

Ethical Issues in Sex and Love Addiction Treatment

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Abstract

Sex and love addiction treatment can involve many, complex ethical issues. Awareness of these potential problems can assist clinicians in improving efficacy and, at the same time, reducing risk. Ethical difficulties flow from the fundamental principle that counseling is a fiduciary relationship. Sex and love addicts present with multiple addictions, strong psychological defenses, and trauma histories, which often result in lengthy treatments. Over the course of such treatment many challenging ethical areas surface including transference/counter-transference problems, evocative and provocative behaviors in clients, questions of therapist self-disclosure, confidentiality concerns, trauma reenactment possibilities, boundary issues, dual relationship questions, competence issues, diagnostic dilemmas, and fees problems. Examples and positive solutions for these and other ethical areas are given in order to foster the best result for both client and clinician.

My academic training while providing course work on ethics left me lacking a practical awareness of ethical risks and benefits. While these were intellectual concerns, practitioners did not really have to worry themselves too much with these problems. Professional post-doctoral seminars did not do much to improve my naïve view of this complex work. Subsequently, through a difficult growth process, I came to know the reasons for developing a deeper understanding of ethics and integrating this in my practice.

One important fact (that may have been highlighted, but I lacked awareness of) is that there are no time limits to ethical complaints. Licensing boards and professional associations will accept and investigate any complaint at any time. By comparison, most legal complaints are subject to statutes of limitations. Even with some legal protections

like time limits, practitioners will function better when they develop an in-depth appreciation of the legal and ethical dimensions of treatment.

Contrary to my uninformed view, one in 10 (12%) psychologists have an ethical, license, or malpractice complaint (Pope & Tabachnick, 1993). Of these, 70% of the complaints are deemed to have merit. In this same study, there was a considerable gender difference with 17% of male and 6% of female psychologists having complaints filed against them.

The procedures for processing complaints vary but often take considerable time. Professional associations typically act more quickly than state boards, but there, the process takes years, not months even when the psychologist is innocent. If found guilty of an ethical violation, the restoration procedure for good standing in a professional organization or return to full licensure from a state board is lengthy and can take five years or more.

The consequences of having a complaint, even if proven wrong, are profound. It is a permanent mark on your record. A clinician will be asked about ethical complaints and need to report and explain any in all future applications for membership in professional organizations and insurance panels for the rest of their professional life. The cost of malpractice insurance, which can be hard to find after a violation of ethical standards, can increase five times what others in your profession are paying. These higher rates can last for decades. With any record of a complaint, regardless of guilt or innocence, clinicians often can be from insurance panels at least for a number of years if not forever.

Principles

Obviously, a lack of appreciation for ethics can have serious consequences for clients and practitioners. The foundation of ethical practice is having sound ethical principles. Ethical treatment begins with understanding that the client/therapist relationship is a fiduciary relationship. Fiduciary is defined as “relating to or of the nature of a legal trust.” (Webster’s Online Dictionary, 2008). Clinicians, of course, are well schooled in the importance of developing trust in a therapeutic relationship. As will be expanded later, sex and love addicts often require considerable work in order to build this trusting relationship, which in turn means that there are many potential pitfalls and challenges for the treating therapist.

Most professional organizations expand on the idea of trust in their ethical guidelines. For example, the American Psychological Association lists these principles: “beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, respect for people’s rights and dignity” in their ethical principles (1992). For physicians, the Hippocratic Oath, “first, do no harm,” is often quoted (American Psychiatric Association, 2001). The National Association of Social Workers identifies core values of “service, social justice, dignity and worth of the person, importance of human relationships, integrity, [and] competence” (1999). American Counselor’s Association Code includes client welfare, diversity, patients’ rights, personal needs and values, and dual relationships among others (2005).

A reasonable assumption is that most harm by clinicians is unintended. In their professional training and development and their certification and licensing processes, therapists are exposed to these ethical principles. While some errors are the result of

inadequate preparation, others are due to “blind spots” such as family of origin issues. Sex and love addiction treatment can surface such weaknesses.

Complicated Treatment

Sex and addicts are difficult to treat. One reason is the length of treatment. In traditional mental health treatment, the average therapy client attends 6 sessions. Carnes (1989) suggested that recovery from sex and love addiction could require 5 to 8 years of treatment. Longer treatment is not unheard of and has happened with a few clients in my twenty years in practice. More treatment means more opportunities for mistakes.

Most colleagues assert that recovery from sex and love addiction is the most complex addiction recovery. Chemical recovery typically involves time limited therapy and usually a strong Twelve Step emphasis. Adult children of alcoholics (A.C.O.A.) helped define “dysfunctional families,” but treatment for this aspect of a chemically dependent person is often seen as a luxury, not a necessity. Identification of A.C.O.A. issues can enhance chemical dependency recovery, but it is not essential for staying sober. Addiction to food is not a well-accepted view despite the fact that overeating is an obvious problem with 50% of US adults overweight (60% of men). Little support exists for addiction treatment and eating disorder programs usually have the primarily focus on anorexia and bulimia. Likewise, other “process” or “behavioral” addictions do not get much recognition. Gambling, including internet gambling websites, is getting more recognition that it is a disorder that requires treatment as lotteries and casinos proliferate, e.g., the 1-800-gambler hotline. Other behavioral problems such as over-work and compulsive exercise have few treatment advocates.

Many sex and love addicts suffer from multiple addictions (Carnes, 1991) having compulsive behaviors with food, money (e.g., shopping, debting, online trading), chemicals (including nicotine). Only recently have chemical dependency programs incorporated the treatment of nicotine addiction, and screening for sex and love addiction is rare in these programs. Chemical dependency itself is a concept that is only 30 years old. Carnes et al. (2005) have proposed an Addiction Interaction Disorder to describe how these various addictions not only co-occur but also interact making treatment even more complex and difficult.

