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Managing Risk When Contemplating Multiple Relationships

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Entering into dual relationships with psychotherapy patients has been a topic of significant controversy in professional psychology. Although these types of extratherapeutic alliances have generally been considered to be unethical conduct, some authors recently have supported their development as both ethical and, in some cases, even therapeutic (A. Lazarus & O. Zur, 2002). In this article, the authors briefly review the general literature regarding dual relationships and offer the reader guidelines in applying an ethically based, risk-managed, decision-making model that could be helpful when a practitioner is considering entering into such relationships or when such relationships inadvertently develop.

One of us (Jeffrey N. Younggren) recently attended an ethics workshop where the presenter, an attorney, said, "All dual relationships in psychotherapy are unethical or at least run the risk of getting you into trouble with your licensing board." This is a common view pervading the mental health professions, although some have taken an opposing stand, arguing that dual relationships do not always cause harm and can sometimes prove helpful (e.g., Lazarus & Zur, 2002). The coexistence of these opposing arguments may cause confusion because both oversimplify a very complex area of professional practice.

Professional practice abounds with the potential for multiple relationships, and the circumstances under which these types of relationships occur are quite varied. Although psychologists frequently choose to enter into these types of relationship, many may actually be unavoidable, and in some situations one can even conceptualize the avoidance of the dual relationship not only as unethical but as potentially destructive to treatment itself (Campbell & Gordon, 2003). For example, consider the solo practitioner in a very small community, who must of necessity maintain some multiple relationships with his or her patients by virtue of proximity and living conditions. To avoid all contact with patients in this situation would require the practitioner to lead the life of a virtual hermit. To make matters worse, this type of unusual conduct could raise questions in the minds of other members of the community as to why the practitioner acts in such a manner. A socially isolated practitioner will attract few patients and arguably will serve them less well by failing to integrate himself or herself into the community. Such examples have forced the profession to accept the logical position that not all multiple relationships are unethical per se (American Psychological Association [APA], 2002).

The key considerations for practitioners who are faced with deciding if they should participate in a multiple relationship, or who inadvertently find themselves already in such a relationship, involve thoughtful analysis of potential hazards. Our purpose is twofold: First, we focus on how to evaluate and manage such relationships to avoid exploitation of and harm to patients, and second, we discuss how to minimize risk for the practitioner.

We do not extensively review the literature on multiple role conflicts; such overviews already exist elsewhere (e.g., Borys & Pope, 1989; Kitchener, 2000; Lazarus & Zur, 2002; Younggren & Skorka, 1992). Instead, we propose a set of questions that practitioners may use to evaluate whether they should embark upon multiple relationships with patients.

This article should not be seen as a definitive or exhaustive checklist of issues that must be addressed when dealing with multiple relationships. The complexities of professional–client relationships dictate guidance by many factors. We present a series of questions with the goal of assisting practitioners in thinking through these issues broadly and in a more systematic fashion. These questions focus on both the welfare of the patient and the practitioner's need to manage risk to both patient and therapist. We make several assumptions in addressing these issues, which are provided below.

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Assumptions

1. *Engaging in multiple relationships has a high potential for harming patients and, as a general matter, should be avoided* (APA, 1992, 2002). The proscription against multiple relationships has a strong foundation in the prohibition against sexual relations with patients. Although sexual misconduct can unquestionably cause harm to patients, plainly constitutes unethical behavior, and violates the law in some states, the concept of multiple relationships extends more broadly and includes many types of nonsexual relationships that possibly may pose danger to patients or risk to the practitioner. These more ambiguous situations establish the need for the following guidelines.

2. *Psychologists have many different types of professional relationships; not all of them involve psychotherapy patients.* The range of potential professional relationships varies so much that we cannot address all such possibilities in this article. Therefore, we confine ourselves to psychotherapy relationships in which the treatment becomes more personal and intense. The issues we address may affect both short- and long-term psychotherapies.

The ethical and risk-management issues that arise in other types of professional relationships and with other types of psychotherapy do not necessarily have the same types or degrees of risk. Logically, those who engage in less intimate professional activities such as biofeedback, consultation, forensic services, and some types of assessment need to be aware of the risks associated with multiple relationships, but the relational dynamics in these situations are often different from those of psychotherapy. However, the reader should bear in mind that individuals who perform these types of functions could also ask themselves many of the same questions prior to entering into the additional relationship with a consumer and could work to resolve risks if such relationships inadvertently arise.

