IMPLICATIONS OF DUAL RELATIONSHIP BETWEEN A COUNSELLOR AND A CLIENT IN THREE SELECTED HEALTH CENTRES IN LUSAKA DISTRICT

By

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ABSTRACT

This study examined the implications of dual relationships amongst the counselors and clients at the three selected health centers at Mtendere, Chelstone and Chainama Hospital. The study used qualitative methods of data collection and analysis. The main research used was questionnaire and interview guides Data was collected through questionnaires which were administered to clients and counsellors. Among the major findings of the study with regard to, implications of dual relationship amongst counsellors and clients. Themes found in the data of the present study indicated that Dual relationship amongst clients and counsellors contributed to a low turnout of clients accessing counselling services. Dual relationships lead to lack of protection of the therapeutic relationship. There was loss of confidence in the clients, as this was immoral and clients were insecure in areas which were considered to be ethical in dealing with safety. In fact, most evidence suggested that, in most cases, client's faced higher risk during treatment due to negativity of dual relationship. Professional training also highlighted that boundary crossing was likely to affect client's right and also caused unjust sexual contacts. The study has established that the negative effects of dual relationship have led to compromise in the counselling services. Therefore, the researcher recommends that Government becomes proactive in the counselling services.

DECLARATION

I, Elina Kamanga, declare that the content of this research and findings is my own work and that this work has not been submitted before for any other Masters award at any other institution.

……. ……..

Elina Kamanga DATE

SIGNATURE

DEDICATION

I would like to dedicate my work to my family for the support given to me in the times that I have not been home. Iam particularly grateful to my husband Mr. Siabwengo M. A. My children Lweendo, Bweengo, Dunga, Needy, Emmanuel and my Mother Zelesi.

CERTIFICATE OF APPROVAL

This dissertation by **Elina Kamanga** is approved as a partial fulfillment of the requirements for the award of the Master of Science in Counselling of the University of Zambia in collaboration with the Zimbabwe Open University.

Examiner‘s Signature…… Date……

Examiner‘s Signature…… Date…….

Examiner‘s Signature…… Date……

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DEFINITION OF KEY TERMS

The following terms are defined in the context of this study

Dual relationship: This is when a counsellor has a second, significantly different relationship with his or her client in addition to the traditional client- counsellor one.

Dual relationship: either sexual occur when professionals assume two (or more) roles simultaneously or sequentially with a person seeking professional counselling Corey (2009).

Multiple relationships: Any relationship between the therapist and the client in addition to or separate from the therapeutic relationship.

Boundary crossing: In (2004) Knapp and Slattery stated that when a counselor strays from their professional role, a boundary crossing has occurred.

Ethical decision making: an ethical decision is one that endangers trust, and thus indicates responsibility, fairness and caring to an individual

CHAPTER ONE

1.1 INTRODUCTION

1.2 BACKGROUND OF THE STUDY

The study aimed at establishing the implications of dual relationships between counsellor's and clients on their work performance especially, autonomy of a client and confidentiality of administrative issues by the counsellor. The study is important in that, the findings would greatly benefit government, ministry of health planners, decision makers up to the health center levels, families and communities in their efforts to stop intimacy relationships in health centers which disadvantage the clients. The findings informed the stakeholders and the Ministry of Health about rampant dual relationship in health centers and the study also sensitized other stakeholders such as NGOs, families, and communities on how they can solve the problem of dual relationships.

The study added a new knowledge to the existing one. This new knowledge acted as a stimulant for other upcoming scholars to make further investigations on the same subject. Finally, the findings enabled policy makers, administrators of our laws and those that implement the laws to seriously adopt and adapt visionary dimensions that were recommended for the betterment of our clients in various health centers in Lusaka district.

Multiple or dual relationship was a frequently encountered dilemma in counselling and Psychotherapy. Historically, dual relationship, or even multiple relationships are considered to have a negative connotation, and are often associated with client exploitation and sexual transgressions (Cottone, 2005; Gross, 2005).The profession has been besieged with clear messages about the immorality and negativity of dual relationship between counsellor and client boundary crossings, to the extent that the values and moral foundation of the counselling discipline was seriously challenged both by clients and consumers. No time in the history of counselling profession has the ethics of professional conduct being questioned or confronted with a wide range of contemporary ethical problems like it is today in our society.

Unfortunately there was no widely agreed definition of intimacy (Register and Henley, 1992). The term dual means any relationships beyond the strictly professional, are generally considered inappropriate in the counseling professions. (Cottone, 2005; Moleski & Kiselica, (2005Other

authors approached the definition of intimacy from a perspective which emphasis's the self. An intimate relationship was one which either party silences, sacrifices, or betrays the self and each party expressed strength and vulnerability, weakness and competence in a balanced way. (Lerner. 1990).

Multiple/dual relationships in psychotherapy referred to any association outside the standard client-therapist relationship. It was reportedly one of the most common ethical dilemmas encountered by psychotherapists and other mental health professionals (Colnerud, 1997; Pope &Vetta, 1992; Slack &Wassenaar, 1999). Ebert (2002) examined the history of dual relationship prohibitions.

The APA's (1953). Ethical Standards of Psychologists made no specific reference to dual relationships except for prohibiting against the misuse of the relationship for profit, power, prestige, or personal, or person gratification. The term "dual relationships" first appeared in the APA's (1958).) Ethical Standards of Psychologists, which prohibited psychologists from entering into a clinical relationship with members of their own clinical relationship with members of their own family, friends, associates, students, and others whose welfare might be jeopardized by such a relationship. Later in the APA's 1977 and in 1981 ethical standards and principles (APA, 1977, 1981), "dual 1981), dual relationships with clients that might impair professional judgment or increase the risk of exploitation were prohibited. "Dual relationships in these codes of ethics encompassed clinical relationships with employees, supervisees, friends, or, relatives.

The British Psychological Society's (2000) Code of Conduct, ethical principles & guidelines defined dual relationships as those relationships in which individuals engage in a personal loving or sexual relationship with someone to whom they also had professional responsibilities". (Since the publication of the APA's (1977).) Ethical Standards of Psychologists, sexual relationships between therapist and client were explicitly declared as unethical.

The APA's (2002) Code of Conduct reiterated that sexual intimacies with current clients, relatives and significant relatives and significant others of current clients, and former clients were considered "exploitative. Therapists who engaged in such relationships (APA, 2002) "had responsibility " to demonstrate that there was no exploitation based on a number of factors, including duration and intensity of therapy , circumstances of termination , client's mental status, and likelihood of adverse impact on the client . The ACA continued to use dual relationships in its 1995 Code of Ethics and Standards of Practice, while the APA adopts "multiple relationships" in its Code of Conduct since 1992.

Counsellor-client dual relationship has been a major subject of concern in counselling practice in recent time and other mental health professionals have grown increasing concerned about counsellor-client dual relationship in clinical practice. Including the boundary crossing and boundary violation. The most concern was that, the issue has developed in the context of professionalization to say the least. Whenever a professional counsellor or client initiates a relationship other than the one preconditioned by the therapy they entered the domain of dual relationships (Gross, 2005, Moleski&Kiselica, 2005).

According to Corey (2009), the issue of dual relationships, involving clients and counsellors has been widely addressed by the various professional ethical guidelines. Corey continued to say that, except for sexual intimacy with a client, there was not much consensus in the professional world of counselling practitioners regarding the appropriate way to deal with dual or multiple relationships. Professional training also highlighted that boundary crossing was likely to affect client's right and also caused unjust sexual contacts (Corey, 2009).

This position also received plaudit from large number of researchers who have made massive contributions in the area of study particularly as regard to boundary crossing and dual relationship between counsellor's and clients (Corey, 2009). Many people used the terms dual and multiple relationships interchangeably. The term dual means any relationships beyond the strictly professional, were generally considered inappropriate in the counselling professions. (Cottone, 2005; Moleski &Kiselica, (2005).

Factors that conditioned counsellors to have dual relationship with clients according to (Derlega and Margulis, 1983), was the amount of self- disclosure, a number of studies have shown that one person strategically releasing more personal information could lead to the other person responding with equally increased levels of intimate response (Duck, 1988, p57).

The amount of self – disclosure must not be too much; the client counselor relationship was a highly specialized relationship quiet unlike most relationship between two people.

Assuming the counselor used Roger's core conditions (Roger's, 1957), at least as a foundation, the counselor were present which invited intimacy. The three core conditions of empathy, unconditional positive regard and congruence assisted the client in feeling valued and listened to non- judgmentally. Thus, the counselor provided the unconditional support that was seen as one aspect of a dual relationship (Monsour, 1992).

The client counselor relationship was frequently governed by explicit boundaries which had a powerful effect on the degree of dual relationship. For instance, the provision of confidentiality helped the client self –disclose easily. Confidentiality provided an atmosphere of trust, which had been described by (Monsour, 1992) as another aspect of dual relationship. Roger's argued that the client often comes to a counselor because of an in-congruence between the clients' self- image and their ideal self (Roger's, 1957).

The counselor facilitated the client to resolve this in-congruence by either changing the self-image or ideal self or both. The result was that the client came to know themselves better. That helped to fulfill a necessary precondition for intimacy that were proposed by some writers (Lerner, 1989).

Amodeo and Wentworth, (1986). As a client counselor relationship developed, the client learned more about themselves and this lead to a more intimate relationship with the counselor. The client counselor relationship could be perceived relationship only in one direction, namely from the point of view of the client. Clients expected their problems and themselves to be the cornerstone of the discussion and as they feel safe, they revealed more of their inner selves. It might be expected that a counsellor cannot help but disclose (Strong and Clairborn, 1982, p173) in (Egan, 1986).

1.3 THEORETICAL FRAMEWORK

In this research, the Researcher used the Grounded theory of renowned sociologists Strauss and Glaser (1967).The researcher used this theory because the research was based on investigations of social processes. The Researcher applied the theory based in her study titled "IMPLICAATIONS OF DUAL RELATIOSHIP BETWEEN A COUNSELLOR AND CLIENT"

The Grounded theory was further supported by Strauss and Corbin (1968), p.158) who referred to this approach as "a general methodology for developing theory that is grounded in data systematically gathered and analyzed". This theory did influence the study in that, the use of questionnaires and interview guides sort to strongly get into the insights of the participants so as to tap get their authentic views on their involvement in the dual relationship.

Further, this Grounded theory was supported by the researchers' objectives which sort to establish, factors that lead to dual relationship, effects of the dual relationship between the counsellor and client and finally, the motives counsellors have about dual relationships. Through the researchers questionnaires and interviews, the participants brought out their inner most feelings and opinions which did influence the study as it was interactive in nature. The Researcher's findings on bad counsellingpracticesledtoinstabilityinmoral,physical, social,political,cultural,emotional,economic and mental faculties.

Therefore, the Researchers findings are a general statistical inference on the Zambian population as regards to counseling practice and services.

1.4 **STATEMENT OF THE PROBLEM**

Zambia has been associated with counselling challenges from independence to present, and many of these shortfalls in counselling has exposed the clients to a greater risk, hence promoting unethical counselling sessions between the counsellors and the clients of a bigger family in Zambia. A review of relevant literature showed that there were no studies that had been done so far on the implications of dual relationships between a counsellor and a client in health centers.