Most sex and love addictions have histories of trauma (Carnes, 1991). Trauma work needs to be balanced with addiction recovery (Griffin-Shelley, 1991). Raising trauma issues can trigger an addiction relapse if handled poorly. However, understanding a client's reenactment scenario is important in decoding acting out. For example, a man came into treatment who acted out domination fantasies of women. He originally found domination scenes in his father's pornography. His childhood was dominated by his mother and demanding, paternal grandmother. His acting out script recapitulated his childhood trauma in a way that allowed him to become the aggressor, a position he was afraid to take in every day life, and to have the power in the relationship. Unfortunately, acting out this way lead to profound shame, self-hatred, and feelings of powerlessness and retraumatization. Recovery from other addictions focuses on more concrete triggers for relapse prevention, but, because sex and love addiction is an intimacy disorder, long-term recovery involves trauma resolution.

Transference and counter-transference reaction need to be monitored more carefully than in traditional addiction work due to these intimacy issues. In Alcoholics

Anonymous there is a slogan, “talk it out, so you won’t act it out.” For sex and love addicts, talking things out involves feelings generated in the therapeutic relationship. For example, one sex and love addict had abandonment issues that were triggered when his therapist went on vacation. The analysis of his acting out slip identified this hurt when they were able to talk through his thoughts and feelings. Healing happens in the relationships that are developed in recovery.

Trauma victims are both over- and under-reactive. They are numb and hyper-vigilant and hyper-reactive. Awareness of these extremes in client’s reactions requires the therapist to be on the look out for the client whose mental set (from severe abandonment and abuse) is that people “don’t care.” One such client was convinced that long term treatment was for the financial benefit of the counselor, not the needs of the client.

Sex and love addicts carry a profound level of shame (Griffin-Shelley, 1991). They hold what Carnes (1983) called core beliefs that lead to identifying themselves as being a “worthless, unlovable, bad person.” Rebuilding a sense of self in such a totally damaged person takes time, caring, and tenacity. Some such clients need a litany of their good qualities repeated over and over again before they can begin to believe that they have any worth or goodness.

Sex and love addicts tend to be in denial of their dependency needs (Weiss, 2000). Unlike other trauma victims who tend to be overly needy, sex and love addicts act in a counter-dependent way hiding their intense need for love and approval. This makes them hard to engage, isolative, avoidant, and preferring fantasy to real relationships (Leedes, 2001). With high levels of shame, these clients present with strong defenses: denial, minimization, and projection making engagement and creating a working

relationship difficult. They present with a high level of compartmentalization or dissociation (Griffin-Shelley, et al., 1995). An example of this is their capacity for sex and love addicts to act out in an active sex addiction while they are sexually anorexic (shut down) in their primary relationship, which is quite common in this population.

Many have significant authority issues, which make it difficult to give suggestions or develop the treatment alliance. Their resentment of authority may be evident in their difficulties with fees. Sex and love addicts often report that their “addict” is in control and unwilling to take the step that recovering addicts refer to as “surrender,” i.e., admitting powerlessness and unmanageability (Augustine Fellowship, 1986). Parental neglect and abuse led one sex and love addict to adopt the motto: “trust no one ever.”

Finally, there are some who have what might be called the Offender Syndrome, i.e., they are victimizers who feel victimized. Typically, these are clients who are involved with the legal system. Similar to the idea that no one in jail is guilty, they exhibit narcissism, sociopathy, and a lack of empathy for victims, e.g., the client who is in federal prison for soliciting sex with a minor across state lines focuses on how other prisoners are getting a bad deal or the injustice of law enforcement sting operations and insist that they would not follow through with a hands-on offense of a child. Often, once their probation (formally through the courts or otherwise, e.g., “wife-mandated” to treatment) ends, they are out of treatment even though they have been quite convincing in the sincerity and need for help. Apparently, their underlying shame is too overwhelming to approach. In many cases this includes their own victimization. While victims can become victimizers, victims who victimize cannot work through their own trauma if they remain in the victimizer role. Recovery involves being aware of and experiencing their

own vulnerability, pain, and suffering and learning to share these with others and ask for help and support.

Ethical Issues Arise in Complex Treatment

When exploring ethical issues that can arise in sex and love addiction treatment, an important place to begin is to consider the role of the therapist's personal needs. While this is the antithesis of what counselors seek to do, it can be a major blind spot in their work. Ask the question: what is my capacity for exploiting and victimizing my clients? It is rare that this is a conscious aim for a therapist, but it is also naïve to think that personal needs do not enter into the treatment process. Receiving a fee for our expertise is designed to help us meet our needs in a direct way, but, indirectly, most of us are strongly motivated by our need to succeed with clients and have them do well under our guidance. All of us are capable of taking advantage of and/or offending others, so we need to be able to own this side of ourselves, what Dr. Carl Jung (1939) popularized as the shadow or dark side of the self, in order to act responsibly in the treatment setting.

Self-disclosure is a good example of how personal needs can slip into the treatment relationship. The essential question for the therapist to ask is: for whose benefit is the self-disclosure? It needs to be for the client, not for the professional. How does a therapist answer questions about their personal recovery or marital status or if they have children? Most often, a brief, direct answer is sufficient to meet the client's needs and any more probably has to do with the counselor's needs. Having a home office or pictures on your desk can lead to personal questions. Inappropriate or excessive self-disclosure is first on a malpractice defense lawyer's list of therapists "pitfalls" (Caudill,

2002). However, learning appropriate and limited ways to be open about our selves with clients is important because “over 70 % [of us] use self disclosure at least occasionally.” (Pope, Tabachnick, & Keith-Spiegel, 1987).

Confidentiality is a primary responsibility of the treating professional and such a high value that it can rarely be compromised. Pope and Vetter (1992) found that practicing psychologists identified confidentiality as their most common ethical dilemma. Caudill (2002) indicated that it was the fourth most common basis for malpractice suits. Confidentiality can be compromised unintentionally by incidental contacts, such as happens in waiting rooms or calling people at home or work. Leaving phone messages or membership in group therapy can raise confidentiality issues. Therapists need to know their particular profession’s ethical guidelines as well as the legal requirements of their practice jurisdiction.