3. *Some multiple relationships are completely unavoidable and even obligatory, such as those that occur in the military* (Barnett & Yutrzenka, 1994). Psychologists can be placed in legally mandated dual relationships by virtue of the roles they occupy. For example, military psychologists are frequently placed in situations in which they are required to engage in administrative evaluations of individuals they treat. Because of frequent personnel limitations, combined with the unique nature of the military mission, psychologists must perform these dual functions or risk being found in violation of the Uniform Code of Military Justice. This paradox is a reality attendant to the unique role of the military psychologist, and it is only through informed consent that psychologists in the military, and others in similar situations, manage these potentially risky conflicts. Although highly problematic, such unique issues reach beyond our intended scope.

4. *Practitioners create risk for themselves and their patients when they make decisions in a vacuum.* We assume that consultation with trusted and knowledgeable colleagues should undergird all steps in the decision-making process. Those who give consideration to entering into a dual relationship should make consultation central to that process.

5. *Good risk management also means providing good care, and these notions are not viewed as mutually exclusive.* This article focuses on providing good care to the patient while also protecting the provider. Although achieving both of these objectives becomes impossible in some circumstances, we believe that they constitute realistic goals in the vast majority of the professional situations practitioners encounter. If one is to assume that good care is generally care that is satisfactory to the patient, we know that satisfied consumers become originators of litigation and disciplinary complaints far less often than those who are disgruntled clients (Hickson et al., 2002).

6. *When adjudicatory panels such as ethics committees or state regulatory boards evaluate cases alleging harmful multiple relationships, they must of necessity focus on the clinician's behavior retrospectively.* When practitioners consider entering multiple relationships, they must think prospectively to consider how professional bodies might evaluate the complaint retrospectively. Therefore, when considering whether to enter into a multiple relationship, a wise course will involve evaluating how those in the future, in an entirely different setting and circumstance, would react to the present conduct. Although a very difficult task, this commonly used risk-management strategy guides our thinking (APA Insurance Trust [APAIT], 2002a).

Questions

1. *Is entering into a relationship in addition to the professional one necessary, or should I avoid it?* Psychotherapy, by its very nature, becomes a uniquely complex interpersonal process. Diagnostic formulations may evolve as more information comes to light, causing treatment planning and goals to change. Simply speaking, one cannot know at the outset where the course of treatment will lead. Seemingly straightforward initial clinical presentations may become highly complex and difficult clinical-treatment situations that even the most experienced practitioner could not have predicted. In these circumstances, participating in dual relationships is fraught with unnecessary risk. Therefore, the best interests of the patient and the practitioner generally dictate avoiding dual relationships whenever possible.

2. *Can the dual relationship potentially cause harm to the patient?* A basic principle of biomedical ethics (Beauchamp & Childress, 1994) is that interventions should not harm patients. In addition, if some harm is a necessary component of treatment, an attempt must be made to minimize it. In this connection, any proposed relationship in addition to the therapeutic one must yield to an analysis of risk of harm (Gottlieb, 1993). That is not to say that a professional entering into a dual relationship must anticipate and prevent all risk, but that professional has a fiduciary obligation to anticipate reasonably foreseeable risks and make every effort to avoid, minimize, and manage them.

Consider the following example. A practitioner in an isolated community agrees to serve on the vestry of the local church. Subsequently, the minister's wife seeks out the practitioner for treatment. The practitioner, knowing that the prospective patient would be forced to travel great distances to obtain services elsewhere, agrees to see her. It would seem that such a decision would benefit the minister's wife, but agreeing to treat this woman has foreseeable risks. What if, sometime after treatment begins, some members of the church become dissatisfied with the minister, and the vestry must decide whether to renew his contract? Because the patient knows of the therapist's position on the vestry, the professional relationship could be seriously damaged even if the practitioner is recused from the vestry's discussions. This example only adds further emphasis to the point that what may seem to be a

prudent decision at one time can create risk in the face of subsequent unpredictable events. Although the therapist did not create the problem, the situation must still be managed holding the best interest of the patient paramount.