The studies that had been done in these health centers focused on dual relationships that existed between a counsellor and a client. Since the commencement of counselling in the health centers in the mid 1980's, the numbers of clients seeking counselling have more than doubled. However, the implications of dual relationship between a counsellor and a client have not been studied. There have been a lot of different opinions expressed by counsellors and clients over the implications of dual relationships. Some counselors have indicated that work would be affected as the counsellor would be required to protect both the client and the other relationship. Others have said that dual relationship would cause clients to shun the health centers. Some clients said they would develop fear and fail to open up. In view of this problem of dual relationship, the researcher decided to carry out the study which aimed at establishing the implications of dual relationship amongst counselor's and clients.

1.5 PURPOSE OF THE STUDY

This study sought to establish the factors that lead to dual relationships and its implications between a counsellor and a client in three selected health centers namely Mtendere, Chelstone and Chainama Hospital. The research was important because despite other researchers and various professional ethical guidelines who conducted the same research on the same problem, the implications of dual relationship amongst counselor's and clients, supervisees and supervisor's there was little or no change in behavior of counselor's and clients.

1.6 MAIN OBJECTIVE

To establish the implications of dual relationships amongst counsellor's and their clients in three selected health centers.

1.7 STUDY OBJECTIVES

1. To identify factors that cause counsellor's to have dual relationship with their clients.

2. To establish the effects of dual relationship between the counsellor and the client

3. To establish the motives that counsellor's have about dual relationships

1.8 RESEARCH QUESTIONS

1. What contribute to having dual relationship between a counsellor and a client?
2. How does the conduct of dual relationship between a counsellor and a client affect the counseling relationship?
3. What motivates dual relationship between a counsellor and a client?

1.9 DELIMITATION OF THE STUDY

The study site was Lusaka district in Lusaka province of Zambia. Lusaka is Zambia‘s capital city and is currently the most populated district in Zambia. It is located in typical urban environments where the cost of living is high and there is easy access to entertainment facilities. Robson (2002) observed that the principle of selection in purposive sampling is the researcher‘s judgment and the sample selected enables the researcher to satisfy the specific needs in a research project. This site was selected because this was the suitable site where access of information would be easily obtained from both the counsellors and clients because of their availability. The study site was selected because of the limitations imposed by the onset of the Covid-19 by the Government of the Republic of Zambia which had limitations on movements and restrictions on the number of contacts. In addition, counsellors were suitably selected for this study because, they were trained and thus had vast experience having worked in these health centers for a long time. The clients also had their own experiences as to what happens in counseling health centers.

1.10 SIGNIFICANCE OF THE STUDY

This study was important in that, its findings would greatly benefit the public, Government, clients and the Hospital authorities to help in the mitigating of the implications of dual relationship between a counsellor and a client in selected health centers in Lusaka district.

The study would help the Ministry of health and the community to take an evaluation of how the counsellors would carry out their duties when attending to clients who in turn resulted in improving the counselling services. The study would also help the Ministry of Health to take a positive stance

in improving the counselling services offered to clients and to help the government to understand the factors that caused clients and counsellors to engage themselves in dual relationships.

1.11 LIMITATIONS OF THE STUDY

Although the study was very important, it was confined to three selected health centers in Lusaka Urban District. The ideal population for the study could have been the inclusion of the health centers from Lusaka rural. Unfortunately due to financial constraints the study was only confined to three selected health centers in Lusaka Urban District.

CHAPTER TWO

LITERATURE REVIEW

2.1 RESEARCH ON DUAL RELATIONSHIPS

The term dual means any relationships beyond the strictly professional, were generally considered inappropriate in the counselling professions. (Cottone, 2005; Moleski & Kiselica, (2005). Counsellor-client dual relationship has been a major subject of concern in counselling practice in recent time and other mental health professionals have grown increasing concerned about counsellor-client dual relationship in clinical practice including the boundary crossing and boundary violation.

Dual Relationships and sexual intimacies often involved sexual intimacies between the therapists and the client. For example, Ebert (2002) noted that dual relationships referred to circumstances in which there are noted multiple relationships between the therapist and the client, such as when the therapist is sexually involved with a client.

To support this position, the Committee on Ethics of the American Psychological Association in their report suggested that around 40 to50% of the complaints received during the period of 1990 to 1992 were on intimacy relationship. Though no dual role relationship, other than a sexual one, would be considered unethical, (Haas &Malouf, 1989) several models have been proposed to support the notion that counselors should avoid dual role relationships.

Haas and Malouf (1989) have proposed three reasons why dual relationships should be generally avoided. First dual relationships may exploit a client because a clear power differential exists between the counselor and the client, the client can rarely determine when the counselor is acting as a counselor and when the counselor is acting in some other role. For example, clients felt intimidated into providing information that they do not want to provide if their counselor was also their teacher or supervisor

2.2 WHY EXISTING MODELS AND THEORIES WERE RARELY APPLIED IN PRACTICE

These were explained by a general lack of training in the area of dual relationships (Halverson & Brownlee, 2010; Helbok et al., 2006). Responsibilities, for this were in part due to the urban focus of current therapist training (Helbok et al., 2006; Schank &Skovholt, 1997). Thus, most therapists were forced to resort to intuition and experience rather than evidence based practice guidelines to address this issue (Halverson & Brownlee, 2010). Most of these intuitive techniques seemed to be based on assessing two crucial states the level of intimacy and or quality of the relationship and the type and severity of the client's problem (Halverson & Brownlee, 2010; Schank &Skovholt, 1997).

When already engaged in dual relationship, many therapists would readily agree to see clients with clear-cut and less severe symptoms while being more cautious when it came to grave personality disorders (Schank &Skovholt, 1997).This was based on a belief that clients with severe personality or delusional disorders were less able or inclined to respect boundaries set by the therapist. In the matter of intimacy the position was less clear. Some therapists felt that strong and multiple ties to a client were highly beneficial (Halverson & Brownlee, 2010). Meanwhile, others saw the need to reduce dual relationships to a minimum (Schank &Skovholt, 1997). Both positions had value since what matters was how in control and comfortable the involved parties felt.

As long as a client's autonomy was not endangered, a therapist would likely to feel able to maintain objectivity, and comply with set boundaries (Halverson & Brownlee, 2010; Kitchener, 1988). In any case, there appears to be consensus among therapists on the need to properly address the implications of dual relationships early on (Brownlee, 1996; Gross, 2005b).

In addition to constant documentation and assessment of non-professional relationships outside of a therapy setting (Gross, 2005b; Schank &Skovholt, 1997). In fact, most evidence suggested that, in most cases, client's faced higher risk during treatment due to negativity of intimacy relationship. Professional training also highlighted that boundary crossing was likely to affect clients 'rights and also causes unjust sexual contacts. Though this is reported as immoral and often linked to abuse and harm, its continuous existence in clinical practice remained an issue of concern till date.

Similarly, health professional associations obligated their members to respect and uphold ethical standards and codes of conduct that guides, regulates and protect clients from experiencing bad practices.

As we all know, psychology profession strive to promote the emotional well-being and social welfare of others. However, events in recent time continued to point toward its utmost scrutiny Clinical psychologist faced daily challenges by handling the issue of dual relationships and boundary crossing without compromising their professional conduct and practice. In facts, earlier research, particularly in the 80s and 90s demonstrated how hypothetical orientation, community size, psychoanalyst sexual characteristics, client sexual category, occupation, and other issues impact psychology profession, particularly on the issue of nature and suitability of borderline crossings in clinical practice. Besides, the period between the 1980s and 1990s also witnessed practical outburst of healthy argument and considerable works on dual relationships, bartering, companionable touch, out of office consultation and other nonsexual boundary matters to mention a few in clinical practices.

Also, thought-provoking and considerable literature on intimacy relationship in clinical psychology observed a constructive and undesirable aspect of boundaries and boundary crossings. This was the article published by American Psychologist in 1992 requested for drastic changes in the ethics code of the profession. The publication further showed lack of clarity and awareness on when and how counselor should engage with clients.

Also, Sonne (1994) reported that, of all the problems facing APA members, the issue of dual relationship was the most common reason for their membership termination. Unfortunately, as a result of the ambiguity attracted, the concept continued to face serious litigation and disciplinary cases, such as ethics committee hearings, and complaints to professional boards of licensure. Research saw boundary crossings as a well-fashioned treatment strategy that increased the therapeutic success (Lazarus and Zur, 2002). For instance, the recent APA Code of Ethics of (2002) offered a new insight into the issue of boundary crossing by stating that, “Psychologists ordinarily refrained from bartering”, that was in the 1992 code, and incorporate a new sentence, “Multiple relationships that would not rationally be expected to cause impairment, risk exploitation or harm were not unethical” (APA, 2002), to the multiple relationships. In addition, the dual relationship

also focused on role theory. Any dual relationship represented a scenario where a professional assumes “two roles simultaneously or sequentially with a person seeking help” (Pearson & Piazza, 1997).

2.3 FACTORS THAT CONTRIBUTED TO HAVING DUAL RELATIONSHIP BETWEEN A COUNSELLOR AND A CLIENT.

According to (Derlega and Margulis, 1983) self-disclosure is the amount of self- disclosure, a number of studies have shown that one person strategically releasing more personal information can lead to the other person responding with equally increased levels of intimate response (Duck, 1988, p57). The amount of self–disclosure must not be too much.

The client-counselor relationship is a highly specialised relationship quiet unlike most relationship between two people. Assuming the counselor uses Roger’s core conditions (Roger’s, 1957), at least as a foundation, the counsellor would exhibit a presence which invites intimacy. The three core conditions of counselling according to Roger’s are empathy, unconditional positive regard and congruence assist the client in feeling valued and listened to non- judgmentally. Thus, the counsellor was providing the unconditional support that was seen as one aspect of a dual relationship (Mansour, 1992).

The client counsellor relationship was frequently governed by explicit boundaries which had a powerful effect on the degree of dual relationship. For instance, the provision of confidentiality helped the client self –disclose easily. Confidentiality helped to provide an atmosphere of trust, which has been described (Monsour, 1992) as another aspect of dual relationship. Roger’s argued that the client often comes to a counsellor because of an in-congruence between the clients’ self-image and their ideal self (Roger’s, 1957). The counsellor can facilitate the client to resolve this in-congruence by either changing the self-image or ideal self or both. The result was that the client came to know themselves better. This helped to fulfill a necessary precondition for intimacy that was proposed by some writers (Lerner, 1989) (Amodeo and Wentworth, 1986).

As a client-counsellor relationship develops, the client learned more about themselves and this lead to a more intimate relationship with the counsellor. The client - counsellor relationship could be perceived as dual relationship only in one direction, namely from the point of view of the client.

Clients expected their problems and themselves to be the cornerstone of the discussion and as they felt safe, they revealed more of their inner selves. It is expected that counsellor would not help but disclose (Strong and Clairborn, 1982, p173) in (Egan, 1986).

The other cause of dual relationships among counsellor's and clients was the inherent power differential in the therapeutic relationship that counsellor 'succeed to take advantage of clients vulnerability and exploit clients for their personal gain. Some clients from disenfranchised backgrounds heightened vulnerability to therapist exploitation due to increased power differentials between a counsellor and client, respectively this revolve more around the abuse of power and conflicts of interest (Koocher &Keith-Spiegel, 2008). Koocher, & Keith-Spiegel, (2008). Clients were vulnerable to those with evaluative authority and thus felt coerced into pursuing a dual relationship.