One important area within the domain of confidentiality is disguising client’s identities in publications, presentations, case consultations, and examples given to clients. Initially, an author might strive to describe particular case examples accurately. Such a practitioner will be surprised to discover that some clients were trying to identify themselves in their writings. This instance of client narcissism (“Is that me?”) can lead them to make more of an effort to disguise clients by changing important elements in their case descriptions like intentionally saying they had three children when they only had one. Confidentiality can also be compromised when clients seek to identify other clients in a form of competition or sibling rivalry (“Do you like them better than me?”). Again, inaccuracies in clinical information will protect all concerned parties.

A therapist can find it helpful to disguise their own identity in examples given to clients. So, they might say, “I was talking to someone earlier this week about...” when, in fact, they were using their own experience to illustrate a point. Getting themselves out of the limelight allows the message to take center stage thereby keeping their own needs in check while putting the client first.

Reenactment of the client’s trauma in the therapeutic relationship is, of course, quite possible if not inevitable due to their trauma histories. Sex and love addicts are quite good at preventing their vulnerability from being exposed. With someone who exposed them selves in an illegal way, the therapist can emphasize therapy as an opportunity to learn “healthy exposure,” i.e., openness and honesty. Clients’ fear being exploited, shamed, and humiliated because they have been. Unfortunately, due to their tendency to dissociate and live “secret lives,” they have split off these parts of them selves and are reluctant to integrate them. This creates the potential for the therapist to be seen in the role of the abuser, the one who wants to use and exploit them for their own gain because the therapist gains recognition from peers by “using” client examples. Sometimes, feelings of being used get acted out around fee payment, other times it can happen with comments or feedback that are experienced as negative when not intended to be such. The therapist inadvertently becomes the abuser, someone who hurts them.

Boundary issues are important in the therapeutic process with sex and love addicts. They tend to come from families that are either too distant, or detached, or too close or enmeshed (Carnes, 1991). Coming from families that are too rigid or too loose sets up the therapy relationship for conflicts around expectations, suggestions, and direction. These conflicts can be experienced or thought of, as coming from the

therapist's needs rather than from what is best for the client. Clients' verbalizing these thoughts and feelings will help strengthen the therapeutic alliance and reduce questions about ethical behavior on the part of the professional. Consultation by the therapist with other professional peers, supervisors, or consultants is recommended when these issues surface.

Respectful boundaries can be highlighted by a discussion of interpersonal interactions outside the therapeutic office. A therapist might comment, "if I meet you outside the office, I will take my cue from you, i.e., I will let you initiate any interactions." These encounters are common in small communities and less likely in larger, urban areas.

Therapists need to be aware of boundaries in terms of identifying other people during therapeutic discussions. Some clients are overly cautious about this and it can be hard to follow whom they are talking about. A suggestion to use first names only, which corresponds with the anonymity traditions in Twelve Step programs, can be helpful. Other clients are too open about other's identities and may need to be cautioned that you only need a first name to follow their story. Clients frequently are confused about these issues if they are in group with other clients that you know or they may refer to people they interact with at Twelve Step meetings who you may or may not know.

Boundaries are an issue in "small communities" like sex and love addiction treatment and Twelve Step fellowships, especially when professionals are in recovery. It is helpful to identify this as a potential concern in your practice information hand out (often many of these ethical issues can be addressed in written material given to each client and signed off on by them) or early in sessions with a client. Some recovering

professionals have addressed this by establishing “Two Hatter” meetings, i.e., Twelve Step meetings that are open only to professionals in recovery, so that they are less likely to run into current clients at meetings that they attend for their own recovery and are freer to speak than they would be if clients are at the meetings that they attend.

Dual relationships between client and therapist are a specific example of a boundary problem that can have profound negative effects for clients. A dual relationship raises the question of whose needs are being met and who is the client? Pope and Vasquez (1998) found that this problem was the highest cause of licensing board complaints and was identified as the second most common ethical dilemma encountered by psychologists. Business relationships with clients were 2nd on Caudell’s (2002) list of therapy pitfalls. An example of this business dual relationship would be renting an apartment to a client who is currently in therapy. Another example would be using a recovering client as a para-professional such as a co-therapist. One practice required continued sobriety of at least 5 years after termination from the therapy relationship before a former client would be considered for employment.

Issues of dual relationships can also surface when a therapist sees a client in both group and individual therapy or in individual and couples therapies. Some believe strongly that one therapist cannot do both. Others find that it is difficult but can be helpful. Again, the main focus needs to be on what benefits the client, what meets the client’s needs as opposed to which arrangement meets the needs of the therapist, e.g., financial gain from providing both therapies. On the other hand, splitting can occur with more than one therapist. A common problem is how often and how much do therapists communicate with the other therapists. This often is a neglected area of care since it is

not reimbursable time. Similarly, having more than one therapist opens the door for negative attitudes towards the other therapist to leak into the dynamic and can become like parents talking badly to the children about their partner.

Similar concerns about boundaries and dual relationships occur when third parties are involved. For example, when an employer or a court refers a client, the client needs to agree in advance (documented in writing with a release form or clinical note) regarding what, if any, information will be given to his or her employer or to the court (usually via a probation or parole officer). Employee assistance professionals can find themselves in a difficult bind when employers demand private information. These scenarios bring in the therapist's need for business referrals to make a living versus the client's need for confidentiality. A helpful action for the therapist would be to document a pro's and con's list in the client's chart.

Another grey area for counselors involves advocacy for clients. The question of whether objectivity is compromised by self-interest is raised when therapists advocate for clients. Often this takes the form of written letters and reports, which can be reviewed in advance with the client before they are sent out. Often it is difficult to see a situation from another perspective. Consulting others can help. For instance, a vice president of a managed care company suggested that her therapist had harmed a client when the therapist advocated for more intensive treatment for her and, thereby, raised the client's expectations. Similar objections of self-interest are raised when therapists take part in political advocacy for reforms in insurance coverage for mental health services, especially when clients are aware of these actions.

