Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists

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Managing Dual Relationships in Rural Healthcare Settings: An Education
Module for Occupational Therapists

by

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A Scholarly Project
Submitted to the Occupational Therapy Department
of the
University of North Dakota
In partial fulfillment of the requirements
for the degree of
Master's of Occupational Therapy

Grand Forks, North Dakota

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This Scholarly Project Paper, submitted by Jennifer Maus and Caroline Olson in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Faculty Advisor

Date

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Title Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists

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Degree Master’s of Occupational Therapy

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The authors wish to thank our advisor Sonia Zimmerman, Ph. D, OTR/L, FAOTA, as well as our professors, family, and friends for all their support throughout this process.
Dual relationships are a common challenge for health care providers serving a rural community. A dual relationship is when a therapist has a professional and a personal relationship with a client. Occupational therapists may be at greater risk for dual relationships because of the personal nature of their interventions. These relationships create ethical dilemmas between the patient and the therapist and impact the effectiveness of the delivery of therapy services. A literature review includes information on the following topics: issues of rural healthcare, occupational therapy in rural healthcare, dual/multiple relationships, and continuing education.

The project is a continuing educational course on the management of dual relationships for occupational therapists in rural settings. It is designed to be presented in a videoconference format. The Ecology of Human Performance framework and The Andragogy in Practice Model were chosen as foundations for the education course. The course content is presented in three modules: (a) Definition and Foundation of Dual Relationships, (b) Dual Relationships Explored, and (c) Managing Dual Relationships. Teaching methodologies employed include PowerPoint lecture/discussion sessions, small group activities, and use of a discussion board for follow-up and networking opportunities for therapists enrolled in the course.
CHAPTER I
INTRODUCTION

Healthcare professionals, including occupational therapists, in rural practice appreciate the sense of greater independence and responsibility and the opportunity to work with a variety of diagnoses. The professionals also state they enjoyed the rural area because of the community spirit, creativity, and work environment (Devine, 2006). In rural communities, these professionals are highly visible because they are expected to be involved in community activities and organizations. (Helbok, 2003). Healthcare professionals become involved in the community to be accepted by community members and to create effective delivery services. As a result of the involvement in the community, the professionals create relationships with many of the community members. One of the challenges professionals face in a rural setting is delivering services to an individual with whom he or she has another relationship apart from the clinical setting. Endacott et al. (2006, p.988) states “two or more distinct kinds of relationship with the same person” define a dual relationship. These relationships often create ethical dilemmas and blurred boundaries between the patient and the professional (Kagle & Giebelhausen, 1994).

Dual relationships are often unavoidable for rural healthcare providers who are frequently the lone providers of their profession. This is especially true for the providers residing in several rural communities. Occupational therapists may be at greater risk for dual relationships because of personal nature of their interventions. Occupational
therapists need to find an effective way to identify these relationships and manage them early on in therapy (Scopelliti et al., 2004).

The Ecology of Human Performance (EHP) is a framework that considers relationships among the person, task, context, and how these interactions influence performance. The EHP framework was created by Dunn, Brown, and McGuigan (1994), occupational therapy department faculty members at the University of Kansas Medical Center. A key principle of the EHP is that to fully understand a person it is essential to understand their context. An individual’s context influences one’s performance, as well as an individual’s performance influences one’s context (Dunn, McClain, Brown, & Youngstrom, 2003). The context of rural practice is unique and challenging because of the limited support and geographic and professional isolation. A person’s performance range is determined by the interaction between the person and context. In rural settings, the range of performance may decrease because the therapist is unable to perform all the tasks and provide effective services due to the personal relationship in addition to the professional relationship.

According to the EHP framework, the context can provide a variety of supports and barriers to performances. The personal and professional roles of an individual are defined by the current context (Kramer, Hinojosa & Royeen, 2003). In a rural setting, contextual barriers can impact the way healthcare professionals deliver effective services. At times, several roles may result in an overlap of the individual’s tasks. Therefore, when in the clinical context, it may be difficult for the healthcare practitioner to distinguish between their personal and professional relationships with the client.
The EHP framework encourages the use of interdisciplinary collaboration, which is applicable to a rural setting where healthcare practitioners must be prepared to work closely with fellow team members (Kramer, Hinojosa & Royeen, 2003). Although created for occupational therapists, the educational module presented here could be utilized as a resource for other healthcare professionals practicing in a rural setting. Through the EHP model, the educational course will help occupational therapists establish skills needed for the management of dual relationships within a rural context.

In addition to the EHP model, this project will utilize The Andragogy in Practice Education Model, a framework of adult engagement in learning experiences (Knowles, Holton III & Swanson, 2005). According to the model, six principles provide a starting point for the development and implementation of an effective adult learning program or experience. The principles are: (a) need to know, (b) learner’s self-concept, (c) learner’s experience, (d) readiness to learn, (e) orientation to learning, and (f) motivation to learn (Knowles, Holton III & Swanson, 2005). These principles will be utilized in the education modules of this project. Many clinicians have experienced dual relationships and will build off of those experiences when learning about different strategies on how to manage them. Adults become ready to learn when they understand what they need to know in order to effectively deal with difficult situations. Therapists will be ready and motivated to learn strategies and implement them to deliver effective services to their clients. This scholarly project will provide a much needed resource to educate and train therapists to effectively deal with dual relationships among patients, family members, and caregivers.
Organization of Remaining Chapters

Chapter II consists of a comprehensive literature review addressing issues of dual relationships in rural settings including: concerns of rural healthcare, occupational therapy in rural healthcare, ethics of dual relationships, establishing meaningful boundaries, and managing dual relationships. The methodology utilized throughout this project is described in greater in Chapter III. The education module is presented in Chapter IV. Chapter V consists of a summary of the scholarly project, key information found throughout the process, and recommendations for implementation and further development of the product. The scholarly project concludes with a full listing of the references.
A dual relationship is defined as having “two or more distinct kinds of relationships with the same person” (Endacott et al., 2006, p.988). Dual relationships are common in a rural setting and can be difficult to deal with when a professional and client are engaged in a secondary relationship, which in turn may effect the therapeutic process. Instruction and guidelines are available to practitioners to help identify a probable dual relationship or boundary violation, however, no information was found in the professional literature regarding the management of dual relationships.

In this comprehensive literature review, we will provide definitions of rural, issues effecting rural healthcare, an occupational therapist’s role and ethical dilemmas in rural settings. This section is followed by a description of dual relationships, specifically the pros, cons, and ways in how to manage more than one relationship with a client. Lastly, we will discuss continuing education for rural healthcare professionals, such as the barriers and the most effective ways to provide opportunities for professional development and competence.

Rural

The term rural is a complex term without a standard definition but is offered to refer to any community that is non-urban. The rural definition used by the Census Bureau, which is used for statistical purposes, is all areas outside urban areas that have a population of less than 2,500 (Hart, Larson, & Lishner, 2005). According to this
definition, in 2000 the United States had 59.1 million rural residents that accounted for 21% of the population.

The federal government uses the Office of Management and Budget (OMB) definition of rural when determining eligibility and reimbursement for federal programs such as Medicare (Hart et. al, 2005). The OMB defines rural as any area with a population less than 10,000 people. According to the OMB rural definition, 48.8 million people lived in rural areas in the year 2000. The United States Department of Agriculture defines rural as any locations outside places of 50,000 or more people and their associated urbanized areas (Hart et. al, 2005). The definition of rural can include a variety of terms depending of the purpose for the user.

_Rural Health_

There are a variety of working definitions of rural health presented in the medical literature. According to Wakerman (2004), rural healthcare is defined as medical services provided in non-urban areas where the practice requires general practitioners/family physicians to acquire skills not required in an urban practice. Rourke (1997) defines rural practice as the provision of services outside urban areas where the medical care is provided by a small number of doctors/physicians that have limited access to specialty services and resources and high technology facilities. The Rural Committee of the Canadian Association of Emergency Physicians (http://www.caep.ca/) defines rural health in relation to distance as any community that is at least one to four hours away if transporting in good weather to a major hospital.
Rourke (1997) stated that because there are very few rural specialists, there is a strain on rural physicians because they are asked to be competent and provide care in all the areas of service. In a 2005 study of physician supply and distribution in rural areas, it was found that only 11.4% of total physicians worked in rural areas. The majority of the physicians providing care for rural areas were generalists. Furthermore, it was found that the presence of specialists decreases as rurality increases (Fordyce, Chen, Doescher, & Hart, 2005). As a result of these challenges and the expectations of physicians to be generalists, many rural hospitals have difficulty recruiting and retaining healthcare professionals (Rosenblatt, 2004).

Along with the stress of being competent and providing care in all areas, there are other barriers that serve to limit healthcare provision in rural areas. Brems, Johnson, Warner, and Roberts (2006) report greater barriers and challenges for professionals providing healthcare in the smaller communities as compared to urban areas. Research has found that as compared to urban providers, rural providers struggled more with the barriers related to resource and confidentiality limitations, overlapping roles, provider travel, service access, and training constraints. Resource limitations referred to the rural healthcare providers’ lack of access to colleagues for referrals, consultations, and special expertise. Confidentiality limitations included the healthcare providers’ concerns of assuring client’s confidentiality, accessing sensitive records, and having to report information to authorities. Healthcare providers in rural areas had more overlapping roles in which they had contact with the client in nonprofessional settings. Provider travel was seen as a barrier because of cost and possible hazardous driving. Lack of access to services was due to transportation difficulties, travel distances, and healthcare costs.
Training constraints were less accessible for rural healthcare providers because of limited time and staffing available.

