: Author.

Washburn, P. (1994). Advantages of a brief solution-oriented focus in home-based family preservation services. *Journal of Systemic Therapies*, 13, 47-58.

Weigel, D. J. & Baker, B. G. (2002). Unique issues in rural couple and family counseling. *The Family Journal: Counseling and Therapy for Couples and Families*, 10, 61-69.

Welfel, E. R. (2002). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues.* (2nd Ed.). Pacific Grove, CA: Brooks/Cole.

Werth, J. L., Hastings, S.L. & Riding-Malon, R. (2010) Ethical challenges of practicing in rural areas. *Journal of Clinical Psychology* 47,537-548.

Williams, M. H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of Humanistic, Behavioral, and Eclectic Psychotherapies? *Psychotherapy*, 34(3), 238-249. Retrieved from http://drmwilliams.com/SAdocs/bv.html.

Williams, M. H., (2003). The curse of risk management. *The Independent Practitioner*, 23(4), 202-205.

Woody, R. H. (1998a). *Protecting your mental health practice: How to minimize legal and financial risk.* San Francisco: Jossey-Bass.

Woody, R. H. (1998b). Bartering for psychological services. *Professional Psychology: Research and Practice*, 29(2), 174-178.

Woody R. H. (1999). Domestic violations of confidentiality. *Professional Psychology: Research & Practice.* 30(6), 607-610.

Younggren, J. N., & Gottlieb, M.C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice*, 35(3), 255-260.

Zelig, M. (1988). Ethical dilemmas in police psychology. *Professional Psychology: Research & Practice*, 19(3), 336-338.

Zur, O. (2000). In celebration of dual relationships: How prohibition of non-sexual dual relationships increases the chance of exploitation and harm. *The Independent Practitioner*, 2(3), 97-100. (Also available at https://www.zurinstitute.com/dualrelationships2.html).

Zur, O. (2001a). Out-of-office experience: When crossing office boundaries and engaging in dual relationships are clinically beneficial and ethically sound. *Independent Practitioner*, 21(1), 96-100. (Also available at https://www.zurinstitute.com/outofoffice.html).

Zur, O. (2001b). On analysis, transference and dual relationships: A rejoinder to Dr. Pepper. *The Independent Practitioner*, 21(3), 201-204.

Zur, O. (2004a). To cross or not to cross: Do boundaries in therapy protect or harm. *The Psychotherapy Bulletin*, 39(3), 27-32. (Also available at https://www.zurinstitute.com/boundariesintherapy.html).

Zur, O. (2004b). A chicken for a session: Bartering in therapy. *Voices*, 40(1), 75-80.

Zur, O. (2004c). The risky business of risk management: How risk management guidelines can increase risk?and decrease clinical effectiveness. Online publication. Retrieved from https://www.zurinstitute.com/riskmanagement.html.

Zur, O. (2005a). *HIPAA Compliance Kit, 3rd Edition*. Sonoma, CA: OZ Books. Distributed by W. W. Norton. New York: Norton Professional Books.

Zur, O. (2005b). Dumbing down of psychology: Manufactured consent about the depravity of dual relationships in therapy. In R. H. Wright & N. A. Cummings. (Eds.). *Destructive trends in mental health: The well-intentioned road to harm* (pp. 253-282). New York: Brunner-Routledge. (Also available at: https://www.zurinstitute.com/dumbingdown.pdf).

Zur, O. (2005c). The standard of care in ?psychotherapy and counseling: Bringing clarity to an illusive standard. Retrieved from https://www.zurinstitute.com/standardofcaretherapy.html.

Zur, O. (2005d). Beyond the office walls: ?Home visits, celebrations, adventure therapy, incidental? encounters and other encounters outside the office walls. Online publication. Retrieved from https://www.zurinstitute.com/outofofficeexperiences.html.

Zur, O. (2005e). Gifts in psychotherapy. Online publication. Retrieved from https://www.zurinstitute.com/giftsintherapy.html.

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. Washington, DC: American Psychological Association.

Zur, O. (Ed.) (2017). *Multiple relationships in psychotherapy and counseling: Unavoidable, common and mandatory dual relations in therapy*. New York: Routledge.

Zur, O., & Gonzalez, S. (2002). Multiple relationships in military psychology. In A. A. Lazarus, & O. Zur. (Eds.). *Dual relationships and psychotherapy* (pp. 315-328). New York: Springer.

Zur, O., & Nordmarken, N. (2004). To touch or not to touch: Rethinking the prohibition on touch in psychotherapy and counseling – Clinical, ethical & legal considerations. Online publication. Retrieved from https://www.zurinstitute.com/touchintherapy.html.

Top of Page

CONTACT OFER