When counsellors fail to maintain their clear boundaries when interacting with their clients and deviation from these boundaries presented a potential threat to the therapeutic process, Register and Henley (1992). Register and Henley (1992). Carried a small phenomenological study of people's experiences of intimacy. On –verbal communication was seen as an important theme. The presence of individuals or entities of two of the experiences of non-sexual intimacy were with entities other than people were seen as necessary. Time was a theme which raised question as to whether intimacy was a state which was entered for only for a period or whether it was a trait (Acitelli and Duck.1987).Transformation represented the movement from one state to a different richer state and this theme was seen by some subjects as the aspect that gave dual relationship a powerful tool.

On a daily basis, mental health professionals and their clients interacted in various therapy settings. Within this close context, interactions were based on a therapeutic alliance with the purpose of helping clients with their difficulties. Establishing this primary relationship was an important central feature for the majority of therapeutic approaches and thus desirable. Nevertheless, different forms of relating might co-emerge over the course of treatment, or shortly after termination. For example, what if both client and therapist share a church, meet regularly at the grocery store, or have a mutual friend? These non-primary relationships certainly posed several ethical concerns and challenges for every-day practice. In psychotherapy, dual relationship

occurred when a counsellor has a second, significantly different relationship with his or her client in addition to the traditional client- counsellor one. This was a professional relationship, such as playing the part of both counselor and client or, it may be of a non-professional nature, as in the case of a therapist who were also a friend or intimate partner of the person seeking therapy. (Lerner.1990).

Due to the complications that rose in sexual and nonsexual situations, the existence of an intimacy relationship presented ethical considerations and potentially, legal issues. However, a dual relationship was not necessarily unethical, it paved the way for a strengthened relationship bond or a beneficial exchange of goods and services. The distinguishing factor between ethical and unethical relationships was the establishment of mutual trust and whether it was honoured or misused. As a therapist, it was difficult to avoid some amount of dual role involvement in the lives of colleagues and loved ones. When your profession was built around helping people sort through their issues, many who were already close to you would seek out your insight and advice naturally.

Other definitions involved less obvious relationships that were embedded within a therapist's different professional roles. For example, at any point time a therapist was a helper, a note-taker who kept track of sessions, and a source of information for health care systems (Cottone, 2005; Moleski Kiselica, 2005). This second type of complex relationship has its own pitfalls, especially in times of managed care and lawsuits (Gross, 2000. Cottone, 2005).The general approach towards dual relationships, as reflected by the ethical codes and standards of mental health professionals' associations, has been one of minimization (Brownlee, 1996; Cottone, 2005; Gross, 2005a; Stockman, 1990). However, there are several sets of circumstances that made it nearly impossible to completely bypass dual relationships. In small and rural communities this was a particular issue since social overlap was difficult to avoid. In rural settings, a mental health professional, while being part of the local community, was most likely to be the only available option for treatment (Stockman, 1990).

Other situations that generated dual relationships were those of matched minorities. For example, deaf clients would have substantially reduced options of finding a therapist able to provide sessions in sign language. At the same time, the chances that such a therapist would be part of a deaf community were high even in major urban environments. The same conditions applied to various ethnic, linguistic, and other minorities. For example, a client from a specific ethnic or cultural background (e.g., Hmong, an Asian ethnic group that migrated to the US in large numbers after the Vietnam War) might be more comfortable seeking help from someone of their own ethnic or cultural group. For example, a client could find it easier to relate to a professional counsellor who has the same cultural background and speaks their native language. However, ethnic and cultural diversity among mental health professionals was limited (Bui & Takeuchi, 1992).

As mentioned previously, many (mental) health associations address dual relationships in their ethic codes or guidelines, which were readily available through their websites (American Psychological Association, 2010; British Psychological Society, 2009; Canadian Psychological Association, 2000). This was likely due to the fact that about half of the complaints and lawsuits filed against therapists address some of the concerns related to dual relationships (Gross, 2005a).

2.4 HOW DOES THE CONDUCT OF DUAL RELATIONSHIP BETWEEN A COUNSELLOR AND A CLIENT AFFECT THE COUNSELING RELATIONSHIP?

The main concern was that intimacy relationships caused harm to a client (Cottone, 2005; Moleski & Kiselica, 2005). This concern seemed to be legitimate given the high percentage of complaints related to this matter. There were two main ways in which engaging in dual relationships could harm a client. Firstly, it caused loss of professionalism by a therapist who was a counsellor that resulted in poor judgment and decision making Brownlee, (1996).

The Secondly, harm was usually connected to some kind of exploitation of the client, be this an undue exertion of power, or even sexual transgression (Gross 2005b; Kitchener 1988). The latter was clearly addressed and forbidden in the ethical codes of mental health associations (Cottone, 2005; Gross 2005b; Syme, 2006), as well as by law.

Engaging in any kind of sexual behavior, from verbal and physical insinuations to actual sexual relations, was considered unethical with current clients and highly problematic with former clients

(Moleski&Kiselica, 2005). While it would be easy and unambiguous to place a general ban on all intimacy relationships (Kagle & Giebelhausen, 1994), in practice this would neither be practical, nor desirable (Brownlee, 1996; Stockman, 1990). Even in big urban environments, counsellors and clients could potentially meet in a non-therapeutic setting by accident (Gross, 2005). The common practice of private and word-of-mouth referral also resulted in having to deal with two clients that were good friends, a situation that constituted a type of intimacy relationship (Gross, 2005b). Being referred to a specific counsellor by a close friend could, in turn, help establish trust and a working alliance.

In fact, when they were appropriately monitored, intimacy relationship could not only have therapeutic value (Gross, 2005b), but avoiding them altogether could actually have detrimental effects on a client (Moleski&Kiselica, 2005; Stockman, 1990). Specifically, refusing to go to a personal event or avoiding all contact with clients outside of therapy resulted in a breach of trust and disrupt the treatment, thus causing harm to clients (Stockman, 1990).

For example, a client may justifiably feel that therapy has had an immense impact on their private life and subsequently invited their therapist counsellor to attend their wedding. If the counsellor did not attend the wedding, this caused the client to think that the therapist's counselor's interest in their life were disingenuous, potentially creating a setback to the therapeutic relationship. Consequently, managing the potential blurriness of intimacy relationships should be a primary focus for mental health professionals.

The blurring of clear therapist/client roles could lead to anything from mild discomfort to high distress in a client (Gross, 2005b), and should thus always be addressed and clarified in therapy. This would appear a more tenable approach than an indiscriminate ban on all kinds of intimacy relationships. However, there is a clear need to resolve the ambiguities in ethical codes and t determine ways in which to deal with intimacy relationships when they seem unavoidable (Brownlee, 1996; Kitchener 1988).

Some of the ethical principles arising on the counsellor's side of an intimacy relationship are those of justice (e.g., do they attend every client's private events, or just some?), confidentiality (e.g., do they greet clients in the grocery store and risk the client's exposure?), and autonomy (e.g., should

a client's wish for an out-of-therapy interaction be granted?). In any case, a therapist has the responsibility to make an informed decision and to balance these types of concerns with those of potential harm to ensure a client's overall progress.

While some of the above examples of dual relationships may occur in any urban setting, small and rural communities often generate many complex relationships. It is more common than not to occupy several roles at the same time (Brownlee, 1996). A hypothetical but realistic example is that of a local mental health professional, who as a parent may be part of a small community's health board while at the same time be treating a counsellor of that health center, who is, or may become their child's homeroom counsellor.

Research offers compelling evidence that rural practice is qualitatively different from urban practice when it comes to the ethics of intimacy relationships (Helbok, Marinelli, & Walls, 2006). Stockman (1990) argued that by isolating themselves from the local community mental health professionals counsellors would likely dissuade people seeking help. Therefore, therapists need strategies to effectively address and evaluate how their multiple relationships with clients may affect treatment. Kitchener (1988) proposed a threefold model that focused on role expectations and the conflicts that may occur first, the level of potential harm could mainly be determined by the grade of incompatibility of the expectations that both the therapist and client have towards the different roles they hold.

Consequently, the more expectations diverge, the more the dual relationship would lead to harm (Kitchener, 1988). One of the roles occupied by a therapist is that of a 'friendly listener'. If the therapist did not comply with such expectations, relational discord would be more likely to occur. To specify Kitchener's proposition, the more a client sees their therapist as a friend, the more detrimental it is likely to be when their therapist dismisses a client's expectations of social affiliation.

In a second step, the issue of plural obligations was addressed. In the example above, the mental health professional is part of the school board and treating a teacher of the same school. Thus, a conflict may occur in which the role obligations of those positions may collide. For example, the question of whether the counsellor is able to counsel in spite of obvious personal struggle could

place the therapist in a compromising position regarding confidentiality. Moreover, if this situation also involved a possibility of the counsellor being suspended from work, the therapist would need to balance their client's needs with those of the health center and their own child's health. More specifically, having a job could be an essential component of the client's self-esteem and losing their job, even if temporarily, it could be detrimental. Conversely, the counsellor may not be emotionally stable and reliable enough to be trusted with handling of clients. A scenario such as this highlights the complexity of dual relationships and can place a therapist in a very complicated position.

The third risk-factor included in the model was that of a power imbalance which may arise within dual intimacy relationship. According to Kitchener (1988), whenever the power balance is disturbed by shifting focus toward the therapist, the risk of exploitation is substantially increased. Having to fulfill several roles at the same time, the danger of incompatibility becomes heightened in the face of uneven power distribution (Kitchener, 1988). Thus, it would be ill-advised for a therapist to treat their own housekeeper since the power hierarchy of their relationship could have an impact on developing a therapeutic one.

Following Kitchener's model, it is mandatory to prioritize the needs of the client over those of the therapist at all times. To act in accordance with this principle may be difficult, particularly when the therapist's needs or goals overlap with parts of the larger community as in the school related example above.

However, it is important to emphasize that this guideline can be used to asses both the negative and positive potential of dual relationships. When any of the three domains are out of balance or conflicted, an intimacy relationship bears a higher potential of having a negative impact. Conversely, when the domains are balanced and healthy, it becomes increasingly likely that this particular dual relationship may be an asset to a client's treatment.

While this kind of theoretical model seems relevant to rural practice, it does not seem to be widely applied. Indeed, the most important concern pointed out by most therapists in a survey conducted by Helbok et al. (2006), was to openly address possible issues related to dual relationships.

The issue of dual relationships involving clients and counselors has been widely addressed by the various professional ethical guidelines. The Code of Ethics for the American Counseling Association has touched on this, urging professional to avoid such relationship due to their potential to be harmful to the client and the reputation of the counselor. It states that counselors should "avoid exploiting the trust and dependency of clients." It goes on to note that they should "make every effort to avoid relationship with clients that could impair professional judgment to increase the risk of harm to clients. (ACA, 2005)

The American Psychological Association code of ethics while recognizing the inevitable nature of such relationships advises caution and avoidance of instances where clients may be put into the harm way. Scholars are in agreement that some relationships are out rightly unethical and will erode the nature of the relationship the counselor and the client are supposed to have. In some instances, a conflict of interest may arise. Counselors may resolve or result to put their interests first and gain of sexual or financial favours. Such interests may supersede the need to address the client's problems first.