Finally, and, hopefully obvious to all professionals, sexual and/or romantic contact with clients is wrong under any circumstances. Sexual intimacies with clients are the number one cause of malpractice suits and loss of license.

Counter-transference, i.e., the feelings the therapist has towards his or her client, need to be monitored and managed if ethical violations are to be avoided. Awareness of the counselor's feelings toward a client offers important clues about the client and the relationship/intimacy that you experience with that person. Appropriate management of these feelings can lead to growth and recovery for the client while mismanagement can cause irreparable harm. Pope and Tabachnick (1993) indicated that a counselor's denial of anger, hate, fear, and sexual feelings lead to treatment that is adapted to the needs of the therapist. Consultation with peers and more experienced professionals can be quite helpful in dealing appropriately with these feelings and not avoiding conflict, tension, or confrontation that is in the service of the client's needs.

Blindness to pathology can impede therapy. Clinicians need to remember to assess for other diagnostic problems because clients can have more than one psychological problem (Sealy, 2002). Some clinicians see only addiction and are blind to the possibility that other disorders may co-exist. The typical addict's self-centeredness, depression, and mood swings may disappear with sobriety, but, when they don't, the clinician needs to consider other diagnostic possibilities. This is similar to the need to rule out physical problems as a basis for dis-inhibition. For instance, neurological damage or disorders can lead to sexual acting out. Some mentally retarded clients masturbate compulsively to self-soothe. Neither of these cases would be appropriately diagnosed as sex addiction. Likewise, problems like mood, anxiety, and personality

disorders can complicate sex and love addiction treatment. An ethical clinician keeps this big picture in mind and resists the impulse to blame the client when these issues are not resolved with a period of sobriety.

Over-pathologizing works much like under-diagnosing. Some clinicians can see clients as sicker than they really are. For example, a therapist's hopelessness about a client's ability to recover can lead to blaming the client for "not working the program." The opposite would be the therapist who thinks, "he/she's so sick, they need a superior therapist like me to help them." The needs of the therapist to be successful trump the client's need to be helped even if they have a difficult and complex series of problems. Therapists tend to come from families where they had 'helping' roles, so they may reenact this dynamic with a client in a way that keeps them in the 'sick' role (Barnett, Baker, Elman, & Schoener, 2007).

Anger is a common feeling for clinicians when they encounter resistance in clients, e.g., passive/aggressive behaviors such as coming late, missing sessions, and/or not paying fees. In order to deal with these angry feelings in a healthy way that model good boundaries, the therapist needs to avoid acting on feelings of getting even, being unavailable, wanting to shame or humiliate clients, over-charging, abandoning, or engaging in abusive confrontations. In the 1970's, chemical dependency treatment engaged in confrontation as a primary treatment strategy. Programs like Synanon and Gaudensia were infamous for putting clients in diapers to make them confront their childishness and "breaking down" defenses with marathon therapy sessions. Defenses can be confronted without humiliation when clients are given a little "wigggle room," e.g., asking questions rather than making interpretations. Therapists need to be able to react to

manipulations by clients without judgments but with compassionate understanding of the pain the client is in that drives such behaviors. Feelings of hatred, rage, and/or sadism towards clients can be taken to consultations with other clinicians in order to understand and appropriately cope with such feelings. Clinicians often need to have these reactions normalized by other clinicians before they can use them in constructive ways in their interactions with their clients.

Abandonment (theirs, ours) may not be as much of a concern with sex and love addicts as with other populations. Like addicts in general, sex and love addicts' style is more numbing, avoiding, withdrawing, so they are more likely to drop out of treatment than to accuse a therapist of abandonment. As indicated above, treatment is long-term and it is not uncommon for these clients to drop out of treatment and, then, come back when the pain of acting out in their addiction has brought them to another "bottom." Some therapists feel the need to set boundaries or expectations regarding sobriety or assignments. A therapist can get in that situation when they require attendance at Twelve Step meetings as a part of treatment. Clients often express their fears and resistance by defying such a suggestion. If a therapist gets to the point of deciding, "I can not continue to work with you unless you do ...," then the therapist might request a second opinion from a colleague or provide the client with at least two alternative treatment professionals with whom the client could continue treatment. This kind of power struggle can be avoided by making suggestions to clients rather than requirements.

Even without confrontation, abandonment issues do surface, e.g., clients feeling that a therapist does not care about them if the therapist doesn't give them a discounted fee. Likewise, a therapist can feel rejected or abandoned (and hurt/anger) when a client

chooses another therapist to work with, especially if the relationship has lasted for a while or progress has been difficult. In the former case, the client may need to keep distance and remain unsuccessful due to their trauma reenactment and, in the latter; the therapist's personal issues may be triggered, especially if they are overly invested in the client. Therapists can avoid acting out on their own trauma and family-of-origin issues by engaging in their own treatment and getting supervision or consultation.

Termination is related to the question of client abandonment. Whether the termination is at their initiative or yours it can be a difficult time if the client has not made significant progress. Some premature terminations are necessary such as when a therapist moves or changes employment. In cases like these, it is important to provide the client with a termination process (preferably four weeks) and referrals to other competent professionals to continue their recovery. There are some situations where termination is necessary without treatment completion, e.g., clients who harass the therapist or make them feel unsafe or someone that the therapist thinks that they have gone as far as they can go with. A key question in the termination is what is in the client's best interests? If a client is harassing a female therapist in some form, perhaps it is in the client's best interests to work with a male therapist where this dynamic will not prevent treatment. If the client is not making progress, this issue will surface in the therapy and therapists can suggest getting a second opinion (in my experience, no one has followed through on this), taking a "break" from the current therapy arrangement, adding a different type of therapy (like group, individual, or family therapy if these have not been used), or increasing the intensity of therapy (such as two or three times a week, intensive out patient or residential therapy).