One may argue that predicting future harm as a function of the additional relationship is an impossibility. The reality is that it is easier to believe that a multiple relationship had risk for harm after harm has occurred and a complaint has been filed. However, adjudicatory bodies will look closely at whether a practitioner considered the possibility of future harm, and if harm were a reasonably foreseeable outcome, the practitioner should assume that sanctions will follow.

3. *If harm seems unlikely or avoidable, would the additional relationship prove beneficial?* This type of dilemma occurs frequently for those who work in isolated communities. For example, what should a practitioner do about purchasing a car from the only automobile dealership in a small town when the owner is also a patient? Could making such a purchase enhance the therapeutic alliance by increasing the patient's trust of the therapist and thereby have a positive effect on the therapy? Or, does purchasing the car increase the patient's sense that the therapist trusts him or her? If the practitioner decided to buy the car from the patient, what is to be done regarding negotiating the price? Should the psychologist pay the vehicle's sticker price? Would doing so lead to resentment on the psychologist's part for being forced to pay more than necessary for the vehicle? On the other hand, would purchasing the vehicle elsewhere cause people to wonder why the therapist avoided the local dealership? This might cause particular problems for the practitioner if strong social pressures exist to support the local economy. In this example, purchasing the car elsewhere not only could raise questions among one's neighbors but also might negatively affect the therapeutic alliance. From this very plausible example, it becomes clear that assessing how patients and practitioners may benefit from additional relationships requires caution, careful thinking, and foresight.

4. *Is there a risk that the dual relationship could disrupt the therapeutic relationship?* This question not only requires careful consideration before treatment but also may require periodic reevaluation throughout the treatment process. Given the need to minimize risk, the practitioner who chooses to enter into a dual relationship with a client must manage the relationships in such a way that the therapeutic relationship is not damaged by the additional one. Whenever possible, the practitioner has an obligation to discuss the issue of potential harm in detail with the patient prior to entering into the additional relationship. Furthermore, both therapist and client should revisit the topic regularly to prevent damage to the therapeutic alliance. In addition, the therapist has the obligation to anticipate the types of situations that could damage the therapeutic alliance, because it seems highly unlikely that the client would recognize them. This type of forethought might even benefit the therapeutic process by offering a starting point for discussion of these types of issues with the client. The client may feel more cared for and protected by the practitioner, and this may lead to enhanced therapeutic effectiveness.

Consider this example. A young, attractive female patient has symptoms that initially suggest a diagnosis of a mild, acute depression. The male practitioner finds himself in the midst of a painful divorce, and he has recently considered joining a dance group to increase his socialization opportunities. In the process of treatment, he learns that his patient loves dancing and belongs to the very club he considered joining. After obtaining consultation from a trusted colleague and discussing his own struggles with that colleague, he decides to join a different group. As therapy progresses, the practitioner begins to suspect that his patient may have borderline personality disorder.

In this example, the practitioner had no reason to believe any problem would necessarily arise if he joined the same dance club as his patient, but the consultant brought two issues to his attention. First, the practitioner's emotional state made him vulnerable and might lead to his projecting feelings onto his patient that could complicate her treatment. Second, given the relative newness of the patient, he had no way of knowing whether his diagnosis would remain unchanged once her depressive symptoms began to remit. Here the practitioner imposed a restriction on himself that many might believe unnecessary. Nevertheless, in this case the judgment proved highly prudent and preserved the professional relationship by putting the therapeutic relationship at the forefront in the decision-making process.

5. *Can I evaluate this matter objectively?* This very difficult question demonstrates a fundamental of good risk management. One must always assume that a compromise in one's objectivity might reach beyond one's awareness. However, when one is confronted with this type of problem, careful self-evaluation is always a good place to start. Standing back from a potential dual relationship and looking at it, oneself, and one's own motivation will surely help lend clarity to the matter. In addition, reviewing the available literature in this area can also improve one's objectivity and could even provide answers to questions about current professional standards of care.

The only other way to approach answering the question about objectivity begins with obtaining consultation from trusted colleagues. (It is important to note that obtaining consultation from others, such as attorneys, may also be entailed.) The inherent high level of risk associated with acting out unconscious needs, or conscious but neglected ones, makes addressing these types of professional concerns with others extremely valuable. When the answers to questions about personal objectivity are unclear, one should discuss and process them with other individuals to ensure that the answers maximize thoughtful, objective consideration; good clinical care; and sound risk management.