Pope and Vasquez (1998) advanced the idea that the reason why a dual relationship is unethical and can turn out to be harmful to the client is because of the power differences between the two. Caution hence is the prerogative of the counselor who should initiate steps to avoid harming the client. As afore mentioned, dual relationships have inherent disadvantages as they lead to the crossing of boundaries in the relationship. This is among other problems as recognized by Lynn M. Mayer (2005). These are "role confusion and power exploitation.

She goes on to note that "boundaries exist to protect the client from misuse of the social worker and to establish the professional" The erected boundaries hence should not be crossed or violated (2005). A dual relationship between a counselor and a client may end up with a client feeling confused, exploited and betrayed. It would create a scenario where the client loses trust in counselors which is eventually detrimental to his or her well-being. A counselor should avoid circumstances or a relationship that will result to the client losing credibility in him or in the whole profession.

Such a dual relationship may also result to ripple effects with other clients resenting the fact that a particular client seems to be enjoying a special relationship with the counselor, a relationship that is not replicated to the other clients. One recognized greatest taboo by counselors that stems from dual relationships is sexual relations with a client. This is recognized by the majority of scholars as the core reason why professionals are advised against dual relationships. Where it is important to note that not all dual relationships eventually lead to sex, it is unfathomable that anyone can deny that this is the initial stage.

Secondly, dual relationships may affect the therapist's ability to make appropriate clinical decisions. For example, if the counselor is also a friend of the client, the counselor's ability to confront the client can be damaged either because objectivity has been lessened by the friendship or because of the counselor's own very natural need to be liked by his or her friends. One helpful aspect of Stadler's position is that she goes beyond merely relying on the American Psychological Association (1981) and American Association for Counseling and Development (1988) ethical guidelines as her basis for avoiding dual relationships. She also relies on three basic ethical principles to support her case that dual relationships should be avoided. These principles are autonomy, beneficence, and justice. Stadler claims that client’s autonomy can be compromised by involvement in dual relationships with counselors.

Stadler emphasizes the point that under ideal circumstances, a client has more autonomy in a counseling relationship unencumbered by dual roles. The principle of beneficence involves promoting good and preventing evil or harm. Stadler particularly stresses the potential for harm to the client, to others close to the situation for example, friends of the client or colleagues of the counselor, and to the profession of counseling if dual relationships go unchecked.

The principle of justice is the final ethical principle discussed by Stadler as it relates to dual relationships. Other clients who are aware that dual relationships exist between certain clients and counsellors may feel resentful that they have not also been singled out for special attention from the counsellors. This is an example of a perception of a lack of fairness or justice by these other clients. It should be noted, though, that a perceived lack of justice by clients, though unfortunate, does not necessarily violate the principle of justice. Stadler's contribution to the literature is clear.

Another theoretician in the field of ethics in counseling psychology is Karen Strohm Kitchener. Her ideas are useful because she addresses the question, "What is the line between those dual relationships that are clearly unethical and those that are acceptable when they are handled with caution?" (Kitchener, 1988, p. 218). She relies on role theory. A basic tenet of role theory is that social roles have attached to them certain expectations. Tension occurs when an individual occupies two or more social roles that conflict. Despite Kitchener's laudable attempt to help the counselor make distinctions between those dual relationships that have a high potential for harm and those that do not, she does not provide practical criteria for determining compatibility of role expectations, degree of power differential and amount of conflict of interest. For example, for the counselor who is attempting to determine the potential danger of counseling a close friend of a current client, how does the counselor determine the amount of conflict of interest? Though Kitchener's model helps to provide a theoretical framework for discussing the potential harm of different dual relationships, the counselor still has the decidedly difficult and ambiguous task of determining how incompatible the expectations of his or her roles are, how much power differential exists, and how much conflict of interest exists. In a very thorough discussion of dual relationships, Keith-Spiegel and Koocher (1985) elaborate on several specific types of dual relationships and their potential dangers. These researchers state that "it is probably impossible to create clear guidelines for psychologists with regard to dual-role relationships not involving sexual intimacy, since each situation presents unique features that must be considered".

A significant hurdle in setting these guidelines is the extreme difficulty in developing operational definitions of different dual relationships. For example, engaging in a professional counseling relationship with a friend is considered a dual relationship. How does one define the word "friend"? What distinguishes an acquaintance from a friend? These and many other possible examples highlight the difficulty in providing specific ethical guidelines to govern dual relationships in counseling.

2.5 WHAT MOTIVATES DUAL RELATIONSHIP BETWEEN A COUNSELLOR AND A CLIENT?

According to Lynn M. Mayer (2005) dual relationships arose when a social worker relates to clients in more than one relationship, whether professional, social, or business a counselor. This is where a counselor and his or her client develop more than one relationship in addition to the professional one; this other relationship is mostly concurrent to the professional one. Counselors, like the rest of the people in the society, are flexible and shifting in their social boundaries and their relationships with their clients. This flexibility creates a scenario where they are likely to be in constant collision with their clients, creating the possibility of a dual relationship. Such relationship might develop through socialization at a personal level with the client, accepting gifts or entering into a business association with the client.

The issue of dual relationships involving clients and counselors has been widely addressed by the various professional ethical guidelines. The Code of Ethics for the American Counseling Association has touched on this, urging professional to avoid such relationship due to their potential to be harmful to the client and the reputation of the counselor. It states that counselors should "avoid exploiting the trust and dependency of clients." It goes on to note that they should "make every effort to avoid relationship with clients that could impair professional judgment to increase the risk of harm to clients" (ACA, 2005).

The extent of the boundary that should exist between a client and a counselor has been the focus of a raging debate for years. Personal and professional attachment of counselors and clients usually arises. It is not always though that such relation is unethical, in some cases, as recognized by the various scholars, they are unavoidable. A counselor and a client maybe attending the same book club or the same worship place. In such a case, a close relationship at a personal level becomes unavoidable and in fact many come out as constructive. What is important is that a line be drawn between the therapist and the client.

Dual relationships maybe categorized into five categories according to Reamer (2001). The intimacy category referred to a relationship between the client and the therapist that spills over to sexual activities. Another category resulted to emotional attachment where the client became

emotionally dependent on the counselor. This mostly according to Reamer occurred in new divorcees or those that have had recently been separated. The third category would be when the counselor gets used to receiving gifts and favors from the client, a relationship that resulted into personal benefits. The fourth category according to Reamer depended on the nature and personality of the counselor. A counselor's commitment and love for his work resulted to altruism where his or her instinct pushed him to become too committed to the well-being of the client. The fifth category that Reamer recognized as inevitable was where the counselor discovers later that he or she has a special relationship with the client. For example, the counselor discovered that the client was a son of a close old friend. This created a strong personal attachment that was unavoidable.

This mostly happened in close knit communities especially in the rural areas. With such broadened categories, it made dual relationships difficult to pinpoint as well as avoided, this however does not mean that they were ethically acceptable. It was natural for two human beings to exude a sort of a bond between them, whether such an attachment was based on love, need or convenience. Dual relationships were sometimes as a result of such a bond. The attachment theory was used to explain this sort of a bond between two human beings.

According to Lynne Gabriel (2005), the "attachment theory acknowledges the significance of intimacy, loss and separation issues in human relationships-relational experience that might be encountered within the context of dual relationship." An analysis of dual relationships in counseling revealed that it would be inappropriate to regard all dual relationships as inappropriate. This inappropriateness depended on the context or on the individuals involved. The various counselors and counselors associations recognized the dilemma that arises where dual relationships arise.

2.6 SUMMARY OF LITERATURER REVIEW

In summary, despite reviewed literature from other researchers it is evident that dual relationships and its implications still exist in the health centers between counsellors and clients which raises a lot of concerns and more research still needs to be do

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter discusses and describes the methods used in collecting data and how the data were analyzed, target population, sample size, sampling procedure, research instruments, data collection procedures and data analysis.

3.2 RESEARCH DESIGN

The methodology or procedure used qualitative enquiry using a combination of tools for information collection and analysis so that the uptake of the services is clear for realistic recommendations which can contribute to improved compliance.

The researcher used qualitative descriptive study design; the researcher used descriptive research because it gains insight into situations, from the community or person. This design was chosen because it was the ideal design in qualitative research method; respondents were able to give out their own opinions freely. Questionnaires and Interview guide were used in order to obtain information from clients and counsellors in the selected health centers of Lusaka District.

3.3 TARGET POPULATION

Omar (2011), argued that population is the totality of any group of units which have one or more characteristics in common that are of interest to the researcher. It involves a larger group of people, institution or thing that has one or more characteristics in common on which a study focuses. It consisted of all cases of individuals or elements that fitted a certain specification. The target population for the study were counselors and clients with emotional problems and the accessible population consisted of counselors registered at the three selected health centers Mtendere, Chelstone and Chainama Hospital. The researcher used this population because counselors were professional and knowledgeable enough to provide relevant information related to clients with emotional problems and clients with problems were the people that experienced the problems

under study. In terms of accessing the participants' clients were accessed as they came for counseling and for the counselors in their offices.

3.4 SAMPLE SIZE:

Mark (2010) asserts that samples for qualitative studies are generally smaller than those used in quantitative studies. Sample sizes in a research should not be too large because it may be difficult for the researcher to extract heavy and rich data. (Marshall, 2011) affirms that an appropriate sample size for a research study is one that adequately answers the research question. It is for this reason that this study used the sample size that encompasses the five female counsellors', five male counsellors', ten female clients, and ten male clients from the three selected health center in Lusaka district namely Mtendere, Chelstone and Chainama Hospital. The sample involved a total of 30 participants distributed as follows; 5 male counselors, five female counselors, 10 male clients and 10 female clients. In addition, the Researcher's selection of the research design namely qualitative, coupled with financial limitations and the onset of the Covid -19, arrived at this manageable number of 30 participants for expediency.

3.5 SAMPLING TECHNIQUE

The purposive sampling technique was used. This was used because the researcher had in mind with the required information from Government in collaboration with Ministry of Health concerning the global Covid -19 guide lines of not being in contact with many clients in view of the pandemic and time of interaction was heavily restricted.

20 clients and 10 counselors participated in the study. The study has been an exploratory health facility and community based qualitative study. This study design was selected because it is suitable for identifying and eliciting in-depth insights into (Mtendere 5 clients and 3 counsellors, Chelstone 6 clients and 3 counselor and Chainama 9 clients and 4 counselors.

3.6 RESEARCH INSTRUMENTS

Two questionnaires were used by the researcher to collect data one for the counsellors and the other one for the clients because it was less costly and required less time (Polit & Beck 2004:350). Data collection was done by the researcher using face-to-face in-depth interviews with eligible research participants using an in-depth interview guide and a key informant interview guide. Key informant interviews were conducted in English while interviews with clients were conducted in English and Nyanja, the local language widely spoken in these areas, detailed handwritten interview notes were taken and written in an interview guide.

3.7 DATA COLLECTION

Polit and Beck (2004:32) define data as "information obtained during the course of an investigation or study". Burns and Grove (2001:43) define data collection as "the precise, systematic gathering of information relevant to specific research objectives or questions". According to Burns and Grove (2001:50), data can be collected in several ways, depending on the study, and utilizing a variety of methods. However, the instrument used must accomplish the researcher's objectives. The researcher spent one month in the field collecting data.