Attraction by clients towards therapist and therapists towards clients is an area of treatment that is not often discussed. Pope and Tabachnick (1993) reported that 87% of therapists report attractions to clients, which means that virtually all therapists will deal with this issue. In sex and love addiction treatment, it is important for therapists to be aware of and comfortable with their own sexuality and attraction templates. Since most therapists have psychological vulnerabilities and weaknesses (Barnett, Baker, Elman, & Schoener, 2007), part of our health and wellness program needs to include our own recovery process. For this reason, many ethics and continuing education programs for professionals emphasize wellness and self-care much more than in the past.

Not attending to family-of-origin issues can lead to having a “blind spots” such as attraction to clients. One therapist was blind to same sex attractions and became entangled in a dual relationship with a client due to her inability to see that there was more to the client’s positive feedback than simple appreciation of the therapy process. Because she was opposite sex oriented, the therapist did not recognize that the client was responding to seductive words and actions. Another therapist found himself in the situation where a female sex and love client indicated that she desired a sexual relationship with him. Since she was an incest victim, he realized the closeness of the therapy interaction triggered her abuse history in a way that she did not realize. He needed to make therapy a safe place by indicating that sex would not be a part of their relationship under any circumstances.

Fear is another important feeling in the therapy relationship. Clients have many fears, which become the subject of many sessions. Therapists also have fears, e.g., physical harm to you or client suicide. In his research, Pope found that 40% of therapists

report at least one assault and 97% fear a client's suicide. In fact, some clients think about therapists' fears. One recently asked me if my chair was closer to the door because I was afraid of being attacked? Actually, my chair is closer to the door because my desk is next to the entrance and being closer to the door never occurred to me even though, years ago when I worked at a community mental health center, I had been assaulted while on crisis duty by a client's boyfriend when I was unable to help her get hospitalized (and did have the seat farthest from the door).

Suicide goes with the territory of being a therapist. In my experience, sex and love addicts are not more suicidal than other people with mental health issues, but, when consequences hit, probably two thirds have at least suicidal ideation. Carnes (1991) found " 17 percent of addicts surveyed attempted suicide; 72 percent were obsessed with the idea." (p.93) Most therapists are clear that they need to act if there is a clear danger to the client or someone else. One story was of a client who came to say goodbye to his therapist and had a gun in the car. The therapist asked for the gun and drove the client to the nearest psychiatric hospital. Passive suicide like not taking diabetic medication or hoping to die is more challenging to deal with. Some clients engage in high-risk sexual behaviors, which while not clearly suicidal, are life threatening. Having a strong therapeutic alliance is the most powerful weapon at a time like this. Safety contracts, more frequent contact, and encouragement to get support are all useful strategies. The lawyers and risk managers emphasize the need to keep good notes of incidents like this that include showing that the therapist has weighed the pro's and con's of various efforts to help.

Danger to others in the form of homicide is less common. A duty to warn exists if the victim is known and the client will not agree to a safety plan or more intensive treatment. Often victims are not known, so nothing proactive can be done. Consultation and good note taking are in the self-interest of the therapist. A more frequent dilemma with sex and love addicts is putting partners at risk through high-risk sexual behaviors. In cases like these, agreeing on keeping partners safe and full disclosure are important elements of the treatment. Often, this is an issue when sex and love addicts are HIV positive or have Hepatitis. Therapists should consult legal counsel and senior professionals regarding a possible duty-to-warn the at-risk spouse in their states versus the privacy requirements of federal health information laws.

Power/control issues are frequent areas for struggles with sex and love addict clients, especially early in treatment. Twelve Step recovery emphasizes the importance of “surrender” in the first three steps with admitting “powerlessness” as the initial part of the first step. While letting go to gain control is paradoxical, it works (in Alcoholics Anonymous there is a slogan, “surrender to win”). Unfortunately, many clients and professionals get hung up on this process. Therapeutic relationships, as indicated in the section on counter transference, have the potential to reenact unhealthy family-of-origin dynamics for both the client and therapist.

A prepared therapist knows his or her vulnerability to issues around power and control. For example, a manipulative client attempted to control the therapist in a situation where an evaluation had been mandated by his employer. He sought to appear cooperative in order to get a back-to-work letter from the therapist, but he was obviously superficial, guarded, and withholding. Like many sex offenders, he shared only what the

therapist all ready knew from the work referral source. The therapist walked the fine line between rejecting his as a potential client and simply cooperation with the sham of the evaluation.

While most sex and love addict clients know to refrain from romantic and sexual relationships with other clients, there are rare occasions when this happens. One therapist described such a situation where two group members wanted to date. They kept their relationship public and it ended fairly quickly, so there was no need for formal intervention by the professionals. Some practices have formal (written) practice rules such as dress codes and ‘no romantic or sexual relationships with other clients’ that clients sign off on at the beginning of treatment. Again, the central issue is keeping the clients’ needs first. Formal rules may create clear boundaries, but they may also communicate self-interest on the part of the professional. Sometimes these issues are better dealt with as they come up where they can be framed as therapeutic issues.

Professionals can feel “devalued” by clients in ways that trigger unhealthy responses. One area where this can be played out is with payment. When a client makes promises they don’t keep or run up a large bill, the therapist may find themselves wanting to “make them pay” literally or figuratively. While these feelings are disturbing to the therapist, they can be the basis for constructive interventions that leads the therapy to a deeper level. Other areas where this comes out is in not following suggestions, responding negatively to input, critiquing the therapy process, and questioning the professional’s credentials. Many sex and love addict clients have grown up in homes where there were powerful shame/blame games being acted out between their parents and/or between their parents and the children. The narcissism of addiction quickly

collapses to the underlying self-hatred in most cases, so clients can unconsciously induce feelings of being worthless and powerless in the therapist. Again, this is an opportunity for growth for the client. Professionals may need consultation or supervision to take the most advantage of such an opportunity.