The Rural Assistance Center (http://www.raconline.org) reported research in the state of North Carolina (Fraher, Summers, Gaul, & Rutledge, 2007) tracking the vacancy of allied health jobs. According to the research, allied health jobs accounted for 37% of all healthcare jobs. The number of job advertisements that year was as followed: occupational therapists 275, occupational therapy assistants 135, physical therapists 554, physical therapy assistants 177, and speech-language pathologists 172. A vacancy index was calculated by dividing the number of advertisements for each profession by the professionals' total workforce and then multiplied by 100. Occupational therapy assistants had the highest vacancy index with 15.2, followed by physical therapists with 14.8, and then occupational therapists with 13.8.

The Rural Assistance Center (http://www.raconline.org) reported research on the health workforce recruitment and retention in critical access hospitals (Rural Hospital Flexibility Program, 2003). Therapists ranked number four behind nurses, radiology and laboratory personnel as the most difficult health professions to recruit. The most useful strategy for recruiting healthcare professionals to a rural area was by networking or word of mouth, while the most useful strategy for retaining healthcare professionals was a positive work environment and participation in decision-making.

Shortages of occupational therapists are evident in rural communities across the United States. Kohler and Mayberry (1993) suggest that recruitment methods should aim at occupational therapists over the age of 25 because of experience and the increase likelihood they would stay in the community. A significant barrier in retaining the
occupational therapist is the lack of opportunity for continuing education (Kohler & Mayberry, 1993).

Occupational Therapy and Rural Practice

According to Devine (2006), the majority of occupational therapists practicing in rural areas of Australia felt positive and satisfied about their jobs. They appreciated the opportunity to work with a broader scope of diagnoses and the sense of greater independence and responsibility. The therapists also stated they enjoyed the rural area because of the community spirit, creativity, and work environment. They identified the challenges of working in rural Australia as being the public’s lack of knowledge about occupational therapy, limited access to equipment, difficulties in accessing continuing education, lack of support, and diversity of duties. There are difficulty recruiting and retaining occupational therapists in rural Australia. Occupational therapists in Australia identified the following reasons for their departure: need for greater support, greater career opportunity, and lack of opportunity for professional development (Mills & Millsteed, 2002).

Wills and Case-Smith (1996) suggested five themes of occupational therapists’ perceptions of working in a rural school in the United States. The following themes were: (a) jack of all trades, meaning the therapists some themselves as generalists that needed a broad base of knowledge; (b) bridging the span between services, where the occupational therapist was responsible for coordinating medical and health related services; (c) the world can get kind of lonely out there, they felt that it was lonely being the only occupational therapist but that interaction with other professionals decreased the sense of loneliness; (d) trust and teaming, therapist felt the trust of the teacher was vital in
integrating intervention services; and (e) I cannot do it all, but wish I could, therapists felt overwhelmed with the caseload which led to frustration of not being able to provide effective therapy to all students.

Kohler and Mayberry (1993) reported the five most important skills needed for occupational therapists in rural settings in the United States were problem solving, education of client and family, consultation, giving standardized evaluations, and program development. Therapists also needed to be self-reliant, creative, flexible, and confident in themselves and their profession. Barriers identified by these therapists were lack of knowledge about occupational therapy, lack of continuing education opportunities, large caseloads, and travel conditions. Peterson, Ramm and Ruzicka (2003) reported 54% of the occupational therapists practicing in rural areas of the United States had to travel one or more days to provide services and that many of the therapists felt isolated and a lack of support from co-workers.

*Ethics in Rural Healthcare*

Ethical dilemmas are among the most common challenges faced by rural healthcare providers. In a study of ethical practices of psychologists in rural and urban communities, results showed that rural psychologists encountered significantly more multiple relationships than urban psychologists. Further, rural psychologists were more visible or more likely to be seen by clients in their community as compared to their urban counterparts (Helbok, Marinelli, & Walls, 2006). Ethical dilemmas are present in rural communities but the ethical resources are often limited or nonexistent. Cook and Hoas (2000) reported that more than 72% of family physicians or generalists stated a desire to receive ethical resources.
There is little literature available that pertains specifically to ethical dilemmas faced by occupational therapists in rural settings. Research has shown that other rural healthcare providers, such as psychologists and social workers, encounter dual relationships on a daily basis (Schank & Skovholt, 1997; Kagle & Giebelhausen, 1994). Although not specifically identified in the research, literature regarding dual relationships is likely pertinent to rural occupational therapists as well.

The American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics (2005) states that ethical action goes beyond following the rules and regulations of principles to honorable character and considerate reflection. The principles are statements of commitments to bring about good for the sake of others, to worthy practice of art and science, and to noble acts of courage. One purpose of the Code of Ethics is to assist occupational therapists in recognition and resolution of ethical dilemmas (AOTA, 2005). Principle 2 in the AOTA Occupational Therapy Code of Ethics (2005) states:

Occupational therapy personnel should take measures to ensure a recipient’s safety and avoid imposing or inflicting harm. Occupational therapy personnel shall:

A. Maintain therapeutic relationships that shall not exploit the recipient of services sexually, physically, emotionally, psychologically, financially, socially, or in any manner.

B. Avoid relationships or activities that conflict or interfere with therapeutic professional judgment and objectivity.

C. Refrain from any undue influences that may comprise provision of service.
D. Exercise professional judgment and critically analyze directives that could result in potential harm before implementation.

E. Identify and address personal problems that may adversely impact professional judgment and duties.

F. Bring concerns regarding impairment of professional skills of a colleague to the attention of the appropriate authority when or/if attempts to address concerns are unsuccessful (p. 640).

This principle provides a general guideline for practitioners to follow regarding judgment to maintain therapeutic relationships; however, it does not provide specific guidelines in how to deal with issues once the professional boundary has been violated.

Concerns for ethical issues in clinical practice have extended to the question of multiple relationships. Most professional associations have codes of ethics that label the multiple relationships as unethical and state that they should be avoided at all costs (Brownlee, 1996). Codes of ethics provide statements of principles used to support and maintain high standards of professional conduct within a profession. A practitioner, upon licensure or certification, is expected to abide by these guidelines. However, as Gottlieb (1993) states, general guidelines for professional conduct are addressed in most ethical codes, but little information is provided in how to make a decision when and if a difficult situation arises.

Dual Relationships

Dual relationships are created when a professional is involved in a secondary relationship with the client. In addition to the professional relationship, there is another tie with the individual such as a friend, family member or business partner. A dual
relationship is considered a boundary crossing or violation of ethical practice, therefore providing a difficult challenge, especially in a rural setting (Kagle & Giebelhausen, 1994). The boundary crossing or violation occurs when a professional or therapeutic relationship intertwines with a personal or other close affiliated relationship. For example, a clinician may provide services to a student, employee, friend, or neighbor. Negotiating multiple or dual relationships with patients and family members on a daily basis challenges rural health care workers of all disciplines.

The term dual relationship is used in the literature to refer to boundary crossings between the professional and the client. Other terms commonly used include: overlapping roles/relationships, multiple relationships, ethical dilemmas, interpersonal boundaries, and boundary violations (Brems et. al, 2006; Baer & Murdock, 1995; Smith & Fitzpatrick, 1995; Kagle & Giebelhausen, 1994). A dual relationship can be presented in different forms. Reamer (2003) identified five different types of dual relationships: (a) intimate relationships (sexual or physical contact) between the professional and the individual they serve; (b) personal benefit is a relationship in which the therapist uses the relationship with the client for monetary gain, goods and services, or useful information; (c) emotional needs of the professional can be met through a dual relationship with a client; (d) altruistic gestures create relationships in which the therapist provides nonprofessional services, gives gifts, performs favors, or goes beyond one’s professional role; and (e) unanticipated circumstances such as social and community events, joint affiliations, and mutual acquaintances can create a dual relationship.
Dual Relationships in Rural Settings

A dual relationship is something that most, if not all rural health care providers will face at one time or another. The literature presents this concern related to rural mental health care workers (Scopelliti et al., 2004; Endacott et al., 2006; Brownlee, 1996), social workers (Kagle & Giebelhausen, 1994; Reamer, 2003), and psychologists, physicians and therapists (Gottlieb, 1993; Kitchener, 1988). It is possible that occupational therapists in rural settings may have an even greater vulnerability in encountering similar issues due to their roles in addressing everyday living needs or personal issues.

An issue such as a dual relationship is more pronounced in rural and smaller communities, one reason being the small population. Rural clinicians naturally function in an overlapping role environment, potentially shifting therapeutic boundaries and dealing with ethical issues (Scopelliti et al., 2004). Schank and Skovholt (1997) examined the frequency of dual relationships encountered by rural psychologists and found that all of the 16 psychologists interviewed identified dual relationships as an issue present in their rural area of practice.

In a rural community, one might attend the same community event or be involved in a local organization; it is difficult for one to avoid encounters of current or past clients. Regular contact can occur almost anywhere at anytime. The potential to be involved in a dual relationship further depends upon factors such as the length of time the clinician has worked in the community, whether or not the clinician is originally from the area, and has school or family ties to the community.
Pros and Cons of Dual Relationships

Dual relationships in rural settings are not all bad. There are both advantages and disadvantages of dual relationships in a rural setting for both the therapist and the client. Scopelliti et al. (2004) reported that the positive values of dual relationships include trust and rapport built prior to a therapeutic relationship, familiarity through community involvement, decreased suspicion, and increased approachability. The therapist has a more complete and comprehensive understanding of the client's history and background, as does the client about the therapist. These positive values help to decrease the risk of exploitation and increase clinical effectiveness.