The questionnaires were administered in person by the researcher to the respondents in the study and this was done in order to ensure collection of all questionnaires that were given out and another qualitative instrument that were used to collect data were interview guides.

3.8 DATA ANALYSIS

Boswell and Cannon (2011) suggest that in analyzing of qualitative data, the initial task is to find concepts that help "make sense of what is going on." However, the study used thematic analysis to analyse and categorise the data and major themes were drawn from interviews. Braun and Clarke (2006) affirms that, thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data

Data analysis was done qualitatively .Qualitative data were put into different themes as different groups gave different responses from one another. The themes where entered on excel computer

program in order to come up with tables, which helped to analyse the data from the questionnaires and thereafter were converted into percentages

3.9 ETHICAL ISSUES

Confidentiality means proving the client with safety and privacy. Any limitations on the degree of confidentiality offered are likely to diminish the usefulness of the purpose (ZCC, 1999).Dealing with human beings in research requires that research ethics are adhered to. According to Michelson's (2005) research ethics are important in social sciences. On the basis of Michelson's assertions this study adhered to ethical principles. Since data was collected in Zambia, the researcher is yet to get clearance from the ethics committee from the University of Zambia. However confidentiality was maintained, the data and results were held unavailable to an unauthorized person outside the study. Furthermore, concert was obtained from each of the participants and was treated with respect as participation was voluntary. In upholding the ethics, respondents were also assured that the data was to be solely used for the purpose of the study.

1.10 SUMMARY OF THE CHAPTER

The chapter used qualitative research design in order to obtain specific accurate data.Counsellors who had trained in counselling as well as clients who previously underwent counselling sessions with familiar episodes were involved. The study used the qualitative sample design so as to manage the sample size efficiently and effectively.

The purposive sampling technique was used because of its suitability in identifying and eliciting in depth of the counsellors and clients. Furthermore, the questionnaires used to engage clients in depth were both interpreted in English and Chinyanja Languages. The Data in this study, was analyzed through the use of excel computer programs where tables and graphs were drawn from. Finally, the thematic approach was used to categorise and analyse data were major themes were drawn.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1 INTRODUCTION

This chapter presents and discusses the findings of the study according to the research questions and the major themes. This chapter is aimed at presenting the data as themes become apparent or are revealed to the researcher. The breakdown of data in this study will be aimed at interpreting meanings from the original transcripts. The interpretation will be conveyed through a comprehensive understanding of an analysis of the implications reported by the participants.

Demographic information will be presented first in a tabular format followed by a summary of the emerging themes with a brief discussion. The themes will then be presented in tabular format for clarity and in order to summarize them. Appropriate themes are also discussed in terms of the study research questions namely:

4.2 General Question

Is Dual relationship amongst clients and counsellor's contributing to a low turnout of clients accessing counselling services in health care sectors?

4.3 Research Questions

What contribute to having dual relationship between a counsellor and a client?

How does the conduct of dual relationship between a counsellor and a client affect the counseling relationship?

What motivates dual relationship between a counsellor and a client?

4.4 Demographic Information

Table 1: Questionnaire1

Demographic information of clients participating in the study.

GENDER	NUMBER	AGE	PROFESSIONAL QUALIFICATION	OCCUPATION
MALE	1.	30	University	Employed
	2.	35	University	Self-employed
	3	26	College	Volunteer
	4.	25	Secondary	Employed
	5.	35	University	Self-employed
	6.	29	College	Employed
	7.	35	University	Employed
	8.	35	University	Employed
	9.	25	College	Unemployed
	10.	26	University	Volunteer
FEMALE	1.	35	College	Employed
	2.	30	College	Employed
	3.	35	College	Employed
	4.	35	College	Employed
	5.	35	College	Employed
	6.	30	None	Employed
	7.	32	None	Employed
	8.	35	University	Employed
	9.	25	College	Employed
	10.	25	University	Self-employed

In table 1 above for clients, bears the male age range from 20 to 30, whereas for the female ranges from 20 to 35 with a valid qualification range from being un employed, self-employed, college and university experience in all the two female clients have had no formal education.

Table 2: Questionnaire 2

4.5 Demographic information for the counsellors participating in the study

GENDER	NUMBER	GENDER	AGE	LEVEL OF EDUCATION	OCCUPATION
MALE	1.	M	20	College	Employed
	2.	M	29	Secondary	Employed
	3.	M	35	University	Employed
	4.	M	35	University	Employed
	5.	M	24	College	Employed
FEMALE	1.	F	35	College	Employed
	2.	F	29	university	Employed
	3.	F	25	University	Employed
	4.	F	20	University	Employed
	5.	F	35	University	Employed

In table 2 above for counsellors the age group for female counsellors ranged from 20 to 35,while that of the male was from 20 to 35with a qualification range of college to University status with a balanced gender.

4.6 CHARACTERISTICS OF THE PARTICIPANTS

The interviews were held with respondents from Mtendere, Chelstone and Chainama Hospital in Lusaka Province, Lusaka district in Zambia. The respondents were five female counsellors, five male counsellors, ten female clients, and ten male clients' participants. The counsellors were purposefully selected because they dealt with clients who had emotional problems and they also had detailed information about them and they knew the best way of generating solution through one on one interaction with clients who accessed the health facilities at Mtendere, Chelstone and Chainama Hospital.

The research participants were counsellors and clients who visited the health centers for emotional support. The researcher sampled the following participants 5 female counsellor's, 5 male counsellor's, 10 female clients, and 10 male clients from the three selected health centers in Lusaka district in Lusaka urban namely Mtendere, Chelstone and Chainama Hospital bringing the total number to thirty respondents.

The clients and counsellors were in different levels. The age of the clients was somewhat higher. A preliminary discussion aimed at building rapport with participants, before the interview revealed that, clients with emotional problems experienced a lot of challenges that was because they had found it hard due to lack of protection of the therapeutic relationship amongst clients and counsellor's hence contributing to a low turnout of clients accessing counselling services.

4.7 RESPONSES FOR CLIENTS QUESTIONNAIRES

Questionnaire 3: Clients were asked to give factors that lead to dual relationship with their

Counsellors

The responses leading to dual relationship were shown in Table (3) below:

Table (3) client's factors leading to the development of a dual relationship.

Table 3: Factors for Developing Dual Relationship

S/N	Reasons	Frequency	Percentage
1	Enticing language usage by a Counsellor	3	15
2	Vulnerability (Poor economic status of clients)	11	55
3	Unethical Conduct of a counselor.	6	30
	Totals	**20**	**100**

Table 3 above does indicate that 11 (55%) vulnerability of clients does lead to relationship with the counsellor, whereas 6 (30%) is because of unethical conduct of a counsellor and 3 (15%) is through the use of enticing language by a counsellor

Questionnaire 4 responses leading to dual relationship in this regard were as indicated in the table below

Table.4

S/N	**Reasons**	**Frequency**	**Percentage**
1	Lack of financial instability of a client	4	20
2	Un professional conduct of a counsellor	**14**	**70**
3	Financial status of a counsellor	**2**	**10**
	Totals	**20**	**100**

Fig.4 Responses leading to dual relationship

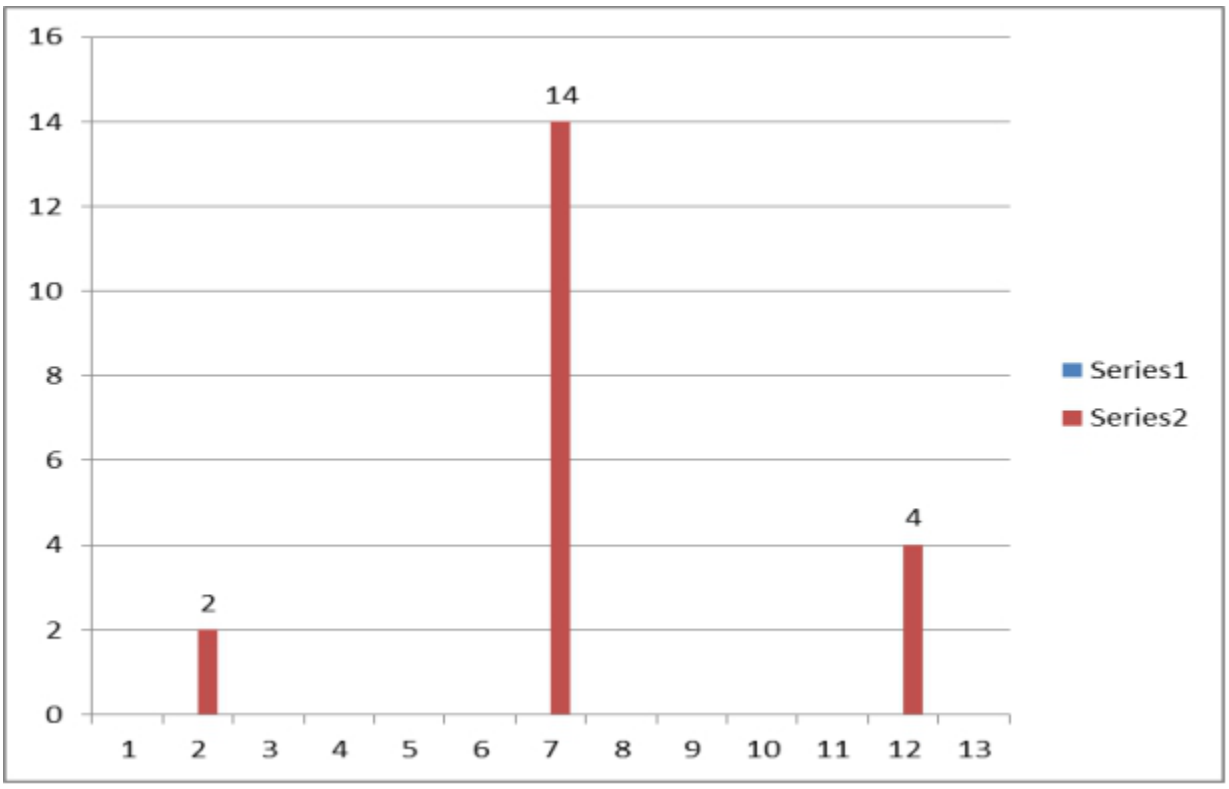


Figure 4 above indicates that 14 (70%) the reason was because of the unprofessional conduct of the counsellor whereby 4 (20%) was due to the poor financial status of the client and 2 (10%) was because of the strong financial status of the counsellor.

The responses leading to dual relationship were shown in fig 4 above where 14(70%) said that the reasons leading to dual relationship between the counsellors and the clients were because of the un unprofessional conduct of the counsellors, whereby 4(20%) of the respondents said that it was due to financial status of the clients and 2(10%) said that it was due to the strong financial status of the counselors.