Another variation of the issue of power and control in the therapeutic relationship is the topdog/underdog dynamic. Most people can be seen as either “top dogs,” i.e., aggressive styles or “under dogs,” i.e., the passive style of relating. In therapy, this style can be identified and clients can develop the capacity to vary their style depending on their needs and the requirements to the relationship. While it is a gross generalization, many sex and love addicts present as underdogs due their shame and the secrecy surrounding their addiction. Often, the keys to the development of this style can be found in the “script” of their acting out. For example, one kind, helping professional was secretly turned on by fantasies of domination that grew out of a childhood experience with a dominant parent whom they had to please in order to feel good. In their secret life of addiction, the roles were reversed and the person could experience the power of the top dog role.

Ethical issues arise with sado/masochistic clients and with clients who are involved with “D/s lifestyle” (dominance/submission) and have bondage fantasies (and behaviors) in terms of the tendency to pathologize or impose values. Respecting human dignity and freedom are primary goals of all ethical principles. The American Psychological Association’s Ethical Code includes: “Principle E: Respect for People’s Rights and Dignity. Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.”(1992) This

principle can be hard to follow when the person in front of you is obviously harming themselves and putting their life at risk. Therapists can use their anxiety and feelings of powerlessness to give feedback to clients about what being in a relationship with them is like, especially when they are in an active addiction. Consultation and therapy help professionals deal with feelings that can derail proper treatment.

Undue influence can be a potential ethical and legal problem when therapists don't give patients a real choice about attending groups or workshops, buying their books, or enrolling in residential programs recommended by the therapist. Helping professionals have a great deal of power in the therapy relationship and it is important that they know and keep in mind that clients will want to please (or frustrate) them. Sex and love addicts suffer with profound feelings of unworthiness and shame, so they can engage in people pleasing often without knowing their own vulnerability. Likewise, they can resist reasonable suggestions aimed at what is best for them in a way that can evoke frustration and hopelessness in the therapist. Additional therapies or activities that will enhance the professional's income need to be well grounded in the needs of the client.

Values, as mentioned above, can be a source of conflict and ethical problems in therapy with sex and love addicts. Values clarification can be helpful for both the client and the professional. One typical problem with sex and love addicts is the question of requiring attendance at 12 Step meetings or a recovery orientation to engage in treatment. Making this a requirement rather than a suggestion or source of discussion about resistance could set the therapist up for complaints about abandonment, competence, rigid boundaries, inappropriate management of transference, and malpractice. While the therapist might be validated by the ultimate outcome of the complaint or legal process,

the cost in terms of having to report the complaint for the rest of the professional's career may not be worth the value of making such a demand of a client. Again, the question of who benefits from such a stance is the ultimate question.

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1998 and The McCain-Edwards-Kennedy Patients' Bill of Rights Senate bill in 2001 (S.1052) are aimed at providing comprehensive protections to all Americans in health plans (U.S. Patients' Bill of Rights, 2008). Efforts like these are intended to develop awareness of power inherent in the professional role and provide balance and empowerment to clients who can feel powerless in relation to a health care professional. Treatment professionals need to be knowledgeable about the difference between the power inherent in their professional role and personal feelings of being powerful that can be enacted in harmful ways in the therapy process. In a consultation, a seasoned professional advised a colleague to adopt a powerless role in relating to a sex and love addict who idolized a former therapist who had been stripped of their professional license for abuse of power. Needing to be right can be seductive especially in a situation where other colleagues are presented as being more competent or having special abilities. A client in a situation like this might unconsciously pull for reenacting the previous unhealthy relationship.

Competence is important to both the client and the therapist. Many clinicians who work with sex and love addicts seek certification to establish credibility in treating this population by earning the Certified Sex Addiction Therapist (CSAT) designation offered by the International Institute for Trauma and Addiction Professionals (IITAP). Generally, professional associations and states offer certification in addiction treatment,

but this usually covers chemical dependency and not behavioral or process addictions. Before the CSAT, many therapist obtained addiction certifications in order to demonstrate competence in the area of addiction treatment. However, even certified therapists can be accused of incompetence if something goes wrong in the treatment process and a board complaint or a malpractice suit is filed.

The best ways to protect against such complaints and provide the best treatment are to continue to learn and to make your work public. These can be achieved by obtaining second opinions, supervision, or consultation from peers and senior clinicians. Working with other professionals can help prevent the myopia that can come with solo practice, e.g., having another professional run group therapy or treat couples of clients that you work with. Attending continuing education, professional reading, giving presentations to other professionals, or writing can be opportunities to get the needed education and feedback about your work to maintain healthy competence. Belonging to professional associations may reduce incompetent practice. In Pennsylvania, only about half of licensed psychologists belong to the state association, but the rate of licensing board complaints is less for those who are members of P.P.A. than for those who are not. Caudill (2002) highlights areas like “using techniques without proper training,” “failure to obtain an adequate history,” and “failure to obtain peer consultation” in his list of common errors that can lead to client complaints about competence and malpractice lawsuits. If the legal standard is what would other professionals do, what is the standard of care for this particular problem?

Codependency may be the polarity to incompetence in the area of ethical concerns. In codependency therapists do too much. Doing too much, giving “110%,”

being loose about boundaries can lead to ethical violations, especially when it leads to resentment. As noted earlier, helping professionals are more likely to have come from dysfunctional families and to have taken on the family “hero” or helper roles. Practicing with a new procedure or in a new area can make a professional proud and identify them as “on the cutting edge.” Where pride goes before a fall is where the therapist loses sight of putting the clients needs first. If a new intervention is used, it should be used with caution and identification of its limitations, e.g., “this is a new way of helping sex and love addicts, let’s experiment and see if it helps you.”

Professional ego, grandiosity and narcissism (our own needs) can come into play to the detriment of the client. A “new” treatment paradigm for codependency was developed by a group in Pennsylvania identified as “Genesis” which evolved into a therapy cult. They “discovered” a way to treat codependency that required cutting off ties to all who were not in treatment with their leaders. Then, their leaders felt persecuted and misunderstood when these professionals were sued by their victims (former cult members) and their professional licenses were revoked. Some professionals consider sex and love addiction as unproven and lacking in scientific rigor due to its lack of inclusion in the professional “bible,” the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994).