Disadvantages of a dual relationship are more prominent and can cause harm to the therapy process. Fear of destroying the secondary relationship may cause therapists to be hesitant or avoid providing the best possible treatment. This can obstruct the effectiveness of clinical treatment and make maintaining confidentiality and attending to privacy rights of clients more difficult. Engagement in a dual relationship may create unethical behaviors such as breaching confidentiality or violating a client's privacy that can result in revocation of one's license, certification or membership (Kagle & Giebelhausen, 1994). For example, when a therapist encounters a client or family member of a current client in a public place and he or she asks questions relating to treatment, it places the therapist in a difficult situation. The therapist needs to maintain professional boundaries within the other personal or secondary relationship, however, in a rural setting, maintaining those boundaries are a primary concern and sometimes a difficult challenge.
Avoiding Dual Relationships

In small towns and rural communities, a practitioner can engage in a dual relationship before, during, or after the professional relationship (Kagle & Giebelhausen, 1994). As Brownlee (1996) states, "Such relationships are almost impossible to avoid when there is no choice but to shop at a client’s store or when one’s children are in school with or even friends with client’s children,” (p. 499). To completely avoid the situation is unrealistic (Brownlee, 1996).

Given that a dual relationship is difficult and almost impossible to avoid, clinicians need to know what to do when a challenging situation arises. There are few strategies available to rural health clinicians regarding how to approach a dual relationship, and no available strategies in how to manage a dual relationship. This means that there is information available to one who foresees a dual relationship or boundary crossing and provides guidelines to help determine if one should enter the relationship. There is no evidence or guidelines found in the literature that supports someone who is already engaged in a dual relationship and is or may experience an ethical dilemma. Smith and Fitzpatrick (1995) suggest that the more informed a therapist is about the ethical issues and dilemmas pertaining to dual relationships, the more he or she will be prepared to deal with and manage situations that may arise.

Emphasis is placed on the therapist seeking help both personally and professionally when treatment boundaries become blurred. Scopelliti et. al (2004) recommends that this can be done through means of discussions with colleagues and clients to hopefully negotiate a solution when either the client or clinician foresees a dual relationship or boundary violation. Kagle and Giebelhausen (1994) also recommend
actions be taken to report a dual relationship to appropriate authorities, to terminate licenses or certifications when clear ethical violations have occurred, and to seek further consultation. As for a rural healthcare practitioner, he or she will likely not have a choice to enter or not to enter in a dual relationship. “The issue for rural practitioners is not how to decide whether to engage in dual relationships but how to manage the dual relationship,” (Scopelliti et. al, 2004, p. 957-958).

Decision-making models present in current professional literature discuss the ethics of a dual relationship, yet do not specify how to manage a dual relationship; rather the models consider whether or not one should enter such a relationship (Scopelliti et. al, 2004). Decision-making models by Kitchener (1988), Gottlieb (1993), and Younggren (2002) are available to provide healthcare clinicians with information in identifying and determining problematic dual relationships. Ethical issues pertaining to such relationships are addressed as well as strategies in how to make an ethical decision prior to engagement in a dual relationship.

Kitchener (1988) established a model to provide a set of ethical issues for clinicians to consider before entering a dual relationship. Three guidelines are used when identifying and differentiating between dual relationships. The first guideline states that as the incongruity of expectations increases between roles, so might the risk of harm and misunderstanding. The second guideline states that as responsibilities change, such as the clinician placing his or her own needs first, it will be difficult to meet the needs of the client; therefore dependability and trustworthiness between the client and therapist decreases. The third guideline states that as power and prestige between the roles increase, the potential for an exploitative dual relationship also increases. Professionals
must be aware of potential role conflicts between the therapist and client in order to prevent confusion and probable harm to the client or self.

Gottlieb (1993) created a decision-making model based on the work of Kitchener (1988). Similar to Kitchener (1988), Gottlieb (1993) focused on avoiding and identifying dual relationships, viewing them as ethical dilemmas. The model is based on three dimensions: power, duration, and termination. Power relates to how much power the therapist has in relation to the client, duration is the length of the current relationship, and termination refers to the likelihood that the therapist and client will have further contact outside of the clinic. The model is used when a clinician is predicting the entry of a dual relationship when engaged in a professional relationship. In addition to the dimensions of power, duration, and termination, there are five steps for the clinician to consider: (a) assess the current relationship, (b) examine the anticipated relationship, (c) look at both relationships in terms of role responsibilities, (d) obtain consultation from a colleague, and (e) discuss with the client if he or she wishes to proceed with or forgo the additional relationship (Gottlieb, 1993).

Gottlieb’s model is designed specifically to address potential ethical dilemmas applicable to all types of dual or multiple relationships. The model assumes that although dual relationships may be pursued at a low risk, they must be avoided when there is potential for a harmful situation. Gottlieb (1993) states that in general, ethical principles typically provide guidelines in ways to address a dual relationship, however there are not specified guidelines to assist professionals in the practical decision-making or managerial process.
Younggren (2002) provided a list of questions to assist clinicians in a decision-making process when considering entering a dual relationship with a client. This model guides the clinician to make a correct and ethical decision that is both in the best interest of the client and the clinician. Younggren’s questions include:

(a) Is the dual relationship necessary? (b) Is the dual relationship exploitive? (c) Who does the dual relationship benefit? (d) Is there a risk that the dual relationship could damage the patient? (e) Is there a risk that the dual relationship could disrupt the therapeutic relationship? (f) Am I being objective in my evaluation of this matter? (g) Have I adequately documented the decision making process in the treatment records? (h) Did the client give informed consent regarding the risks to engaging in the dual relationship? (p. 2-5)

The goal of the clinician is to make correct decisions or discuss the issue in detail with the client regarding the entry of a dual relationship and minimizing the risks involved (Younggren, 2002).

An important limitation of Kitchener, Gottlieb, and Younggren’s decision-making models is the lack of guidance and direction for the clinician to take when engaged in a dual relationship. Kagle and Giebelhausen (1994) recommend that more information on dual relationships be given along with supervision due to the fact that many practitioners may fail to identify and understand the risks involved. One may not realize when a boundary violation or crossing has occurred until it has impacted treatment and the therapeutic relationship. “Clinicians working in rural areas should be provided with education, training and support, both personal and organizational, to deal with dual relationships,” (Endacott et. al, 2006, p. 994).
Continuing Education

Pui, Lui, and Warren (2005) state that continuing education enhances one's personal and professional development, and is a positive value of learning. The AOTA Occupational Therapy Code of Ethics (2005) Principle 4 reads,

Occupational Therapy personnel shall achieve and continually maintain high standards of competence. (DUTY). Occupational Therapy personnel shall:

A. Hold the appropriate national, state, or any other requisite credentials for the services they provide.

B. Conform to AOTA standards of practice, and official documents.

C. Take responsibility for maintaining and documenting competence in practice, education, and research by participating in professional development and educational activities.

D. Be competent in all topic areas in which they provide instruction to consumers, peers and/or students.

E. Critically examine available evidence so they may perform their duties on the basis of current information.

F. Protect service recipients by assuring that duties assumed by or assigned to other occupational therapy personnel match credentials, qualifications, experience, and scope of practice.

G. Provide appropriate supervision to individuals for whom they have supervisory responsibility in accordance with Association official documents, local, state, and federal or national laws and regulations, and institutional policies and procedures.
H. Refer to or consult with other service providers whenever such a referral or consultation would be helpful to the care of the recipient of service. The referral or consultation process shall be done in collaboration with the recipient of service (p. 640).

This principle describes the responsibility of an occupational therapist to practice competence by participating in professional development and education activities.

Similarly, AOTA’s Standards for Continuing Competence (2005) encourage lifelong learning and professional development. Standards include the demonstration of skills pertaining to: ethical reasoning, knowledge, performance, interpersonal abilities, and critical reasoning. These standards are necessary for occupational therapists to perform their roles and responsibilities within the profession.

Standard 5. Ethical Reasoning

Occupational therapists and occupational therapy assistants shall identify, analyze, and clarify ethical issues or dilemmas to make responsible decisions within the changing context of their roles and responsibilities. The individual must demonstrate

- Understanding and adherence to the profession’s Code of Ethics, other relevant codes of ethics, and applicable laws and regulations;
- The use of ethical principles and the profession’s core values to understand complex situations; and
- The integrity to make and defend decisions based on ethical reasoning (p. 662).
In a rural setting, due to the diversity of a professional’s role and the limited number of allied health professionals in the area, there may be few local opportunities to participate in professional development or continuing education opportunities (Gillham & Ristevski, 2007). Local educational opportunities are not easily obtainable due to the geographic and professional isolation. Therefore, it is important for continuing education opportunities to be flexible and convenient for therapists to participate (Pui et. al, 2005).

In rural settings, however, accessing continuing education for professional development can be difficult. Curran, Fleet, and Kirby (2006) state that the most frequently perceived barriers and challenges in the delivery and access of professional development and continuing education include geographic isolation and the lack of funding available for travel and attendance. For many rural clinicians, the increased amount of time away from the work setting and the cost of educational activities are limiting professionals’ advancement in rural areas.

Distance education is one way to overcome barriers of delivery and access of professional development for rural practitioners (Gillham & Ristevski, 2007). Studies have shown that some methods of technology, such as videoconferencing, telemedicine, Internet and on-line or web-based modules, for example, have helped overcome the barriers by cutting costs and travel time for the facility and practitioner (Curran et. al, 2006; Gillham & Ristevski, 2007; Tabriziani, Hatcher, & Heetbry, 2005). According to Tabriziani et. al (2005), web-based modules, for example, can easily be applied to provide access to learning to a healthcare provider’s continuous education and professional development in a rural setting.

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Pui et al. (2005), studied Alberta occupational therapist’s perceptions of Internet-based continuing education. Their results showed that 90% of the occupational therapists had access to a computer and Internet either at work or at home. However, the participants that use the Internet often also attend videoconference and teleconference educational activities. Of those that did not have the technology educational experience prior to the study, 55% were interested and 52% were likely interested to participate in the future. Sixty-five percent of the occupational therapists thought their knowledge about computers was adequate enough to participate in an Internet learning session, even though only 7% had taken an Internet course sometime in their professional career.