Risk Management

Once a practitioner has addressed the "treatment-oriented" questions above and has decided to proceed with a dual or multiple relationship, he or she should now turn to what we term the "risk-management mode." Because the decision to enter into additional relationships has risk for the patient, the therapy, and the practitioner, he or she must engage in a risk-management strategy that provides protection if charges of unprofessional conduct ever surface as a result of the choice. Although some might see such a strategy as "self-serving," the realities of a litigious society require self-protective conduct. Furthermore, in keeping with our assumptions, we contend that good risk management is also consistent with good clinical and ethical practice. Therefore, when choosing to engage in a dual or multiple relationship, the prudent practitioner should now address the following questions.

1. *Have I adequately documented the decision-making process in the treatment records?* Because the spirit of the law is "If it isn't written down, it did not happen," inadequate documentation can negate the existence and value of the entire decision-making process regardless of how comprehensive and thoughtful it may have been. No matter how well the practitioner may have addressed the questions raised earlier in this article, if the process was not documented, then the protection afforded by having done so is largely lost. Once a complaint or lawsuit is filed, efforts to explain the process without documentation will result in considerable skepticism and will be viewed as self-serving and as an effort to put one's own interests ahead of the patient's. On the other hand, good record keeping can significantly contribute to a strong defense against allegations of professional misconduct (APAIT, 2002a; Nottingham & Hertz, in press). If the record reflects a carefully considered decision-making process that led to the choice to engage in a dual relationship, it can lend great weight to one's defense, even if that choice turned out to be the wrong one.

More specifically, the record should reflect the process by which the choice evolved and demonstrate full consideration of other alternatives. Creating documentation in this manner produces a record that should lead the reader to reach the same conclusion, or at least to have a good understanding of the practitioner's thinking on the matter. To meet this standard, the practitioner should ensure that the record reflects all consultations and logically explains the rationale for the choices made.

Finally, how does the record reflect that the patient has received appropriate information and consents to the additional relationship? Ideally such documentation could take the form of a signed agreement, something that is discussed in the next section, but at the very least this type of consent should consist of a note in the patient's chart. Although a note affords weaker evidence of informed consent, it remains a testament to the fact that some agreement did, in fact, occur. If the record fails to incorporate these considerations, it may leave the practitioner as the only witness who supports the choice. A good record serves almost as a second witness to what actually occurred. If this "witness" provides data supporting the practitioner's choice, it lends great strength to the argument that the choice was a sound one.

Let us once again consider our dancing colleague and assume that he chose to join the club where his patient also danced. Before deciding to join, he spoke with a colleague and discussed his personal vulnerabilities in the situation as well as the possible harm it could cause his patient. He then reviewed the issue with the patient as a matter of informed consent. She understood and felt that his action would not pose a problem for her. After joining the club, he also periodically inquired regarding the patient's feelings in order to address potential transferential issues and documented each of these inquiries at the time. Now, because this prudent therapist created a very strong record of what happened, if the patient were to file a complaint against him, he will stand on much firmer ground when defending himself.

2. *Did the practitioner obtain informed consent regarding the risks of engaging in the dual relationship?* Patients are in relatively less powerful positions with respect to their psychotherapist (Kitchener, 1988). When a practitioner faces a difficult decision that entails the risk of a multiple relationship, he or she should make sure that the client fully understands the issues, the alternatives, and the advantages and disadvantages of each as a matter of informed consent (APA, 1992, 2002; Beauchamp & Childress, 1994). Informed consent, in the era of HIPAA (the Health Insurance Portability and Accountability Act), is increasingly complex, and many consent forms and therapist–patient contracts are currently available commercially, in the published literature, and as part of free risk-management services offered by various organizations (e.g., Harris & Bennett, 1998; APAIT, 2002b; APA Practice Organization & APAIT, 2003). However, the type of informed consent being addressed here would clearly require a detailed addendum to an existing standard form or a separate agreement that clearly sets out the issues addressed in this article.

Generally, it is a good practice to allow patients time to consider these matters before making a final decision (Gottlieb, 1993). If the patient agrees to proceed with the additional relationship(s), then they may proceed.

We hasten to note that patients cannot give informed consent to something that poses severe risk to them and/or is a violation of the law, because these rights cannot be legally waived. A good example is consent to engage in a sexual relationship with a therapist. Even if attempts to use informed consent as a defense in this type of case were made, they would fail.