Some professionals consider Twelve Step programs as a “cults” because of the special language and relationships that can come out of meeting attendance. Professionals combining Twelve Step involvement with sex and love addiction treatment may be viewed as stretching the boundaries of competence, especially if these therapists think (even just to themselves) something like, “we’re too advanced. Other professionals

don't appreciate us." Again, exposure to other professional's views is a healthy antidote for unhealthy narcissism.

Treatment Dynamics

Disclosure of a sex and love addiction is an important and difficult process for the addict and those close to him or her. While Corley and Schneider (2002) have "written the book" about this process, it deserves mention because of its potentially explosive nature. Some disclosures are quite public with arrests and/or publicity, but most of the time, the disclosure comes between an addict and his or her partner. Often, especially these days with the Internet, sex and love addicts are discovered due to their online activities. Usually partners have some idea that there are sexual and emotional problems, but sex and love addicts go to great lengths to keep the extent of their addiction hidden. When sex and love addicts come into treatment, decisions need to be made regarding full disclosure, if nothing has happened, or managing the amount and nature of the material that has been disclosed as well as partner's responses.

The national organization devoted to sexual addiction and compulsivity, the Society for the Advancement of Sexual Health (S.A.S.H., 2007) has a policy regarding disclosure entitled "Disclosure of Sexual History." This statement concludes with "overwhelmingly, couples who have put their relationships back on track after the crisis of the addict's extramarital sexual behaviors tell us that honesty is the key foundation to the survival and growth of their relationship," so the honesty and openness of a full disclosure is encouraged. Ethical practitioners will do well to follow the advice given here and in the Corley and Schneider book since complaints are usually judged by the

“standard of care,” i.e., what other professionals would do in that situation. Again, careful records, especially a list of pro’s and con’s, as well as consultation with other professionals will insure best practice in this challenging area.

Interventions are used to confront addicts with their out-of-control behavior. Perhaps President Gerald Ford and his family did the most famous intervention when they confronted his wife Betty with her drinking and prescription pill abuse. Her subsequent treatment lead to the founding of the Betty Ford Center which is internationally known for treating chemical dependency (The Betty Ford Center, 2008). Success stories like this are gratifying, but there are also failed interventions that have the potential to lead to complaints against therapists.

Triangulation was used by Karpman (1968) to describe the problematic triangular relationships between a victim, a perpetrator, and a rescuer. A surprising dynamic, which seasoned professionals recognize, happens when someone attempts to rescue the victim from the perpetrator. Sometimes, the roles shift and the victim acts to protect the perpetrator and the rescuer is labeled the “bad” person or perpetrator. An example of this would be a domestic abuse victim who defends the perpetrator, perhaps saying “I provoked the attack,” and attacks the person trying to help, possibly saying, “it’s none of your business; leave us alone!” These unhealthy dynamics can often be played out in relationships with participants who have experienced trauma (Carnes, 1997). Professionals need to approach intervention with an awareness of the potential for which these efforts may be seen by clients or their families as not in the client’s best interests.

Diagnosis is important in the formulation of treatment plans since knowing what the problem(s) is defines how to deal with it. As mentioned earlier, sex and love

addiction is not formally recognized as a diagnostic category, but it has become well known enough for over fifty books to be published on the subject. The S.A.S.H. website lists over 30 of these. With any diagnosis or classification, the concern is with false positives and false negatives, i.e., identifying a client as a sex and love addict when they are not (false positive) or not classifying a client as a sex and love addict when they are (false negative). Pope and Vasquez (1998) found improper diagnosis to be the 5th cause of malpractice suits and Caudill (2002) had it 4th on his list of therapists' pitfalls.

While there is not scientific data to use to determine accuracy of diagnosis, a professional specializing in sex and love addiction is most likely vulnerable to over diagnosing (false positives) and a professional unfamiliar with the concept or treatment is most likely to under diagnose (false negative) the problem. In clinical practice, it is more common to find sex and love addicts who were seen and not diagnosed by other therapists, e.g., clients who had marital therapy after an affair was discovered but never told the whole truth about their sexual activities outside the marital relationship. Occasionally, a client comes in believing they have a sex and love addiction but after some exposure to treatment and recovery, they find that they do not identify with the obsessive and compulsive nature of the addiction. Ethical practice would require being open to both false positives and false negative and to focus on developing an agreement on what the problem is with the client. When difficulties in perception or agreement arise, consultation, a second opinion, or providing referrals are useful strategies.

One issue that comes up in sex addiction treatment is reporting a sex addiction diagnosis to insurance companies. Because most sex and love addicts have co-existing problems with depression and anxiety, these diagnoses usually suffice to trigger medical

coverage. Insurance company reviews get more complicated since many sex and love addicts do not want their sexual behavior included in computerized, medical databases. Some clients, and clinicians as well, choose to avoid this problem by not using insurance coverage at all, while others follow the policy of sharing as little information as possible while insuring access to health benefits. Client choice in this area is useful although most clients are naïve about the amount of information given to insurance companies. A particular difficulty can arise when a client's company self-insures. Barriers should exist to protect the client's private medical information, but clients need to know that there is some risk involved.

Other Issues

Fees can be a source of conflict and lead to complaints. Pope and Vetter (1992) found that fees were the 3rd typical ethical dilemma for psychologists. Most helping professionals have little or no business training, so managing money such as fee setting, collecting, and managing are areas of practice that they have little knowledge about. Many are uncomfortable asking for money for their services. Some have unrealistic expectations about the value or worth of what they do for their clients. Fees and billing practices should be clarified early in the therapy relationship. Some do this over the phone before the first visit. Some make it part of the written material given to clients about their practice. Some review financial expectations in the first session. Some have clients sign financial responsibility agreements. Some male clients report feeling triggered by giving a female therapist money because it reminds them of paying prostitutes.