*Continuing Education for Rural Practitioners*

For some rural practitioners, especially those who are sole providers of their discipline in a community, it is difficult to leave the area or facility to attend an educational session. Continuing education opportunities have traditionally occurred via face-to-face workshops and conferences, presentations and seminars (Pui et al., 2005). For a rural practitioner, attending a conference or workshop can be costly, time consuming and inconvenient (Wallner et al., 2007). However, through the use of tele-education and other web-based learning modules, the learning process may be more cost effective and save time. Curran et al. (2006) report that technology-based or tele-education delivery systems such as videoconferencing were identified as positive ways to improve access to continuing education activity. Meyer et al. (2005) also reports that online programs or technology-driven courses help to decrease barriers such as professional isolation in rural health care settings.
Rossaro et al. (2007) compared videoconferencing to a traditional lecture style of a continuing education intervention provided to rural healthcare providers. The result showed the multipoint videoconferencing technique as an effective means of learning that was rated equal to if not higher than a traditional lecture method. Moreover, the videoconferencing method allowed the rural practitioners to avoid the cost of time and travel. The healthcare providers could easily fit the technology-based method in their schedules due to its convenience and flexibility.

In healthcare settings and other related fields, on-line or technology based learning methods seem to be a capable delivery of education (Rossaro et al., 2007). Due to the growing use and popularity of technology and the Internet, participants are more likely to be attracted to the flexibility and convenience of a self-paced experience. However, there are advantages and disadvantages to technology based interventions. Advantages, according to Tabriziani et al. (2005), include the decreased need for educational support staff and decreased cost of time and travel to learning centers. Employees are able to experience the learning session at their own convenience, and are receiving information applicable and available to all rural areas. Disadvantages include the need for computer technology and access to adequate technology tools such as cameras, monitors, and software that interfaces wireless connections via video (Rossaro et al., 2007). Additional disadvantages include possibly less security and confidentiality while utilizing technology-based learning modules, and the initial cost and development of a technology-based method can be high. Although, by reducing time away from the facility and travel costs, outcomes may outweigh the benefits of providing effective educational opportunities for rural health care providers (Tabriziani et al., 2005).
Summary

The current literature has shown that dual relationships are prevalent and inevitable in rural healthcare settings. Due to the shortages of healthcare providers in rural settings, including occupational therapists, they are often the sole provider of their profession’s practice. As a result, therapists are often obligated to provide services to individuals that they have a personal relationship with prior to the client-therapist relationship. Rural healthcare providers frequently encounter multiple relationships that are commonly considered ethical dilemmas. The potential ethical dilemmas could become problematic and result in disciplinary actions if not handled appropriately. Current literature documents the impression of avoidance and identification of dual relationships; methods to manage the difficult situations are less available.

Professional development and continuing education for healthcare providers in a rural setting are difficult to obtain primarily due to geographic isolation and financial concerns. It is important for professionals to maintain competence and attend continuing educational activities relevant to the settings in which they work. Literature shows that technology-based modules, such as Internet learning, videoconference, and tele-medicine are the preferred methods in providing continuing education to rural practitioners. This will overcome the challenges of geographic and professional isolation in a rural setting and provide the opportunity for professionals to participate in educational activities.

This scholarly project seeks to create an education module addressing dual relationship issues for occupational therapists practicing in rural settings. It is hoped that by educating on the challenges of managing ethical dilemmas, it will help simplify the
situation for an occupational therapist. This can be accomplished via a technology-based module to increase accessibility for all healthcare providers in rural settings.

Chapter III discusses the methodology utilized throughout the project. The chapter also provides information on how the literature relates to the development of the product.
CHAPTER III

METHOD

A literature review was conducted by searching multiple online databases, including PubMed, OT Search, ProQuest, and Academic Search Premier. Occupational therapy textbooks and government based websites were also used to gather information. The purpose of this search was to gather information regarding the occurrence of dual relationships in rural practice, and preferred method of obtaining continuing education in a rural area. The process involved research of various topics including rural healthcare, occupational therapy in rural practice, dual/multiple relationships, and continuing education. The literature provided statistical information about the frequency of dual relationships in rural settings and how to identify and avoid these ethical dilemmas in rural healthcare.

There was limited occupational therapy literature on dual relationships. The majority of the findings were obtained from psychology and social work literature. Research revealed there was a need for training and education on how to manage dual relationships. Research on continuing education revealed that a technology based method of delivery would be the most convenient and accessible for rural therapists. An outline was developed of the probable modules of information to be delivered through an educational session.
Multiple occupational therapy theories and models were considered and evaluated to determine the appropriate fit for the project. Based on the importance of context on performance, the Ecology of Human Performance (EHP) framework was chosen as a foundation for creating an educational session on managing dual relationships for rural occupational therapists. Context is emphasized in the EHP framework and rural life was identified as having unique social context characterized by decreased anonymity and multiple levels of relationships. The context influences performance of essential therapy tasks such as developing and maintaining therapeutic relationships. The EHP is also an interdisciplinary framework that emphasizes collaboration between professionals. This helps the project to be adaptable for other healthcare professionals to use and apply to their area of practice. The Andragogy in Practice Model was also chosen for this project for the use of learning principles as applied to the rural therapists. The educational module is based on using the therapists experiences and motivations when developing strategies to help manage difficult situations encountered in their practice.

Delivery methods that were considered for this educational session were an in-person lecture, online class, compact disc, tele-conference, or videoconference. A videoconference method was chosen for this project because it would require less time and travel for the therapists. The videoconference delivery was chosen for a one day, four hour conference to different sites throughout North Dakota. An email was sent to Don Larson, a lead support technology specialist at the University of North Dakota School of Medicine, to gather more information about the use of videoconferencing technology. Information and questions addressed to Don Larson in the email included the feasible
number of sites that would enhance an effective educational session, the cost, and potential hook-up sites in North Dakota.

A PowerPoint was developed for the following three modules: (a) Definition and Foundation of Dual Relationships, (b) Dual Relationships Explored, and (c) Managing Dual Relationships. The learning objectives for the program and each module were created using Bloom’s Taxonomy. The modules reflect interaction to be utilized by adult learners through the use of scenarios, reflection, discussion questions, and role play. Interactive note guides and companion readings were created to aid the therapist in their learning during the session. Along with the PowerPoint a discussion board site is available to allow networking opportunities among therapists. An email and brochure were created to use as marketing tools to send to all licensed therapists and therapy assistants in North Dakota. Satisfaction surveys were created for the therapists to fill out before and after the educational course to measure the effectiveness of the course.

The goal of this project is to develop a continuing education course for rural occupational therapists on the management of dual relationships. It is believed that therapists will create strategies to manage dual relationships which will enable to provide effective therapy services to their client.
CHAPTER IV
PRODUCT

Introduction

The product is a continuing education course titled *Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists*. The course utilizes a videoconference format and can be delivered to a number of sites simultaneously. The course is available for registered occupational therapists and certified occupational therapy assistants currently practicing in rural settings. Upon completion of the course, therapists will receive a total of four contact hours toward continuing education requirements.

A PowerPoint was created to deliver the course content and is divided into three learning modules: (a) Definition and Foundation of Dual Relationships, (b) Dual Relationships Explored, and (c) Managing Dual Relationships. Module I provides foundational knowledge and introduces information on rural practice, dual relationships and ethics. Module II describes pros and cons of a dual relationship, and therapeutic versus destructive relationships. Module III includes strategies for managing dual relationships. Module II and III utilize group interaction among therapists, as well as scenarios and reflections. The use of a discussion board is available for follow-up and networking opportunities for therapists enrolled in the course.

A brochure and email were developed with course information, registration form, and contact information for therapists interested in participation of the course. A
registration conformation email was developed to send to therapists after they have registered to direct them to the discussion board site and welcome them to the class. A pre and post-course survey were created to measure the outcome of the course effectiveness and therapist’s level of competency regarding dual relationships. Four companion materials were assigned for therapists to read prior to attending the educational course. Handouts that follow the course content are provided to assist therapists during the course session. The surveys, companion materials, and course handouts will be available on the discussion board. A certificate awarding four contact hours will be mailed to therapists upon completion of the course.

The Andragogy in Practice Model was utilized in creating this course specifically when incorporating the interactions and group discussion. The course content utilizes the principles of adult learning by focusing on the experiences, motivation, and addresses the issue of dual relationships in rural practice. The Ecology of Human Performance framework is considered when focusing on the unique social context of rural practice. The course is designed for the therapist to establish skills on managing dual relationships, positively impacting their performance range.
Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists

Developed by:
Jennifer Maus, MOTS &
Caroline Olson, MOTS

Advisor: Sonia Zimmerman, Ph. D., OTR/L, FAOTA
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Jennifer Maus, OTR/L
Caroline Olson, OTR/L

Dual Relationships
A dual relationship is “two or more distinct kinds of relationships with the same person” (Endacott et al., 2006)

Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists

Date:

Time: 10:00am-3:00pm
Date:  
From: Caroline Olson colson@medicine.nodak.edu, Jennifer Maus jmaus@medicine.nodak.edu  
To:  
Subject: Continuing Education: Managing Dual Relationships [Videoconference]  

Date:  
Time: 10:00 a.m. – 3:00 p.m.  
Location:  University of North Dakota School of Medicine & Health Sciences  
501 North Columbia Road (Room ____), Grand Forks, ND 58202  

Title: Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists  
4 Contact Hours  

Presenters: Caroline Olson, OTR/L & Jennifer Maus, OTR/L  

Program Objectives:  
• To provide education modules to occupational therapists practicing in a rural setting on strategies used to manage dual relationships  
• Through the education modules, therapists will feel competent in how to handle the situation when faced with a boundary violation  

This class is available to all Registered Occupational Therapists and Certified Occupational Therapy Assistants working in North Dakota.  

VIDEO BROADCASTING: If anyone in your organization would like to participate through one of your videoconferencing devices, please contact _________. The session will be available from the following sites:  

SPECIAL NEEDS: This conference is being held in an accessible facility. Persons needing accommodations or auxiliary aids should contact _________ no later than 10 days prior to the conference.  

