

Dual Therapy Decision Guide



A one page check in for therapists when a client is seeing (or wants to see) another therapist

This guide is written from a clinical and ethical lens, not as legal advice. Regulations, board guidance, and insurance contracts vary by state, license, and payer. Always check your own board, professional association, and payer contracts.

1. Start Inside: Your Own System

Before you decide anything, pause and scan your internal landscape:

- What part of me is responding right now?
Protector, Fixer, Not Enough Part, Shadow afraid of being replaced?
- Can I invite those parts to soften so my Adult or Self led seat can take the lead?

From my wisest clinical self:

- Does this request feel like an aligned expansion of care?
- Or does something feel off, confusing, or pressured?

If your system feels highly activated or defensive, that is data.
Pause, regulate, and consider consultation before making firm decisions.

2. Clinical Fit: Is Dual Therapy Likely Helpful?

Ask yourself:

- Does this client reasonably benefit from a second modality or specialist (trauma reprocessing, ED or SUD work, neurodivergent executive functioning support, OCD or ERP, medical risk concerns)?
- Is there a clear lane for my role that fits my scope and strengths?
- Can I name in one or two sentences what my primary focus would be if dual therapy proceeds?
- Does dual therapy appear to resource the client, or does it risk fragmenting the work with competing goals, mixed messages, or over activation?

If you cannot articulate a clear role, that is a sign to slow down and clarify before saying yes.

3. Safety, Risk, and Proceed With Caution Flags

Consider whether this client may be better served by one primary therapist or a tightly coordinated team:

Is the client:

- In acute crisis or recently hospitalized?
- Actively suicidal or at high risk of self harm?
- Involved in high stakes legal, custody, or forensic processes?

Would adding a second therapist:

- Increase confusion about who is responsible for risk assessment and crisis planning?
- Blur roles such as treating therapist versus forensic evaluator?
- Create dual roles that are clearly inappropriate, such as evaluator and treater, or therapist and decision maker?

If yes to any of these, dual therapy may still be possible, but it likely requires tight coordination, clear primary provider designation, a higher level of care, or in some cases a clear no.

4. Systems Check: Ethics, Insurance, Logistics

Ask the unglamorous but crucial questions.

Ethical and board alignment

- Is my role within my scope of practice?
- Does this arrangement create any dual relationships or conflicts of interest?
- Would I feel comfortable explaining this setup in writing to my board?

Insurance and financial realities

- Is anyone billing insurance?
 - If yes, are goals and interventions clearly differentiated between therapists?
 - Can medical necessity be justified for each role without duplication?
- Is one provider private pay and the other in network?
 - Does any insurance contract limit when or how private pay is allowed?
 - Has the client been fully informed of coverage, limitations, and costs?

If any of this feels hazy, clarify before proceeding, and document your reasoning.

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5. Board and Insurance Litmus Test

Use this as a quick reality check:

Could I sit in front of the Board of Behavioral Sciences or an insurance auditor and clearly articulate why this dual arrangement was necessary, appropriate, and within scope?

If yes, you are likely on solid ground.

If no or you are unsure, slow down and tighten your thinking.

You know you are clinically sound when:

- You can state your unique clinical purpose in two clear sentences.
 - Example:
 - “I provide long term relational and narrative therapy for attachment and identity. The other therapist is providing EMDR for trauma reprocessing.”
 - “I focus on neurodivergent executive functioning, emotional regulation, and identity. The other therapist is addressing co occurring disordered eating with medical coordination.”
- You can demonstrate the client’s need for two modalities.
 - Layered conditions require distinct interventions beyond one provider.
 - The second modality is outside your scope and essential for progress.
 - Frequency or acuity requires additional support that does not yet meet criteria for PHP or IOP.
- You can show separation of goals, documentation, and outcomes.
 - Your treatment goals are not duplicates.
 - Notes reflect distinct interventions and outcomes in your domain (relational patterns, emotion regulation, trauma triggers, somatic stabilization, identity, parts work).
- You can explain how you handled risk, boundaries, and communication.
 - How risk was monitored.
 - How boundaries and lanes were maintained.
 - Whether there was communication, or a clinically intentional decision not to communicate, with a signed release.
 - How you helped the client understand roles, limits, and what each therapy is for.
- You can state why not doing dual therapy would have harmed the client.
 - For example:
 - “Without EMDR, trauma symptoms were worsening despite weekly talk therapy.”
 - “The client’s eating disorder required specialty care outside my competency.”
 - “Single provider therapy was insufficient to stabilize functioning, and a higher level of care was not yet indicated or accessible.”

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If you can say, with a straight face and a calm nervous system, “I chose dual therapy to protect the client, not to soothe my own anxiety or attachment,” your decision is clinically robust.

6. Conversation With the Client: Clarity and Consent

Before you give a final yes or no:

Have you named:

- What your role would be in dual therapy?
- What the other therapist’s role appears to be from the client’s perspective?
- How you will handle pacing so the client is not over activated or flooded?

Have you invited the client to share:

- What they are hoping to gain from each therapist?
- Any worries about disappointing, betraying, or confusing one of you?

Have you discussed:

- Whether they want and consent to coordination between therapists, with a signed release of information?
- What information they are comfortable having shared?

You are not deciding for the client. You are co creating a structure they can realistically hold.

7. Decision Point: Choose Your Path Intentionally

After reflection, consultation if needed, and conversation with the client, check your internal compass:

- **Proceed as is**
Roles are clear, risks are low, documentation and differentiation make sense, and dual therapy appears clinically beneficial.
- **Proceed with conditions**
You will move forward only with:
clear goals and scope, pacing agreements, and a release plus light coordination in place.
- **Pause or decline**
Risk is too high, roles are too muddy, systems are not aligned, or your own internal

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system is too activated to hold this ethically right now. You offer referrals, alternative structures, or recommend one primary therapist instead.

Whatever you choose, document your reasoning and how you arrived there.

You are not expected to hold the entire constellation alone. Your job is to protect the client's process, your own integrity, and the clinical container.