Questionnaire 5. Effects of a Dual Relationship on the counselling session

The responses as to how the counselling sessions were affected by the dual relationship, the answers were as shown in the table below:

Table 5 Responses on the Effects of dual relationship

S/N	**Reasons**	**Frequency**	**Percentage**
1	Compromises the counselling service	4	20
2	Shunning of counselling services	14	70
3	Fear of disclosure of information	2	10
	Totals	**20**	**100**

Fig.5: Responses on the Effects of Dual Relationship in the counseling session

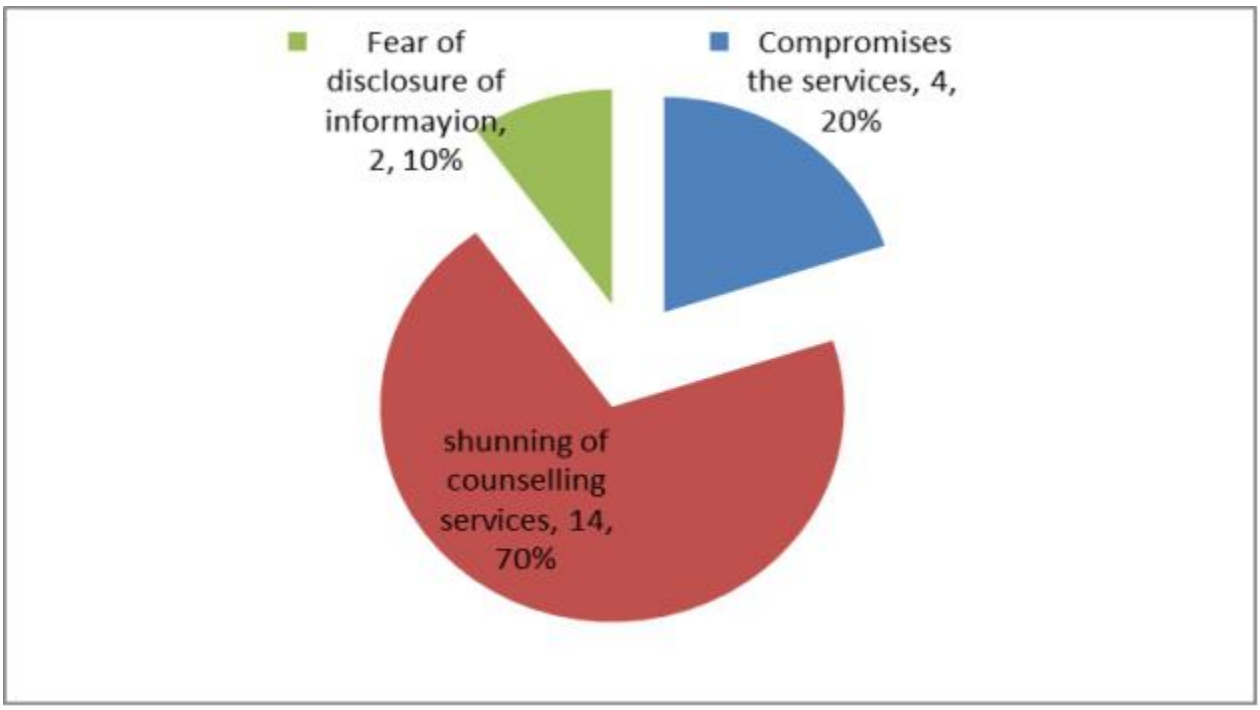


Fig 5 above indicated that 14 (70%) the clients would shun the counselling services 4 (20%) said that the counselling service was compromised, while 2 (10%) said that clients would fear to disclose some information.

The responses on the effects of dual relationship in the counselling session were shown in Fig 5 above where14 (70%) said that the relationship would lead the clients to shun the Counselling services, whereas 4(20%) said that it could lead to counselling services being compromised and 2(10%) responded that the relationship would lead the clients not disclosing the vital information necessary for making informed choices.

The responses leading to the client accepting the counsellor's proposal in a counselling session

Were indicated in the table 6 below;

Questionnaire 6: Reasons for accepting the counsellor's proposal in a counselling session

Reasons	**Frequency**	**Percentage**
Clients lack of knowledge in Counselling	2	10%
Counselors use of inappropriate language	4	20%
Unethical Conduct of a Counselor	14	70%
TOTAL	**20**	**100%**

Table 6 above shows that 14 (70%) of respondents said that it was due to clients lack of knowledge in counselling, whilst 4(20%) said that it was due to the counsellors use of inappropriate language and 2(10%) responded that it was due to counselors unethical conduct in a counselling session

Fig, 6: Clients responses in accepting counselors' proposals

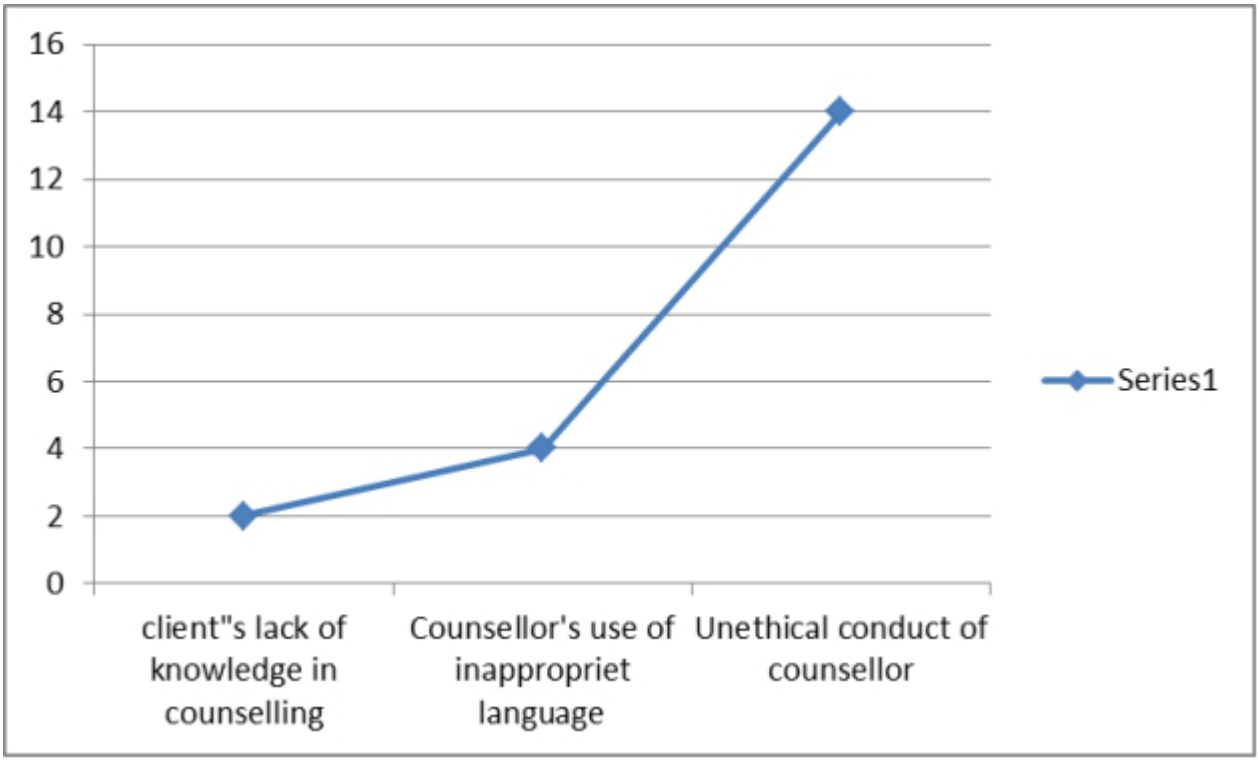


Fig 6 above shows that 14(70%) said that it is due to unethical conduct of a counsellor while 4 (20%) said that was because of counsellors inappropriate use of language to clients and 2(10%) was due to clients lack of knowledge in counseling.

4.8 RESPONSES FOR COUNSELLORS QUESTIONNAIRES

Questionnaire 7 Counselors were asked the meaning of dual relationship

Table 7: The responses of the meaning of dual relationship

S/N	Meaning	Frequency	Percentage
1	It is a relationship between a counselee, a counsellor and other health professionals	2	20
2	It is where multiple roles are performed by a therapist	1	10
3	Knowing each other at a work place	2	20
4	Intimate relationship with client	3	30
5	Relationship involving two people with an intent	2	20
	Totals	**10**	**100**

The table 7 above shows that 3 (30%) indicated that dual relationship is intimate relationship with a client, 2(20%) said that it is a relationship between a counselee, and other health professionals, another 2 (20% said that it was a relationship involving two people with an intent and 2(20%) said that it was knowing each other at a work place and 1(10%) said that it was a relationship where multiple roles are performed by the therapist.

Questionnaire 8 **the** responses on how to counsel a client whom you have a dual relationship with were shown in the table below

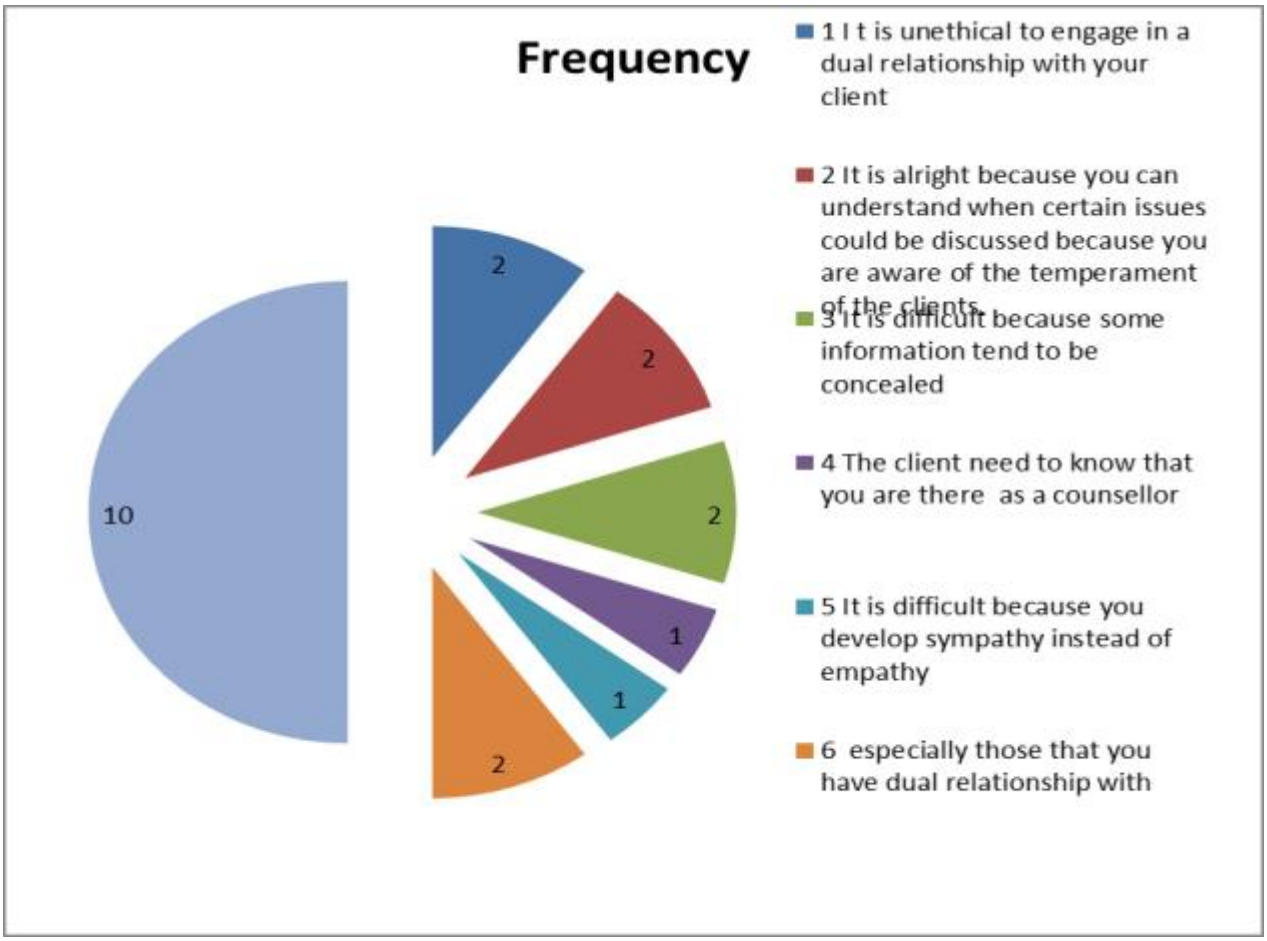
Table 8:Perception on whether it is right or not to counsel a client whom you have a dual relationship with

Table 8.