If you are interested in registering for this session, please contact Caroline Olson at colson@medicine.nodak.edu (218) 469-1442, or Jennifer Maus at jmaus@medicine.nodak.edu (701) 269-9906 with preferred mailing information. If interested, a brochure with registration and course information will be mailed.
Date:
From: Caroline Olson colson@medicine.nodak.edu, Jennifer Maus jmaus@medicine.nodak.edu
To:
Subject: Registration Confirmation

Name,

Thank you for registering for the continuing education conference: Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists on date.

Along with the educational session, there is a discussion board site available at: We have completed your registration and added your name to the site. Please log on using your e-mail address as a login, and your last name as a password. Please note that you will be asked to change your password after the initial login.

Available on the discussion board are links to four companion materials related to the educational session, and a short survey that will help us gain a better understanding of what basic knowledge and experiences you have related to dual relationships. Prior to attending the conference, please read and become familiar with the materials, and complete the short survey at least 10 days prior to the session. Also available on the discussion board site are interactive note guides that follow the content in Modules I, II, and III. Please bring a printed copy with you to the session.

Remember your login and password as the discussion board will remain open for 2 weeks following the session. If you have any trouble with the login or retrieving the materials, please contact ________ as soon as possible.

For further questions or information, please contact Caroline Olson at colson@medicine.nodak.edu (218) 469-1442, or Jennifer Maus at jmaus@medicine.nodak.edu (701) 269-9906.

We look forward to seeing you on date.

Caroline Olson, OTR/L
Jennifer Maus, OTR/L
Pre-Course Survey

Please complete the following questions at least 10 days prior to attending the continuing education course.

1. In what types of setting(s) do you currently work?

2. How many years have you been a practicing therapist or assistant?

3. Describe your basic knowledge of the term, 'dual relationship.'

4. In what ways have you experienced a dual relationship while in practice?

5. What interested you in registering for this course?
Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists

COURSE HANDOUTS

Presented by:
Caroline Olson, OTR/L
Jennifer Maus, OTR/L

Date:
Module I: Definition & Foundation of Dual Relationships

Part A: Rural Interaction

What are some characteristics that are unique to rural practice?

Characteristics of Rural Practice

- Resource limitations
- Lack of specialists
- Shortage of staff
- Dual relationships
- Greater independence

Rural Contribution to Dual Relationships

Community members expect therapists to be involved in the community

Clients have a desire to know their therapists

Interaction is less formal

Therapists are highly visible in the community

Increased opportunity to interact with clients outside the clinic

Impact of Community Involvement

- Trust, acceptance, respect
- Congruent public and private life
Additional Information

Family involvement

Know community values and culture

Dual Relationships in Rural Settings

___% of rural psychologists identified dual relationships as an issue present in their practice (Schank & Skovholt, 1997)

Predictable part of rural practice

Difficult to avoid

Part B: Dual Relationships

Definition

“Two or more distinct kinds of relationships with the same person” (Endacott et al. 2006, p.988)

“Dual relationships occur when professionals engage with clients or colleagues in more than one relationship, whether social, sexual, religious, or business”

(St. Germaine, 1993)

A therapist can engage in a dual relationship before, during, or after the professional relationship

Interaction

Does anyone have an example of when they encountered a dual relationship?

Examples of Dual Relationships

- Member of the same community group
- Business associate
- Member of the same church
- Teammate on same sport team
Related Terms

Boundary violation
Boundary crossing
Interpersonal boundaries
Overlapping roles/relationships
Multiple relationships
Ethical dilemma
Ethical Conflict

Types of Dual Relationships

1.
   Ex. monetary gain, exchange for goods and services, useful information
2.
   Ex. extending relationships with clients, promoting client dependence, confusing personal and professional lives
3.
   Ex. performing favors, giving gifts, providing nonprofessional services
4.
   Ex. social and community events, joint affiliations and memberships, mutual acquaintances and friends
5.
   Ex. sexual relationships, gestures, physical contact, intimate gestures

(Reamer, 2003)

Interaction

What type of relationship have you experienced the most?

Which type of relationship do you think is the most difficult to avoid? Why?
Part C: Ethics

OT Code of Ethics

1. Identify and describe the principles supported by the occupational therapy profession

2. Educate the general public and members regarding established principles to which occupational therapy personnel are accountable

3. Socialize occupational therapy personnel new to the practice to expected standards of conduct

4. Assist occupational therapy personnel in recognition and resolution of ethical dilemmas
   (AOTA OT Code of Ethics, 2005)

Interaction

Pertaining to the OT Code of Ethics, what principles do you think most apply to a dual relationship?

Principle 1:
   Occupational therapy personnel shall demonstrate a concern for the safety and well being of the recipients of their services.

Principle 2:
   Occupational therapy personnel shall take measures to ensure a recipient’s safety and avoid imposing or inflicting harm.

Principle 3:
   Occupational therapy personnel shall respect recipients to assure their rights.
   (AOTA OT Code of Ethics, 2005)

Principle 1: Beneficence

Doing good for others or bringing about good for them. The duty to confer benefits to others.

Provide ___________ and ___________ services to all clients

Have ___________ and ___________ fees for services
Principle 2: Nonmaleficence

Not harming or causing harm to be done to oneself or others the duty to ensure that no harm is done.

Maintain therapeutic relationships that shall not exploit the client
•

Identify and address personal problems that may impact professional judgment

Principle 3: Autonomy, Confidentiality

The right of an individual to self-determination. The ability to independently act on one's decisions for their own well being.

Not disclosing data or information that should be kept private to prevent harm and to abide by policies, regulations and laws.

Collaborate with client on __________, __________, & ________________

Respect individual's right to refuse services

Protect all privileged confidential forms
(AOTA OT Code of Ethics, 2005)

Violations of Principles

Ethical violations may result in consequences and disciplinary actions of ethical agencies

Agencies:
•
•
•

State Regulatory Board

North Dakota State Board of Occupational Therapy Practice
•

A five member committee will review complaints filed against occupational therapists in North Dakota
(www.ndotboard.com, 2000)
National Board for Certification in Occupational Therapy (NBCOT)

Investigate and review complaints against OT practitioners

__________ from state regulatory boards and AOTA’s Ethics Commission

Will notify the state of any complaints received and will refrain from actions until the state does act on the case
(NBCOT, 2007)

NBCOT Disciplinary Actions

__________ – individual barred from becoming certified by NBCOT

__________ – expression of disapproval retained in individual’s file, but not publicly announced

__________ – continued certification is subject to fulfillment of specified conditions

__________ – loss of certification for a certain duration

__________ – permanent loss of certification
(NBCOT, 2007)

AOTA’s Ethics Commission

Responsible for developing the ethic standards for the profession and personnel at all levels within the profession

Two primary roles:

•

  Develops and provides education materials in response to needs, inquiries, and ethical trends

•

  Review and investigate ethics complaints filed against AOTA members

  Recommend disciplinary actions
(AOTA OT Code of Ethics, 2005)
AOTA Ethic’s Commission Disciplinary Actions

- Private formal expression of disapproval of conduct by letter from the Chairperson.
- Failure to meet terms will subject member to any of the disciplinary actions.
- Formal expression of disapproval that is public.
- Removal of membership for a specified duration.
- Permanent denial of membership.

(AOTA OT Code of Ethics, 2005)

Module I: Summary

A dual relationship is when a therapist has two or more distinct relationships with a client.

Dual relationships are difficult to avoid in rural healthcare settings.

OT Code of Ethics assists occupational therapy personnel in recognition and resolution of ethical dilemmas.

Disciplinary actions are taken when an ethical principle is violated.

References


Module II: Dual Relationships Explored

Interaction

What are some pros and cons of engaging in a dual relationship?

Pros of a Dual Relationship

_________ and _____________ between client and therapist

Therapist may seem more approachable and familiar

Client may feel more ___________ and less ____________

A more complete and comprehensive understanding of the client's

•

(Scopelliti et. al, 2004)

Cons of a Dual Relationship

Difficulty maintaining client's ______________

•

Therapist may abuse the ___________ and negatively influence the client

Client may not be honest and willing to share personal information

•

(Scopelliti et. al, 2004)

Therapeutic Dual Relationships

A dual relationship is therapeutic when:

The secondary relationship _______________ or _______________ the therapeutic relationship

•

The interest of the therapist is focused on the well-being and independence of the client

(Moleski, & Kiselica, 2005).
Therapeutic Relationship

Brady and Jane are active members of the same church in their small town. Both Brady and Jane volunteer at church events and attend services every Sunday. They have established a friendship over the last couple of years. Two weeks ago, Jane fell and broke her right hip. After being released from the hospital, Jane agreed to receive home health services.

Brady is an occupational therapist for the local hospital and received the home health referral to provide services to Jane. Brady contacted Jane to discuss the therapy process and schedule and discussed concerns regarding her comfort level with him as her therapist.

Jane was grateful that Brady was going to help her during the rehabilitation phase of her injury, and stated she trusted him and was more than comfortable with him providing care. Jane felt that because they have established rapport and friendship through the church, that he would put her best interest first.

Follow-Up Questions

What are the pros of this therapeutic scenario?

What are the cons, if any, of this therapeutic scenario?

What steps did Brady take to assure effective delivery of services?

In what ways did the prior relationship aid in the therapeutic relationship?

Destructive Dual Relationships

A dual relationship is destructive when:

The secondary relationship ___________ the therapist/client relationship

•

•

Therapist puts personal interests before clients interests

(Moleski, & Kiselica, 2005).
Destructive Relationship

Karen had been seeing Susan, an occupational therapist, for outpatient services. After two months into therapy, Susan began self-disclosing about personal issues and her problems with her ex-husband in which Karen had experienced a similar situation. Susan and Karen became close friends and began to speak on the phone at least once a day.