3. *Does the record show adequate evidence of professional consultation?* In many circumstances, consultation helps to establish that the standard of care was met. Talking with others supports the argument that the decisions made in a given matter were in accordance with the guidance of others who would have behaved in a similar fashion under comparable circumstances. This view of the standard of care can be found in the 2002 APA ethics code, where "reasonable" professional conduct is defined as "the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances given the knowledge the psychologist had or should have had at the time" (APA, 2002, p. 2). Thus, adequate consultation allows the practitioner to say that he or she did what other reasonable psychologists would do under similar circumstances, creating an additional defense against criticism of his or her conduct that is founded on a violation of the standard of care.

As we noted earlier, consultation should not be limited to an exchange that occurred prior to the decision but should occur throughout the treatment process. Finally, as we have emphasized, consultation should always be documented. Too often practitioners fall into the trap of the "hallway consultation" in which neither consultant nor consultee document the conversation. The best practice is to set aside time to meet with a consultant and, for serious matters that potentially have high risk, both should document the consultation (APAIT, 2002a).

4. *Does the record reflect a patient-oriented decision-making process?* Although not an easy task, making notations that reflect a struggle on the part of the practitioner to protect the patient and to make the right choices for the benefit of the patient become a strong defense in legal and ethical proceedings. Even if the choices are arguably incorrect based on subsequent events, the visibility of the process of seeking the right, patient-oriented answer when confronted with a choice of entering into a dual relationship is a very helpful defense.

Consider a therapist who had a patient dying of terminal cancer and the patient wanted the therapist present at the time of death. Is fulfilling this request consistent with the standard of care? Should

a psychologist stand a death vigil to please the patient? Is it appropriate to engage in such nontraditional conduct, given the fact that the patient is not going to recover, if it will make the patient happier? And, if the therapist chooses to be with the dying patient, is there any way that the therapist's conduct could be seen as unprofessional and reflective of a loss of objectivity? Although some might argue such conduct is inappropriate, consultation that supported the decision to be with the patient at the time of death would show an attempt to engage in some type of prudent decision-making process, even though other professionals could still question the behavior (Nottingham & Hertz, in press).

5. *Are the sources of consultation credible?* Credibility is difficult to measure as it frequently lies in the eye of the beholder. However, having consulted someone with expertise, not only in the treatment modality being utilized but also in the relevant area of ethics and mental health law, can be a very strong defense. If one does not know how to find such a consultant, contact with local or national professional associations for such a referral can frequently be of great assistance. In addition, these types of consultative services are often provided free of charge to individuals who are members of various organizations, to include the APAIT and the APA Office of Ethics. The individual with whom one consults can be quite important, and, if colleagues of this stature request payment for their consulting services, it is our view that this money is very well spent. Another benefit that comes from practicing in this fashion occurs when the psychologist is sued or his or her license is attacked. Under this circumstance, the consultant can be brought as a witness to testify and, because of being removed from the case and arguably being more objective, may be able to make a stronger argument on behalf of the psychologist than the psychologist could himself or herself.

6. *Do the diagnostic issues matter when considering a dual relationship?* In a word, yes! Logically, entering into a dual relationship with a patient who has a fear of public speaking could be viewed by other professionals as having substantially different risks from those of a patient with a complex borderline personality disorder and a history of childhood sexual abuse. In general, it is our contention that risk is inversely related to the general level of integration of the patient. Multiple relations with patients who are well integrated may present various risks, but these risks are substantially lower than those that occur when a therapist chooses to engage in the same type of relationship with a patient who is seriously emotionally compromised. Multiple relationships in the latter circumstance are almost never a good idea.

Second, there is no question that diagnosis is always provisional. The initial diagnosis is often not the diagnosis with which the patient is discharged. Although multiple relationships may be permissible under certain circumstances with some patients who are well integrated, there is no practitioner who cannot be fooled, miss a diagnosis, or simply learn more information about his or her patient later that would have led to a different decision in diagnostic formulation. Again considering our dancing colleague, much of the risk the therapist runs will depend on the developing diagnosis of the patient, and undiagnosed borderline tendencies pose substantial risk.

Finally, regardless of whether a practitioner believes a choice to enter into a dual relationship with a patient who is compromised is the correct one, he or she must consider the prevailing views of the profession regarding this type of conduct, for it is these views that will be encountered in the courtroom and during the resolution of the complaint.