Professionals need to recognize that setting and collecting fees is a potential area for reenactment for both clients and therapists. Financial problems may be a reenactment of or reflecting their lack of worth and/or yours. It may be their authority issues and/or yours. Whatever practice the professional prefers, it is important that they knowing their limits, e.g., no fees are allowed to accumulate higher than \$500, and that they not act out their own issues with value or authority with the client around their fees. Anger about fee problems (yours and/or theirs) can trigger complaints and malpractice complaints. A small claims court filing could trigger counter suits that in the long run are more expensive both in legal fees and personal stress. Dealing with these issues directly, with compassion and understanding, can prevent more serious complications further down the road. On a professional email list, the issue of uncollected fees arises from time-to-time and almost universally, other professionals advice the complaining therapist to forget collecting the money and learn the lesson to deal with the problem before it gets to the point where they want to pursue collections or small claims court.

Another wrinkle in the fee area is when patients solicit unethical or illegal (fraud) behavior by asking you to bill insurance companies for missed sessions or incorrect procedures, e.g., online or telephone consultation as face-to-face treatment. While most therapists would quickly dismiss such an idea, a professional who is under financial or other stressors might fall into rationalizing, “just this one time” or “no one will know.” Some professionals do not need patients to suggest unethical and/or illegal behavior around fees. Pope and Vasquez (1998) elaborate on the many types or justifications and rationalizations used to excuse these unethical and illegal behaviors.

Records can be a source of concern for professionals. Caudill (2002) listed one of his pitfalls as failing to get adequate records. While there are many systems, each professional needs to find a method of record keeping that protects him or her and their clients. Typical recommendations include the time, date, goals, interventions, and outcomes. Adequate records also reflect the professionals efforts to engage in ethical practice, e.g., these records include pro's and con's lists around ethical issues, consultations, and any other documentation of ethical concerns. A surprisingly common problem is not keeping notes at all. Records need safe storage, so professionals need to know their state and professional requirements for the length of time to keep records. They also need to know when and how to destroy their records, e.g., in a professional will, a therapist can designate another professional to act as their executor and instruct them as how to deal with their records (Pope & Valesquez, 2005).

Another concern that comes up is who owns the record? The professional or the organization that the professional works for owns the record. Clients can access records, e.g., a clinician can sit and review the record with the client but not give them a copy. Courts or other professionals can obtain copies of records with proper permission from the client or a court order. Generally, it is not in the best interests of a client for them to have a copy of their records. Often, the information in the record is written by and for other professionals and is not easily understood by a non-professional. Also, records can accidentally get into the hands of others and be damaging to the client.

Credentials and how a professional presents him or herself can be misleading, unethical, and occasionally fraudulent. Some therapists want to exaggerate their educational credentials, e.g., listing "all but dissertation" or "Ph.D. candidate" rather than

the degrees that they have completed. It is important that professionals market themselves accurately to clients and other professionals. Therapists who are in supervision or are unlicensed need to communicate their professional status to clients. One way to approach this is to include it in an information packet given to the client at the first session so that they have documentation of the expectations for both parties that they can review at another time. Some counselors have the client sign off that they have read the procedures for therapy so that issues like fees can be addressed more confidently. This information can include supervisor, licensing, and certification board contact information for clients who may wish to file complaints.

Unethical Behavior in Colleagues

Dealing with unethical and illegal behavior in colleagues is quite difficult. Many professionals ignore situations like this because they do not know what to do or are afraid of the consequences of taking some action. For psychologists, our ethics code suggests that we talk to the person who may be engaged in an illegal or unethical behavior. For example, if a therapist became aware that a colleague was billing insurance companies for individual sessions while providing group therapy, there would be a need to do talk to the person doing the fraudulent billing. This is, of course, the most difficult part and may require that the person get support from another colleague or a consultant on how to approach the situation. Some professional organizations and malpractice insurance companies have professional officers or lawyers who are available for such consultations. A hypothetical consultation is also possible where you present a case as a hypothetical situation and ask for the best ways to respond. These days, many professional

organizations have email lists that allow for almost instantaneous consultation with a large number of peers. Ignoring an unethical or illegal situation or procrastinating about what to do may provide some immediate relief, but such sidestepping will lead to guilt feelings and being burdened in an unhealthy way with another person's problem behaviors (Karpman's triangle, 1968).

Discussion

The author began this paper with some references to his own experience as the impetus for the focus on ethical issues. His initial introduction to addiction treatment came at a chemical dependency hospital that had a Twelve Step approach. After graduate school, he worked in an inpatient chemical dependency program and attended lectures given by recovering staff who lived Twelve Step recovery which made this approach to addiction come alive, especially after so little was covered in his academic training. When he was introduced to Twelve Step addiction recovery with compulsive sexual behaviors, the application made sense to him. Since then, he has been exposed to other definitions and treatments for sexual compulsivity, which expanded his understanding and repertoire of therapeutic interventions, but have not changed his primary approach.

Ongoing ethics training is a necessity, and usually a licensing mandate, for all therapists. Even professionals who do not specialize in sex and love addiction will benefit by exploring the many dimensions of ethical practice. Expanding education for professionals about sexual addiction, especially the complicated ethical dimensions, is important for graduate and professional schools and continuing education programs. The format presented here is one way to conceptualize these issues. It might also be helpful

to identify a broader range of ethical dilemmas that arise when treating sexual addiction followed by more in-depth discussion of particular examples.

Conclusion

Sex and love addiction treatment involves complex ethical issues. A therapist's awareness of these potential problems can help them in improving their efficacy and, at the same time, reducing their risk of ethical or legal complaints. Ethical difficulties flow from failure to recognize the fundamental principle that counseling is a fiduciary relationship. Sex and love addicts present with multiple addictions, strong psychological defenses, and trauma histories, which can result in lengthy treatments. As we have examined, over the course of such treatment challenging ethical areas surface including transference/counter-transference problems, evocative and provocative behaviors in clients, questions of therapist self-disclosure, confidentiality concerns, trauma reenactment possibilities, boundary issues, dual relationship questions, competence issues, diagnostic dilemmas, and fee problems. Positive resolution of these ethical areas produces the best result for both client and clinician.

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