S/N	**Reasons**	**Frequency**	**Percentage**
1	It is unethical to engage in a dual relationship with your client	2	20
2	It is alright because you can understand when certain issues could be discussed because you are aware of the temperament of the clients.	2	20
3	It is difficult because some information tend to be concealed	2	20
4	The client need to know that you are there as a counselor	1	10
5	It is difficult because you develop sympathy instead of empathy	1	10
6	especially those that you have dual relationship with	2	20
	Totals	10	100

The responses on whether it was right or not to counsel a client whom you have a dual relationship with were shown in Table 8 above where 2 (20%) said that it was unethical to engage in a dual relationship with a client, 2(20%) said that It was alright because you could understand when certain issues could be discussed because you were aware of the temperament of the clients, 2 (20%) said that It is difficult because some information tend to be concealed, while the other 2(20%) said that especially those that you have dual relationship with, 1(10%) said that the client need to know that you are there as a counselor**,** and 1(10%) said that It was difficult because you would develop sympathy instead of empathy.

Fig 7: was it right or wrong to counsel a client with whom you have a relationship with?



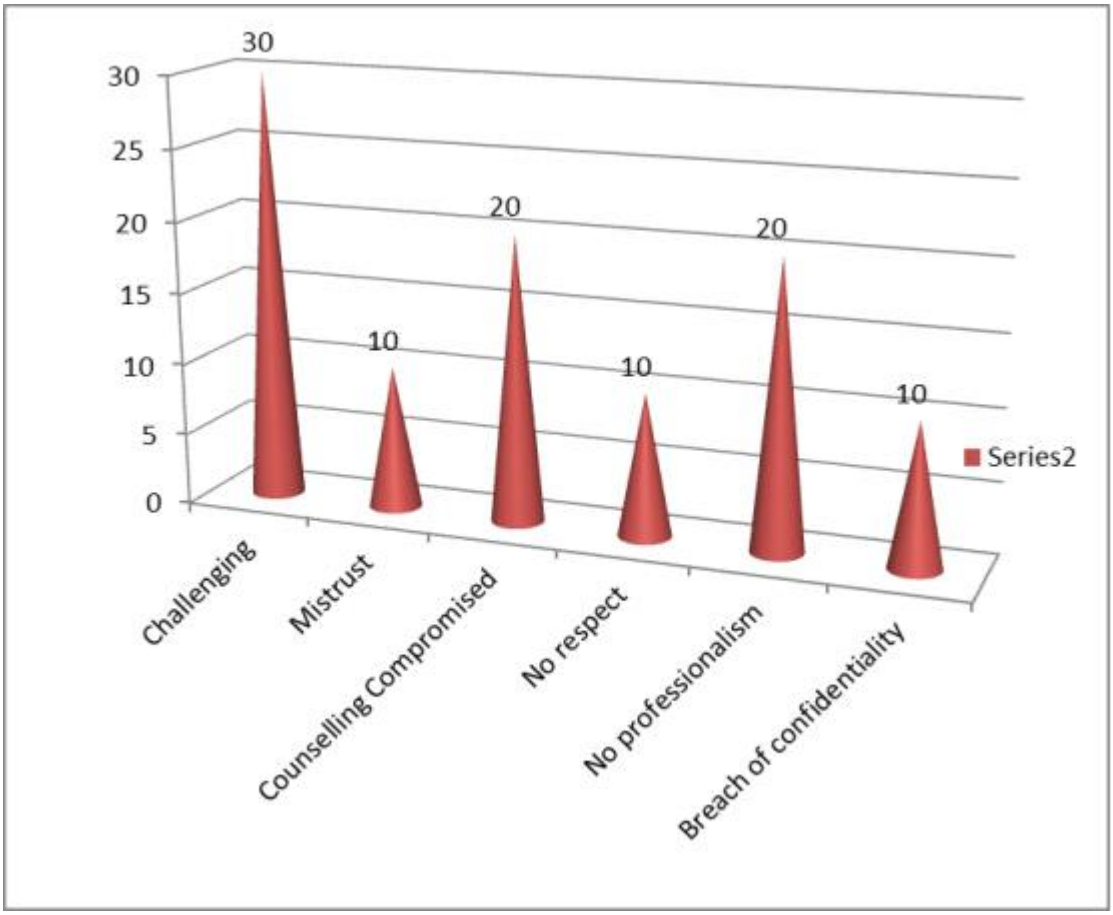
The responses on whether it was right or not to counsel a client whom you have a dual relationship with were shown in Fig:7 above where 2 (20%) said that it was unethical to engage in a dual relationship with a client, 2(20%) said that It was alright because you could understand when certain issues could be discussed because you were aware of the temperament of the clients, 2 (20%) said that It is difficult because some information tend to be concealed, while the other 2(20%) said that especially those that you have dual relationship with, 1(10%) said that the client need to know that you are there as a counselor, and 1(10%) said that It was difficult because you would develop sympathy instead of empathy.

Table 9: **How to confide in a client in whom you have a dual relationship with**

P/N	**Meaning**	**Frequency**	**Percentage**
1	Challenging	3	30
2	Mistrust	1	10
3	Counseling Compromised	2	20
4	No respect	1	10
5	No professionalism	2	20
6	Breach of confidentiality	1	10
TOTAL		**10**	**100**

The responses on how to confide in a client in whom you have a dual relationship were shown in Table.9 above 3(30%) said that it was challenging,2(20%) said that, counseling was compromised,whereas,2(20%) did indicate that professionalism was not observed, also 1(10%) said that there mistrust was of concern, where as1(10%) said there was no respect in the counseling session and 1(10%) vouched that breach of confidentiality was highly flouted.

Fig 8: How to confide in a client you have a relationship with

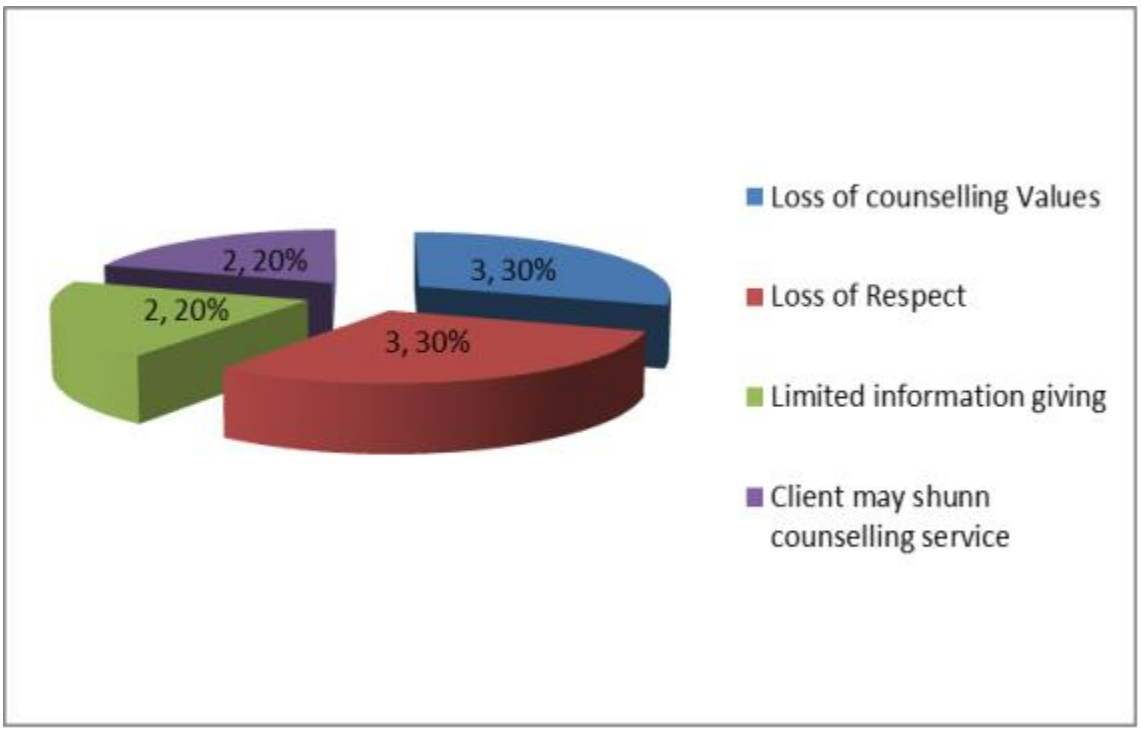


The responses on how to confide in a client in whom you have a dual relationship were shown in Fig.8 above 3(30%) said that it was challenging,2(20%) said that, counseling was compromised,whereas,2(20%) did indicate that professionalism was not observed, also 1(10%) said that there mistrust was of concern, where as1(10%) said there was no respect in the counseling session and 1(10%) vouched that breach of confidentiality was highly flouted

Table 10 Effects of Dual relationship on the client

S/N	Reasons	Frequency	Percentage
1	Loss of counseling Values	3	30
2	Loss of Respect	3	30
3	Limited information giving	2	20
4	Client may shun counseling service	2	20
	TOTAL	**10**	**100%**

Fig 9 **Effects of dual relationship on the Health center**



The responses of the effects of dual relationship as indicated in Fig 9 above

3(30%) indicated that counseling values were lost, 3(30%) said that there was loss of respect,2(20%) did indicate that limited information was given and 2(20%) said that clients shunned the counseling services.

Table 11: Effects of Dual Relationship on the health center

S/N	Meaning	Frequency	Percentage
1	Image of facility will be destroyed	3	30
2	Shunning of health centers by clients	2	20
3	Failure to open up	3	30
4	Compromised services	2	20
	TOTAL	**10**	**100%**

The responses on the effects of Dual Relationship on the Health centers are indicated in table 11 above. 3(30%) said that, the image of the facility would be destroyed, while 3(30%) said that clients would fail to open up, whereby 2(20%) responded that health centers would be shunned, and 2(20%) said that the counselling services were compromised.

4.9 SUMMARY OF PRESENTATIONS OF THE FINDINGS

The unprofessional conduct of the counsellors, coupled with the inappropriate language. Further, the vulnerability of the clients, financial instability and lack of counselling information lead to compromises in a counseling services.