7. *Does knowledge of the patient support the establishment of a dual relationship?* How well one knows a patient has a direct impact on the choice to enter into a dual relationship. Inherent in many of the points made throughout this article is a belief that more, and accurate, information about a patient is helpful in determining whether the choice to enter into a dual relationship is a wise one. Although one might argue that this point relates to the previous one, we believe that not all knowledge impacts diagnosis. Thus, a comprehensive understanding of the patient and the complexity of the patient's life, family, and related issues would be helpful in arriving at the "right choice" in this case. In truth, when faced with the risk (to both client and therapist) that could come from being wrong, logically, more information is always helpful. For example, and simply put, knowing that a patient has a long history of litigious behavior could cause one to pause when considering whether to enter into another relationship with that individual.

8. *Does one's theoretical orientation matter when considering a dual relationship?* Theoretical orientation matters because in some cases it may increase risk. Those who practice from a more traditional, insight-oriented approach are most likely to have patients who develop transferential feelings that must be addressed in therapy. These types of treatment modalities generally call for clear boundaries and, whenever possible, the avoidance of multiple relationships. Conversely, the behavioral modalities could be seen by some as being less prone to the complexities of more traditional treatment relationships.

However, for various reasons, those who practice from a cognitive or behavioral perspective are not immune from the difficulties found in traditional therapies. First, such approaches are not always confined to symptomatic treatment. Second, the treatment itself does not preclude the possibility of perceptual distortions on the part of patients and/or therapists. Third, the type of treatment may be modified as the patient improves and his or her therapeutic needs evolve. Changing treatment modalities may also change the nature of the patient–practitioner relationship (Gottlieb & Cooper, 2002), and multiple relationships appropriate to the initial format may not be appropriate to the new one.

These points may be clarified with the following example. A man had what appeared to be a moderate reactive depression, and the psychologist treated him with a combination of behavioral and cognitive techniques. The patient responded well, but in the course of treatment the psychologist learned that her patient was having marital difficulties and offered to change format and began marital therapy. (For guidelines regarding change of format, see Gottlieb, 1995.) As the therapy progressed, it became apparent that both individuals in the marriage had family-of-origin issues that required longer term care than was first contemplated. This rather typical scenario demonstrates that it is not prudent for practitioners to assume that their therapeutic orientation will serve as sufficient protection for them. In this case, the practitioner who chose to engage in a dual relationship with the patient early in the treatment, based on the assumption that the nature of the theoretical orientation would be protective, now learns, as treatment progresses, that the choice may have created unanticipated risk and is now fraught with potential danger.

Implications for Practice

Whether one chooses to enter into a multiple relationship with a patient or inadvertently finds himself or herself in one, significant risks arise for both the patient and the professional. We acknowledge that these types of relationships are not necessarily violations of the standards of professional conduct, and/or of the law, but we know enough to recommend that they have to be actively and thoroughly analyzed and addressed, although not necessarily avoided. This process becomes extremely important in light of the aforementioned risks to both parties.

A professional finding himself or herself facing such a dilemma must address the problem based on the best interests of the client. Careful analyses of the risk for conflicts of interest, loss of objectivity, and disruption of the therapeutic alliance must be made. Following this, the professional must review and discuss the potential difficulties with the client, making the client an active part of the decision-making process. If from this analysis it appears that the relationship is appropriate and acceptable, the therapist must document the entire process and, if possible, make the client a part of that process through the use of a signed informed consent.

Following the completion of this patient-oriented evaluation of the contemplated multiple relationship, the professional must now adopt a risk-managed approach to the problem. That is, he or she must view the relationship and the decision-making process from the perspective of a regulatory or a judicial authority called upon to determine if the professional's conduct was consistent with the standard of care. The psychologist must do all that can be done to evaluate whether the decision to enter into the relationship was reasonable conduct that the public should expect from the average professional in the same or similar circumstances. This must be done through a careful review of a variety of important issues such as diagnosis, level of functioning, therapeutic orientation, local standards, and practices, and through consultation with qualified professionals who could support the decision to enter into the relationship as being consistent with the standard of care. Only after having taken all these steps can the professional consider entering into the relationship, and he or she should then do so with the greatest of caution.

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