After six months, Karen was discharged from therapy services, but Karen and Susan remained good friends. Susan started depending on Karen for advice and support. Karen felt like she was being exploited by Susan. After awhile Karen felt like she could no longer be responsible for Susan’s emotional stability so, Karen decided to end their friendship.

Follow-Up Questions

What are the pros, if any, of this destructive scenario?

What are the cons of this destructive scenario?

What actions did Susan engage in that may have crossed professional boundaries?

What is the potential impact of Susan’s actions on Karen’s future actions with future healthcare providers?

What would be the appropriate steps to take in this case, or in a similar situation?
Reflection
Think of a situation in which you were engaged in a dual relationship with a previous or current client.

In what ways did the relationship aid in the therapeutic process?

In what ways might the relationship have hindered the therapeutic process?

Module II: Summary
There are pros and cons of each dual relationship

The client may feel more comfortable with a therapist well known to the community

The client may hold back personal information in fear of destroying the prior relationship

A prior relationship with a client can complement or enhance a therapeutic relationship

A prior relationship with a client can obstruct or override a therapeutic relationship

References

Module III: Managing Dual Relationships

Interaction
When meeting a client with whom you also have a personal relationship, what are important steps to take during the initial interview to ensure a therapeutic relationship?

Initial Evaluation
Immediately discuss the dual relationship with client
Involve client in decision-making process
•
Develop of plan of action for chance encounter
•
Maintain _____________ and _____________ communication

Interaction
A good friend has come to receive OT services and you will be the therapist. Role-play the initial interview utilizing the appropriate actions and words addressing a dual relationship issue with the client.

Therapy Process

Be alert for potential conflicts of interests
Be cautious regarding self-disclosure
Be cautious with physical contact

Self-Evaluation
Emotional awareness

•
•
Self-Evaluation Questions
    Am I providing fair and equitable services to all my clients?
    Have I been honest and upfront with concerns and potential conflicts?
    Is the relationship with the client affecting the way I deliver therapy services?
    What actions am I taking to ensure I am keeping the best interests of the client?

Documentation
    Discussions
    Client and colleague consultations
    Encounters
    Case progress

Consultation
    Client
    Colleagues
    Supervisor
    Ethical agencies

Discharge
    Upon discharge, therapy should no longer be discussed among the individual and the therapist

    Discuss with the client a plan of action for community interaction

Scenario
    Your neighbor Bill experienced a flexor tendon laceration and is coming to you for occupational therapy services 3x a week. Bill has been wearing a fabricated splint for a week.

    One day on his way home from work, Bill saw you in the yard and came over to ask a question regarding the home exercise program that was developed for him. You quickly answered his question regarding the home exercise program. Two days later, in the evening, Bill knocked on your front door and complained of splint discomfort. You told Bill that the necessary supplies to adjust the splint were at the clinic, but gave him a quick instruction to relieve the discomfort until the next therapy session.
Follow-Up Questions

What did the therapist do correctly in this situation?

What did the therapist do incorrectly in this situation?

What needs to be documented?

Should the therapist seek consultation? Why or why not?

Use the self-evaluation questions to assess the therapeutic process.

Module III: Summary

The initial evaluation is the first point to discuss the probable dual relationship with the client

A therapist needs to be aware of self-disclosure and maintain therapeutic boundaries

It is a therapist's responsibility to document significant events and consult with colleagues or a supervisor for additional perspectives

Self-evaluation are important for the therapist to balance work and home lifestyles

Discussion Board Opportunity

Website
Satisfaction survey
2 Week discussion
Certification of course completion
Companion Materials


Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists
Jennifer Maus, OTR/L
Caroline Olson, OTR/L
Program Objectives

1. To provide education modules to occupational therapists practicing in a rural setting on strategies used to manage dual relationships
2. Through the education modules, therapists will feel competent in how to handle the situation when faced with a boundary violation
Modules

I: Definition & Foundation of Dual Relationships

II: Dual Relationships Explored

III: Managing Dual Relationships
Module I: Definition & Foundation of Dual Relationships
Part A: Rural

Learning Objectives:
Occupational Therapist will be able to:
1. Understand the contribution of rural practice on dual relationships
What are some characteristics that are unique to rural practice?

Reflect on personal experiences from practice or living in a small town that you may find have had an impact on your personal and professional life.
Characteristics of Rural Practice

- Geographic isolation
- Resource limitations
- Lack of access to referrals
- Shortage of staff
- Greater independence
- Sole provider in professional role
- Lack of specialists
- Work with a variety of diagnoses
- Dual relationships
- Positive work environment

Because of a rural setting there is often geographic isolation in which there is a long commute to a bigger city. As a result of this isolation, therapists often have limitations in resources materials and limited consultation with other allied health professionals. There is a lack of access to receive or give referrals because of limited number of professionals. Due to barriers and challenges small rural practices often have difficulty retaining and recruiting staff which results in a shortage of staff.

Therapists in rural practice are often the sole provider in their profession so have greater independence when providing services. Therapists are also considered generalists in which they must work with a variety of diagnoses and do not often specialize in a specific. As a result of being the sole provider in the profession, many occupational therapists have dual relationships with clients in and out of the clinical setting.
In rural communities, the therapist is often highly visible in the community because there is an expectation for therapists to be involved in different organization and activities.

Many clients in a rural area have a desire to know or relate to the worker in relation to themselves or others in the community.

Individuals in rural communities are often more laid back and friendlier so interactions between client and therapist may be less formal than a professional engagement.

In rural settings, there is an increased opportunity for therapists and clients to come into contact with each other as they go about their daily lives.
Impact of Community Involvement

- Trust, acceptance, respect
- Professional credibility
- Congruent public and private life

Many times, therapists are expected to be involved in the community. However, the therapist should be careful of what type of group, organization, or leadership positions held that as it may have an impact on how others in the community see them. Therapists often engage in social activities and organizations to gain trust, acceptance, and respect of the community members.

Professional credibility of a therapist is determined beyond clinical role but also by personal conduct and community involvement.

The therapist's public and private life is expected to be congruent and consistent.
Not only community involvement is considered and analyzed, family involvement is as well. Family members of the therapist and their actions or community involvement may have an impact on how others view or judge them. Moreover, the families’ involvement may increase possibilities or create situations of a dual relationship (e.g. teacher of a therapist’s child).

Being culturally aware and sensitive of the communities’ values and attitudes is important for the therapist. Treat everyone like they are a prospective client and be aware of your reputation.
Dual Relationships in Rural Settings

- 100% of rural psychologists identified dual relationships as an issue present in their practice (Schank & Skovholt, 1997)
- Predictable part of rural practice
- Difficult to avoid
Part B: Dual Relationships

Learning Objectives:
Occupational Therapist will be able to:
1. Define a dual relationship
2. Identify the different types of dual relationships
Definition

- "Two or more distinct kinds of relationship with the same person" (Endacott et al. 2006, p.988)

- "Dual relationships occur when professionals engage with clients or colleagues in more than one relationship, whether social, sexual, religious, or business" (St. Germaine, 1993)

- A therapist can engage in a dual relationship before, during, or after the professional relationship
Does anyone have an example of when they encountered a dual relationship?

A multiple role with a client, or provided services to a client that had ties to in the community. Or questioned whether to provide services to a client because of a prior relationship with them.
Examples of Dual Relationships

- Member of the same community group
- Member of the same church
- Friend
- Relative
- Business associate
- Teacher of his/her child
- Teammate on same sporting team
- Running into a client in the community

Examples include providing services to:
Related Terms

- Boundary violation
- Boundary crossing
- Interpersonal boundaries
- Overlapping roles/relationships
- Multiple relationships
- Ethical dilemma
- Ethical Conflict

Other terms that may be found in the literature but are synonymous with the term dual relationship are the following:
Reamer (2003) identified five types of dual relationships:
Interaction

What type of relationship have you experienced the most?

Which type of relationship do you think is the most difficult to avoid? Why?
Part C: Ethics

Learning Objectives
Occupational Therapist will be able to:
1. Apply the OT Code of Ethics as it relates to dual relationships
2. Gain awareness on the disciplinary actions taken by ethical agencies
OT Code of Ethics

The specific purpose of the American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics (2005) is to:

1. Identify and describe the principles supported by the occupational therapy profession
2. Educate the general public and members regarding established principles to which occupational therapy personnel are accountable
3. Socialize occupational therapy personnel new to the practice to expected standards of conduct
4. Assist occupational therapy personnel in recognition and resolution of ethical dilemmas

(AOTA OT Code of Ethics, 2005)
Pertaining to the OT Code of Ethics, what principles do you think most apply to a dual relationship?
Principles

**Principle 1: Beneficence**
Occupational therapy personnel shall demonstrate a concern for the safety and well-being of the recipients of their services.

**Principle 2: Nonmaleficence**
Occupational therapy personnel shall take measures to ensure a recipient's safety and avoid imposing or inflicting harm.

**Principle 3: Autonomy, Confidentiality**
Occupational therapy personnel shall respect recipients to assure their rights.

(AOTA Code of Ethics, 2005)

In literature, the issues discussed about dual relationships most often fall under these three principles.
Principle 1: Beneficence

Beneficence - doing good for others or bringing about good for them. The duty to confer benefits to others.

- Provide fair and equitable services to all clients
- Have fair and reasonable fees for services

(AOTA OT Code of Ethics, 2005)

According to this principle, it is the therapist’s responsibility to provide fair and equitable services to all who receive services. Therefore, regardless of a prior relationship, the therapist cannot vary the quality of care they provide. Therapists may feel that they do not want to harm a prior relationship, and in turn not provide the best of most effective care possible.

In rural communities, it is common for members of the community to barter goods and violate this ethical principle. It is a therapist’s responsibility to ensure fees are fair and reasonable for all recipients.
Principle 2: Nonmaleficence

Nonmaleficence - Not harming or causing harm to be done to oneself or others the duty to ensure that no harm is done.