CHAPTER FIVE

5.1 DISCUSSIONS AND INTERPRETATION OF THE FINDINGS

This chapter discusses the findings of the study in terms of the implications of dual relationship between a counsellor and a client in three (3) selected health centers namely Mtendere, Chelstone and Chainama Hospital as presented in Chapter four, as obtained from questionnaires with references to the relevant literature and information obtained from other studies.

The study was based on the literature review, and responses from both clients and counsellors as outlined in the following objectives;

1. To identify factors that causes counsellors to have dual relationship with their clients.

2. To identify the effects of dual relationship between the counsellor and the client

3. To establish the motives that counsellors have about dual relationships

Code of Conduct reiterated that sexual intimacies with current clients, relatives and significant relatives and significant others of current clients, and former clients were considered "exploitative. Therapists who engaged in such relationships (APA, 2002) "had responsibility " to demonstrate that there was no exploitation based on a number of factors, including duration and intensity of therapy , circumstances of termination , client's mental status, and likelihood of adverse impact on the client.

Counsellor-client dual relationship has been a major subject of concern in counselling practice in recent time and other mental health professionals have grown increasing concerned about counsellor-client dual relationship in clinical practice. Including the boundary crossing and boundary violation.

Based on the questionnaires administered to clients responses to question 1: Clients were asked to give factors that lead to dual relationship with their counselors and the findings indicated that, vulnerability of clients does lead to dual relationship with the counsellor, while as others said that,

it was as a result of unethical conduct of a counselors and others said that it was through the use of enticing language by a counselors.

It has been acknowledged by clients that, their being vulnerable compounded by the unethical conduct of the counsellors and through the use of the counselors enticing language lead to dual relationship. The first objective has therefore, been answered as evidenced through the responses.

In addition, the client's responses to the second question which read as, what makes the client to fall into a dual relationship with a counselor the responses were as follows;

The responses indicated that, it was because of the unprofessional conduct of the counsellor whereby others said that, it was due to the poor financial status of the client and others said that, it was because of the strong financial status of the counsellor.

It is very evident from the client's responses that, unprofessional conduct, strong financial status of a counsellor and the client's lack of financial instability lead clients to easily fall into dual relationships. This supports the objectives one (1) and three (3).

Furthermore, the clients response to question three (3) seeks to explain the effects of a dual relationship in a counselling session said that the counselling service were compromised, whilst others said that, client would shun the counselling services, while others said that, the clients would fear to disclose some information.

The clients responses ably answers the second objective which identifies the effects of dual relationship between a counselor and a client as counselling services are compromised, fear of disclosure of information by either party and also that the client may shun the counseling services.

As regards to the responses from the counselors questionnaires, which indicated as to what effects would the dual relationship have on the health center

The responses on the effects of Dual Relationship on the Health centers some said that, the image of the facility would be destroyed, while others said that clients would fail to open up, others said that, Health centers would be shunned, and others also said that the counselling services were compromised

From the responses, it was evident that the Health facilities would have a bad image thereby destroying the confidence of the counselling services which may lead to clients shunning such centers and finally due to compromised nature of the counselors society (Zambia) would remain unstable socially, psychologically, spiritually, physically, politically and emotionally.

5.2 SUMMARY OF THE DISCUSSIONS AND INTERPRETATION OF THE FINDINGS

The findings were based on the study whose objectives were:

1. To identify factors that causes counsellors to have dual relationship with their clients.

2. To identify the effects of dual relationship between the counsellor and the client

3. To establish the motives that counsellors have about dual relationships:

The counsellor client dual relationship has raised concern in Counselling services. Based on the clients responses, from the questionnaires, it is hereby established that the clients were vulnerable and this was compounded by the counsellors unethical conduct during counselling sessions exhibited through the use of enticing language and the counsellors strong financial status..

It is evident from the findings that the counselling services were highly compromised hence leading to some clients shunning the counselling services as this did not inspire confidence. The clients to a large extent had to withhold information necessary for them to have made informed choices that hindered with the aforementioned unethical behaviour. Sadly, the clients often went back with their challenges not being resolved much to their detriment. Furthermore, it was established that the effects of a dual relationship between the counsellor and the client in a counseling service was hampered as both parties feared to disclose information hence affecting the counselling sessions. It has also been established that from the study that, were counsellors who were in such relationships potentially destroyed the positive image of the health centers to negative ones as they were perceived to have been dating sites.

Haas and Malouf (1989) proposed three reasons as to why dual relationship must be avoided and thus:

1. The clear differential power that does exist between the counsellor and client

2. The undermined role of a counsellor

3. The clients feel intimidated into providing vital information necessary for the Counselling session to thrive.

It is evident from the literature review cited and questionnaires given to respondents that the counselling services in the three health centers sampled namely, Mtendere Clinic, Chelstone and Chainama Hospital that counselling services in Zambia has a long way to go. There is dire need to sensitize both the counsellors and citizenry if the counselling services have to add value in Zambia and transform lives. In all the counselling services from this study can be summed that it has been exploitative as the Counselling services are by and large void of the much needed ethics.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

The main objective of the study was to establish the implications of dual relationship amongst counsellor's and clients and how it affects individuals, the government particularly the Ministry of Health and members of the public at Mtendere, Chelstone and Chainama Hospital in Lusaka Province, Lusaka district in Lusaka urban Zambia. Its specific objectives included;

(1). what contributes to having dual relationship between a counsellor and a client?

(2). How does the conduct of dual relationship between a counsellor and a client affect the counseling relationship?

(3). what contribute to having dual relationship between a counsellor and a client?

The study employed qualitative research methods in collecting and analysing data. Interview guides and questionnaires were used to establish the implications of dual relationship amongst counsellor's and clients at the three selected health centers Mtendere, Chelstone and Chainama Hospital , Interview were used to collect data from 5 male a and 5 female counsellors on the effect of dual relationship to the counsellor and client and also on the health centers. Interview guides presented to respondents on the other hand were used to collect data from 10 male and 10 female clients, on their views on how they agree to the counsellors proposal and also on how the dual relationship affects them. They responded to issues relating to health centers programs for the clients with the problem.

The findings revealed that, the health centers were available but with highly inadequate resources that were needed for the clients to solve the problems. The study also found high inadequacy in the expert therapists

6.2. RECOMMENADATIONS

Based on the research findings and the conclusions drawn in the preceding section, three categories of recommendations were made.

Government and all stakeholders to target their sensitization

- **Counselors**

Promote the establishment of systems that promote accountability for ethical behavior, systems that are invested in and promote the welfare of the clients in the health centers

Mass education of the counselors should be embarked on by Government and all stakeholders to sensitize them on emotional health so as to make them develop positive attitude and good practice towards clients.

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The emotional health so as to make them develop positive attitude and good practice towards emotionally ill clients.

- **Policy makers**

- Policies and plans from government to health institutional levels concerning people with emotional problems must be put into actions;
- Health centers and hospitals must be aware about clients with emotional problems so as to allocate relevant services according to needs that are in line with the counseling code of ethics.
- The Government should plan to train enough expertise in the field of counseling for the well-being of the clients.

6.3. RECOMMENDATIONS FOR FURTHER STUDY

This study was specifically carried out in Lusaka District in Lusaka urban in Zambia to establish the implications of dual relationship amongst the counsellors and clients. However, during data collection and analysis. It came out clear that, clients who engaged in dual relationship with counsellors in health center experienced a lot of challenges as compared to the help that they received. More so, the reviewed literature indicated that there was little research done on the implications of dual relationship amongst counsellor's and clients, there is still a gap from the studies conducted by other researchers which shows that there is still little or no change at all in counsellor's and clients. Therefore, recommends the need for further research on all forms of dual relationships in relation to counselling.

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APPENDENCES

APENDIX 1

QUESTIONNAIRE FOR CLIENTS

INTRODUCTION

Dear Respondent,

I am a Master of Science student in counselling at Zimbabwe Open University /University of Zambia. In partial fulfillment of a MSCC Master of Science in Counselling programme. Each student undertakes a research, Iam collecting information on the implications of dual relationships amongst counsellor's and clients in various selected health centers in Lusaka district in Lusaka urban in Zambia. The findings of this study will primarily be used for academic studies. The ministry of health may use the results of this study to influence in addressing the dual relationship amongst counsellor's and clients in the health centers and this in turn may help to improve the counselling services in various health centers. All the answers you are going to give will be treated confidentially and your name will not be revealed. Therefore, give the information correctly, freely and honestly. Please do not write your name on the questionnaire.

Thank you in advance.

Elina Kamanga

INSTRUCTIONS

Please answer all questions

PART A: Background Information please **(**Tick)in the space provided

Gender:

Female { }

Male { }

Age:

(a) 15-19

(b) 20-24

(c) 25-29

(d) 30-34

(e) 35 and above

Professional Qualification :

(a) University

(b) College

(c) Secondary

(d) Primary

(e) None

Marital Status

(a)Single

(b)Married

(c)Divorced

(d)Widow

(e)Widower

What do you do for a living?

(a)Employed

(b)Self employed

(c)Nothing

(d)Still in school

PART B: QUESTIONS

INTRUCTIONS

Please answer all questions

Using your own words, provide a brief answer or explanation in the spaces provided below

6. What factors lead a client to fall into a dual relationship with a counsellor?

---

7. What makes the client to fall into a dual relationship with a counsellor?

---

8. Explain how the dual relationship between a counsellor& a client affects the

Counseling interaction

9.What leads the client to agree to a counsellor's proposal?

Explain

APPENDIX 2

QUESTIONNAIRE FOR COUNSELLORS

INTRODUCTION

Dear Respondent,

Iam a Master of Science student in counselling at Zimbabwe Open University /University of Zambia. in partial fulfillment of a MSCC Master of Science in Counselling programme. Each student undertakes a research, Iam collecting information on the implications of dual relationships amongst counsellor's and clients in various selected health centers in Lusaka district in Lusaka Province in Zambia.

The findings of this study will primarily be used for academic studies. The ministry of health may use the results of this study to influence in addressing the dual relationship amongst counsellor's and clients and this in turn may improve the counselling services in various health centers.

All the answers you are going to give will be treated confidentially and your name will not be revealed. Therefore, give the information correctly, freely and honestly. Please do not write your name on the questionnaire.

Thank you in advance.

Elina Kamanga

INSTRUCTIONS

Please answer all questions

PART A: BACKGROUND INFORMATION please (Tick) in the spaces provided below

Gender :

Female { }

Male { }

Age:

(a) 15-19

(b) 20-24

(c) 25-29

(d) 30-34

(e) 35 and above

Professional Qualification:

(a) University

(b) College

(c) Secondary

(d) Primary

(e) None

Marital Status

(a)Single

(b)Married

(c)Divorced

(d)Widow

(e)Widower

What do you do for a living?

(a)Employed

(b)Self employed

(c)Nothing

PART B :QUESTIONS

INTRUCTIONS

Please answer all questions

Using your own words, provide a brief answer or explanation

in the spaces provided

6 What do you understand by the term dual relationship?

Explain----------

---

7 .As a counsellor, how can you counsel a client you are in a dual relationship with

Explain

-

8.How can you confide in a client you have a dual relationship with?

Explain

---

9. What effects would the dual relationship have on the client in a counselling session?

Explain

---

10. What effects would the dual relationship have to the health center?

Explain

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