- Maintain therapeutic relationships that shall not exploit the client
- Avoid relationships of activities that interfere with professional judgment
- Identify and address personal problems that may impact professional judgment

(AOTA OT Code of Ethics, 2005)

The therapist’s responsibility is to maintain professional therapeutic relationships with all clients that receive services. Exploitation of client’s can include sexual, physical, emotional, psychological, financial, or social harm. With dual relationships, there are certain dynamics that may increase the risk for exploitation and may result in harm to the client and the relationship with the client.

When involved in a dual relationship with a client, personal feelings or attitude in treatment may override the professional relationship with the client and impact judgment. It is the therapist’s responsibility to avoid relationships and activities that may impact professional judgment.
Principle 3: Autonomy, Confidentiality

**Autonomy** - The right of an individual to self-determination. The ability to independently act on one’s decisions for their own well-being.

**Confidentiality** - Not disclosing data or information that should be kept private to prevent harm and to abide by policies, regulations and laws.

- Collaborate with client on goals, priorities, and intervention processes
- Respect individual’s right to refuse services
- Protect all privileged confidential forms

The therapist and client can collaborate with family members, caregivers, or significant others in setting goals and priorities throughout the treatment process including full disclosure of risk and potential outcomes.

In dual relationships, the client may not be completely honest in fear or judgment from their therapist and friend, for example, and the therapist may not fully disclose or address everything in hopes to protect the personal relationship.

Regardless of personal feelings or ties to the client or individual, it is ultimately the client’s right to refuse or discontinue services.

It is the therapist’s ultimate responsibility to protect confidentiality of the client whether written, verbal, or electronically. In small rural communities, because of the strong sense of affiliation, people want to know about other people and it is common for them to relay information. It is often expected that the therapist will be involved in discussion. Another issue is interaction or unexpected contact with the client in the community, and the client may want to discuss their therapeutic issues or concerns not knowing the appropriate time or place to do so.
Violations of Principles

- Ethical violations may result in consequences and disciplinary actions of ethical agencies

- Agencies:
  - State Regulatory Boards
  - NBCOT
  - AOTA's Ethics Commission

All three agencies can be involved in a case or just one agency. Often the state regulatory board is the first to receive a complaint against a therapist.
State Regulatory Board

North Dakota State Board of Occupational Therapy Practice

- Adheres to the AOTA’s Code of Ethics
- A five member committee will review complaints filed against occupational therapists in North Dakota

(www.ndotboard.com, 2000)
National Board for Certification in Occupational Therapy (NBCOT)

- Investigate and review complaints against OT practitioners
- Independent from state regulatory boards and AOTA's Ethics Commission.
- Will notify the state of any complaints received and will refrain from actions until the state does act on the case

(NBCOT, 2007)
Disciplinary Actions

Ineligibility for certification – individual barred from becoming certified by NBCOT

Reprimand – expression of disapproval retained in individual’s file, but not publicly announced

Probation – continued certification is subject to fulfillment of specified conditions

Suspension – loss of certification for a certain duration

Revocation – permanent loss of certification (NBCOT, 2007)
AOTA's Ethics Commission

- Responsible for developing the ethic standards for the profession and personnel at all levels within the profession

- Two primary roles:
  - Education
    - Develops and provides education materials in response to needs, inquires, and ethical trends
  - Enforcement
    - Review and investigate ethics complaints filed against AOTA members
    - Recommend disciplinary actions

When an individual accepts a membership of AOTA it is his/her responsibility to adhere to the Code of Ethics and the enforcement procedures. The Ethics Commission will only review and examine complaints filed against members of AOTA.
Disciplinary Actions

Reprimand – private formal expression of disapproval of conduct by letter from the Chairperson

Membership Probation – failure to meet terms will subject member to any of the disciplinary actions

Censure – formal expression of disapproval that is public

Suspension – removal of membership for a specified duration

Revocation – permanent denial of membership

The Ethics Commission will meet and decide the disciplinary action to be taken against the therapist.
Module I: Summary

- A dual relationship is when a therapist has two or more distinct relationships with a client.
- Dual relationships are difficult to avoid in rural healthcare settings.
- OT Code of Ethics assists occupational therapy personnel in recognition and resolution of ethical dilemmas.
- Disciplinary actions are taken when an ethical principle is violated.
References


Module II: Dual Relationships Explored
Learning Objectives

Occupational Therapist will be able to:
1. Differentiate between the pros and cons of a dual relationship
2. Distinguish between therapeutic and destructive dual relationships
What are some pros and cons of engaging in a dual relationship?
Pros of a Dual Relationship

- Trust and rapport between client and therapist
- Therapist may seem more approachable and familiar
- Client may feel more comfortable and less suspicious
- A more complete and comprehensive understanding of the client's
- May decrease the client exploitation

(Scopelliti et al, 2004)

Client and therapist may have built trust and rapport prior to the therapeutic relationship which may aid in the therapeutic process.

Therapist may be seen as approachable and more familiar to the client through community involvement and activities in which the client has seen therapist in the public

Client may feel more comfortable and less suspicious with someone they already know

Therapist may have a more complete and comprehensive understanding of the client's history and background

Engagement in a dual relationship may decrease the possibility of therapeutic exploitation of the client by the therapist
Therapist may have difficulty maintaining client’s confidentiality in smaller communities due to the fact that everybody knows everybody and likes to discuss safety and concern issues of community members.

Fear of destroying the secondary relationship may cause the therapist to be hesitant or avoid providing the best possible treatment.

Therapist may abuse the power and negatively influence the client or

Client may not be honest and willing to share personal information for fear of judgment and negative opinions of the therapist.

If the dual relationship were to become negative, it may be difficult for the client to engage in another or further therapeutic process.
A dual relationship is therapeutic when:

- The secondary relationship enhances or complements the therapeutic relationship
- The secondary relationship has created trust between the client and the therapist
- The interest of the therapist is focused on the well-being and independence of the client

(Moleski & Kiseica, 2005)
Brady and Jane are active members of the same church in their small town. Both Brady and Jane volunteer at church events and attend services every Sunday. They have established a friendship over the last couple of years. Two weeks ago, Jane fell and broke her right hip. After being released from the hospital, Jane agreed to receive home health services. Brady is an occupational therapist for the local hospital and received the home health referral to provide services to Jane. Brady contacted Jane to discuss the therapy process and schedule and discussed concerns regarding her comfort level with him as her therapist. Jane was grateful that Brady was going to help her during the rehabilitation phase of her injury, and stated she trusted him and was more than comfortable with him providing care. Jane felt that because they have established rapport and friendship through the church, that he would put her best interest first.
Follow-Up Questions

What are the pros of this therapeutic scenario?

What are the cons, if any, of this therapeutic scenario?

What steps did Brady take to assure effective delivery of services?

In what ways did the prior relationship aid in the therapeutic relationship?
A dual relationship is destructive when:

- The secondary relationship overrides the therapist/client relationship
- Autonomy of the client is lost
- Client’s confidentiality is breached
- Therapist puts personal interests before clients interests

(Moleski & Kiselica, 2005)
Karen had been seeing Susan, an occupational therapist, for outpatient services. After two months into therapy, Susan began self-disclosing about personal issues and her problems with her ex-husband in which Karen had experienced a similar situation. Susan and Karen became close friends and began to speak on the phone at least once a day. After six months, Karen was discharged from therapy services, but Karen and Susan remained good friends. Susan started depending on Karen for advice and support. Karen felt like she was being exploited by Susan. After awhile Karen felt like she could no longer be responsible for Susan’s emotional stability so, Karen decided to end their friendship.
Follow-Up Questions

What are the pros, if any, of this destructive scenario?

What are the cons of this destructive scenario?

What actions did Susan engage in that may have crossed professional boundaries?

What is the potential impact of Susan’s actions on Karen’s future actions with future healthcare providers?

What would be the appropriate steps to take in this case, or in a similar situation?
Reflection

Think of a situation in which you were engaged in a dual relationship with a previous or current client.

In what ways did the relationship aid in the therapeutic process?

In what ways might the relationship have hindered the therapeutic process?
Module II: Summary

• There are pros and cons of each dual relationship

• The client may feel more comfortable with a therapist well known to the community

• The client may hold back personal information in fear of destroying the prior relationship

• A prior relationship with a client can complement or enhance a therapeutic relationship

• A prior relationship with a client can obstruct or override a therapeutic relationship
References


Module III: Managing Dual Relationships
Learning Objectives:

Occupational Therapist will be able to:
1. Develop personalized strategies to manage dual relationships
2. Assess professional role and responsibility in the management of dual relationships
Interaction

When meeting a client with whom you also have a personal relationship with, what are important steps to take during the initial interview to ensure a therapeutic relationship?
First and foremost, when an occupational therapist is providing services to client whom he or she has a prior relationship with, an important step for the therapist to take is to discuss with the client the impact that the secondary relationship can have on the therapeutic process. Involve the client in the decision-making process. Also, it is important for the therapist to clearly describe and set boundaries that define and separate the personal and professional roles. Furthermore, flexibility is equally important, but more importantly the maintenance of barriers of the therapeutic process.

The next step is to obtain and secure informed consent, providing the client with the potential risks involved and respecting their right to refuse or discontinue services at any time. By developing a plan of action for a chance encounter outside of therapy, the client has the opportunity to decide how he or she wishes to handle the situation.

It is significant to discuss the importance of open and honest professional communication throughout the therapy process. The client needs to know that what goes on and what is said will remain inside the clinical setting and therapy will not be discussed elsewhere. This is to protect the client’s and other client’s confidentiality and safety, as well as the therapist’s professional responsibility.
Interaction

A good friend has come to receive OT services and you will be the therapist. Role play the initial interview utilizing the appropriate actions and words addressing a dual relationship issue with the client.

Plan B: If an individual is alone at their site, they will write down the steps to take on a note pager.

Plan C: If technology allows, one on one role play will be conducted with individuals from two different sites.
Therapy Process

- Avoid bartering
- Stick to time limits
- Be alert for potential conflicts of interests
- Be cautious regarding self-disclosure
- Be cautious with physical contact
- Utilize best judgment

Bartering includes the exchange of goods or services beyond the fee for service. This should be avoided as it may create situations that are stressful and unethical if not performed to standards. Setting time limits helps with maintaining therapeutic boundaries. This inhibits additional meetings at inappropriate times (i.e. late at night, after office hours), and keeps the focus on the client’s need for services. It is important for therapists to be alert for potential or actual conflicts of interest, a red flag that a problem may arise, and keep the concerns that the client has always a priority.

The issue of therapist self-disclosure can be a powerful intervention. The therapist needs to take caution and use appropriate self-disclosure that is done for the client’s benefit. Disclosing past experiences, events of problems can help the client overcome therapeutic barriers. Too much information may result in the client feeling like a dependant and in a reversed role. Too little information may result in the client feeling defensive or create a non-approachable environment.

Physical contact is difficult to avoid, but the therapist needs to take caution and watch to not cross professional boundaries. Client’s can misread the behavior, therefore sticking to the standard treatment protocol and therapist role will not cause confusion. Brief and limited physical contact may comfort the client and be therapeutic. Because dual relationships are unavoidable, it is the therapist’s responsibility to utilize his or her best judgment. There may be times in which it is necessary to cross boundaries. Throughout the therapy process, the therapist tries to maintain a professional attitude; however this may come across as rude or hurtful to the client. By utilizing best judgment, a therapist outweighs the benefits and risks of professional and personal behavior.
A therapist's emotional vulnerability can lead to a decrease in sound judgment and also knowing that they are trying to fulfill personal needs through the client. A balance of their work and home lifestyle should be established to not rely on a client to fulfill social and emotional needs. Self-evaluation of one's emotions can help decrease emotional attachment to a client and their situation.

Self-evaluation personal needs and problems are important for the therapist to conduct so as to not address or disclose information in the therapy process with a client.

By the therapist continuously evaluating themselves and reflecting on the relationship as a whole before, during and after it occurs, is important to maintain therapeutic and professional boundaries as well as delivering effective services.
Self-Evaluation Questions

Am I providing fair and equitable services to all my clients?

Have I been honest and upfront with concerns and potential conflicts?

Is the relationship with the client effecting the way I deliver therapy services?

What actions am I taking to ensure I am keeping the best interests of the client?
By documenting the case of dual relationship or a significant event is a protection for the therapist and an opportunity to further examine and discuss the counseling process. Documentation should start on the initial interview as to the steps and actions that were agreed upon between the therapist and client. Further discussions throughout therapy that are considered significant to the dual relationship should also be documented immediately.

Consulting with a colleague or allied professional is an appropriate step to inform others of the dual relationships. It is important to document the discussion and any suggestions or advice pertaining to a client or a dual relationship situation that was given.

Encounters with the client in which therapy is brought to attention in any way should be documented. The therapist should document when, where, and what was said if significant to the therapy relationship. At the next therapy session the chance encounter should be encountered and documented as well.

If the therapeutic relationship merges to a more personal and friendly relationship, the therapist should document the case progress and be explicit about the overlapping roles and relationships.
Consultation

- Client
- Colleagues
- Supervisor
- Ethical agencies

First, the therapist should inform the client about boundary violations that have occurred or are at risk, and continue to monitor the plan of action. The therapist can seek out advice or further consultation through colleagues and other allied health professionals when faced with an ethical dilemma or challenge. As the issue becomes more problematic, consultation with supervisors or mentors is recommended to seek or negotiate an appropriate solution. The next step for a therapist to take is to contact a professional regulating body or association. It is the responsibility of the associations to provide a safe and non-judgmental environment when seeking consultation.

Additional perspectives are important when consulting with others.
Once the client has been discharged from therapy services, the therapy process should not be discussed. Discuss with the client the probability of further community interaction and encounters, and ethical standards of confidentiality and client privacy that still remains a therapist’s responsibility.
Your neighbor Bill experienced a flexor tendon laceration and is coming to you for occupational therapy services 3x a week. Bill has been wearing a fabricated splint for a week. One day on his way home from work, Bill saw you in the yard and came over to ask a question regarding the home exercise program that was developed for him. You quickly answered his question regarding the home exercise program. Two days later, in the evening, Bill knocked on your front door and complained of splint discomfort. You told Bill that the necessary supplies to adjust the splint were at the clinic, but gave him a quick instruction to relieve the discomfort until the next therapy session.
Follow-Up Questions

What did the therapist do correctly in this situation?

What did the therapist do incorrectly in this situation?

What needs to be documented?

Should the therapist seek consultation? Why or why not?

Put yourself in this situation. Use the self-evaluation questions to assess the therapeutic process.
Module III: Summary

• The initial evaluation is the first point to discuss the probable dual relationship with the client.

• A therapist needs to be aware of self-disclosure and maintain therapeutic boundaries.

• It is a therapist's responsibility to document significant events and consult with colleagues or a supervisor for additional perspectives.

• Self-evaluation is important for the therapist to balance work and home lifestyles.
A discussion board has been created and is available for you to log on and discuss situations or ask questions. This also allows an opportunity to network with other rural occupational therapists in North Dakota.

Please complete the satisfaction survey available on the discussion board. This will help to evaluate the course content and measure your perceived competency of managing dual relationships.

The discussion board will be open for 2 weeks following the educational session.

Certifications of the course completion, 4 contact hours, will be mailed to the address provided upon registration information within two weeks.
Questions?
Post-Course Survey

Please complete the following questions using the rating scale below that best describes your response.

SD=strongly disagree  D=disagree  N=Neutral  A=Agree  SA=Strongly Agree

1. The program objectives were clear.  SD  D  N  A  SA
2. The session information was useful and applicable to my area of practice.  SD  D  N  A  SA
3. The companion materials were beneficial to read prior to the session.  SD  D  N  A  SA
4. The interactive notes were helpful in the learning process.  SD  D  N  A  SA
5. The interaction opportunities were beneficial to my learning.  SD  D  N  A  SA
6. The presenters covered the course content effectively and in the time allotted.  SD  D  N  A  SA
7. The discussion board was easy to access and use.  SD  D  N  A  SA
8. The videoconference method of delivery was convenient.  SD  D  N  A  SA
9. The content was clear and easy to understand through the use of a videoconference method.  SD  D  N  A  SA

10. Please rate your competency level of managing a dual relationship after completing the course.

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Thank you for completing this survey.
CERTIFICATION OF CONTINUING EDUCATION IN:
MANAGING DUAL RELATIONSHIPS IN RURAL HEALTHCARE SETTINGS

Presented to:

NAME OF RECIPIENT

Presenters:
Caroline Olson, OTR/L and Jennifer Maus, OTR/L

Date
4 contact hours

Signature
Date

Signature
Date
References


CHAPTER V
SUMMARY

Dual relationships are a common and often unavoidable problem for rural healthcare professionals. These relationships create ethical dilemmas between the patient and the therapist and impact the effectiveness of the delivery of therapy services. Rural healthcare professionals need to learn strategies on how to manage these types of situations. This scholarly project provides a resource to educate and train therapists to effectively deal with dual relationships among patients, family members, and caregivers. A continuing education course titled *Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists* is presented. This course is to be delivered using a videoconference format so it is easily accessible and convenient for rural therapists. The course is designed to be available for registered occupational therapists and certified occupational therapy assistants currently practicing in rural settings.

The course content is presented in three modules: (a) Definition and Foundation of Dual Relationships, (b) Dual Relationships Explored, and (c) Managing Dual Relationships. Teaching methodologies utilized include PowerPoint lecture/discussion sessions, small group activities, and use of a discussion board for follow-up and networking opportunities for therapists enrolled in the course. The Ecology of Human
performance and the Andragogy in Practice Education Model were chosen as the foundations to guide the development of the product.

Implementation of Project

The product is designed to be implemented to rural occupational therapists practicing in a rural setting. The first step is to determine the interest of rural therapists in taking the continuing education course. A brochure and email is then sent to all registered occupational therapists and certified occupational therapy assistants within the state of North Dakota. Following completion of the course, the outcomes of the satisfaction surveys are to be calculated to determine the effectiveness of the class. If the education course is found to be effective, it can be offered to rural occupational therapists in different states, such as Minnesota, Montana, and South Dakota. The videoconference format allows the course to be accessible to all rural healthcare professionals across the United States.

Limitations and Recommendations

A limitation of this project is that it is aimed specifically at rural healthcare providers. This may limit the market or overlook those healthcare providers who live in an urban area but contract their services to smaller rural communities. Another limitation is that the project assumes that all rural communities are similar and does not account for possible differences in ethnic or regional/local culture. Community behaviors and attitudes may differ depending on one’s ethnic beliefs or area of the U.S. in which they reside. This project is primarily directed at rural communities in North Dakota.

It is recommended to market to all rural healthcare providers in rural as well as urban areas. If the course is to be delivered to rural communities beyond North Dakota, it
is recommended that exploration into the community values and attitudes is completed prior to the course. Therefore, possible differences in the communities can be incorporated into the course. It is recommended that the impact of dual relationships on both therapists and clients be further researched. Understanding the dynamics of the relationship has the potential to provide information helpful to selecting strategies to manage the dual relationship.

Conclusions

The continuing education course *Managing Dual Relationships in Rural Healthcare Settings: An Education Module for Occupational Therapists* is designed to provide education to rural occupational therapists and occupational therapy assistants. The course has the potential to help the therapist develop strategies and techniques when dealing with dual relationships in rural practice and thereby enable effective intervention for all of their clients.
REFERENCES


knowledge of food safety issues of high-risk populations. *Journal of the American Dietetic Association, 107*(8), 1333-1338.
