

## **Ethical Dilemmas Related to Disclosure Issues: Sex Addiction Therapists in the Trenches**

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*Therapists who treat sex addicts are often faced with ethical dilemmas. Almost every therapist has encountered some unexpected dilemma that has put us in a quandary and by its very nature calls for decisions that could challenge our code of conduct. In this article the authors describe several types of ethical dilemmas related to disclosure. The focus is on revelations made by the patient, the therapist or a third party. Disclosure was chosen as a focus of this paper because of its potential consequences and the possible risks when handled inappropriately. The authors illustrate their findings with insightful examples and give a broad range of possible solutions while describing the potential positive or negative outcomes. They give their opinions and their collective wisdom based on their own research and clinical practice. Several therapists also contributed to this article by generously stating their experiences.*

### INTRODUCTION

Ethics as discussed in this paper relates to a code of conduct that should be followed by all treatment providers. It implies the highest standard of care and protects the community and the treatment provider. Some believe it implies the difference between right and wrong. Ethical issues are inevitable when counseling sex addicts. The possible scenarios are so diverse that it is likely every therapist has faced an unanticipated ethical dilemma and has had to work out a solution in the moment. It would be far better to have given thought to these quandaries in advance and to have some guidelines

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for one's actions. This paper describes various categories of ethical dilemmas involving disclosure of secrets, and presents the authors' recommendations for dealing with them. Although many of these dilemmas have both ethical and legal dimensions, our focus is on the ethical aspects, which often are less clear than are legal guidelines. Moreover, legal mandates may vary with the state and country in which the therapist practices, so the therapist is advised to become knowledgeable about the laws of his or her place of practice. The solution to ethical dilemmas, however, is more generally applicable.

This paper is based in part upon a workshop given by the authors at the October, 2004 national conference of the Society for the Advancement of Sexual Health (SASH), and also in part on a similar workshop presented at the same conference a year earlier by one of the authors (JPS) together with Bill Herring. The focus of both workshops was to work out practical solutions to clinical problems involving disclosure of secrets.

## REVIEW OF THE LITERATURE

Relationships between helping professionals (such as physicians, counselors, therapists, lawyers, ministers, or teachers) and those they serve have always been seen as having special significance and meaning. In each case, there is a power differential, and the person in lesser power assumes that the professional will act in the best interests of the one who is to be helped. In each profession, unfortunately, there have been many cases in which this was untrue. For this reason, professional organizations have increasingly been concerned with clarifying their position on ethical issues between professional and client, and in recent years most have issued detailed position papers spelling out the appropriate role of the professional. Model Rules of Professional Conduct have been published by the American Bar Association (1998), American Medical Association (2000), American Psychological Association (2002) American Psychiatric Association (2001) and National Board of Certified Counselors (2002). Many books and articles have been written to address various ethical issues in the helping professions, such as sexual relations and other boundary violations between professional and client (patient, parishioner, student), for example, Irons and Schneider (1999); the role of touch in psychotherapy, for example Hunter and Struve (1998); disclosure to patients about medical errors (Mazor, Simon, & Gurwitz, 2004; Gallagher, Waterman, Ebers, Fraser, & Levinson 2003); and a feminist perspective on ethical decision making in therapy, for example by Rave and Larsen (1995). Regarding specifically the ethical issues involved in the area of disclosure of secrets, Corley and Schneider's book *Disclosing Secrets: When, to Whom, and How Much to Reveal* (2002b) discusses some of the dilemmas to be addressed in this paper.

An excellent guide to the various core concepts of ethical practice in counseling sex addicts was presented by Bill Herring (2001), who cogently discussed ethical issues in the areas of informed consent, the therapist's

**TABLE 1** Ethical Dilemmas Regarding Disclosure of Secrets in Therapy

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I. Information originating with the client
a. One client in couples' counseling discloses to therapist an affair or another secret not known to the partner
b. Client discloses behavior that has harmed, or may harm another person, adult or a minor; such as a having unprotected sex despite positive HIV status, or sexually exploiting a patient, client, or parishioner in the course of a professional relationship.
c. Client discloses illegal behavior.
d. Client discloses boundary violations with a therapist seen previously.
e. A family member requests information about a former client, now deceased.
II. Information originating with a third party (another client, another therapist, law enforcement, 12-step program)
a. Information indicating the client is lying.
b. Information indicating the client is at risk of harming others.
III. Information originating with the therapist
a. Therapist's beliefs—politics, ethics, etc.
b. Therapist's addiction history
c. Therapist's sexual orientation
d. Other

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competence, confidentiality, duty to warn/protect, HIV disclosure, when to report sexual behaviors with minors, confidentiality issues regarding families of clients, maintaining appropriate boundaries, counselor self-disclosure, touch, sexual attraction, recovery boundaries, supervision, and clarity of values. The reader who wishes to learn about these concepts is referred to Herring's paper.

### Ethical Dilemmas

In an attempt to make more coherent the diverse dilemmas the therapist may encounter regarding disclosure of secrets, we have organized the discussion around the source of the information, which may be the client, a third party, or the therapist. Case examples will illustrate the dilemmas summarized in Table 1.

#### I. INFORMATION ORIGINATING WITH THE CLIENT

##### a. One Client in Couples' Counseling Discloses to Therapist an Affair or Other Secret Not Known to the Partner

The classic issues involving disclosure or nondisclosure of an affair during couples counseling have been discussed in the marriage and family field, where the recommendations are typically situational. For example, noted affairs expert Shirley Glass wrote, "It is inappropriate to conduct conjoint marital therapy when there is a secret alliance between one spouse and an extramarital partner that is being supported by another secret alliance between the involved spouse and the therapist." Nonetheless, she *is* willing to see the couple without addressing the affair if the affair is first terminated (Glass & Wright, 1992).

In considering the effect of disclosure in a situation *when addiction is not present*, the answers to the questions that follow can help a therapist decide what recommendations to make about disclosure (Corley & Schneider, 2000b).

- Is the affair over?
- Does the client still have any contact with the affair partner?
- Does the client still have strong feelings about the affair partner?
- How did the affair impact the couple's relationship?
- What lies were used to cover up the affair?
- Is this the only affair the client had, or was there a recurring pattern?
- Does the affair have any current impact on the couple relationship?
- How comfortable does the client feel about ongoing concealment?
- What is the meaning for the client of disclosing or not disclosing?
- What does the client believe will be the positive as well as negative consequences of disclosure (to himself, to the spouse, to the relationship?)
- What does the client believe will be the positive as well as negative consequences of continuing not to disclose?

The previous list does not, however, mention the impact on the therapist of doing couple counseling while holding such a secret. This issue will be discussed in a separate section that follows.

When making the disclosure there are many different frameworks that therapists adhere to, depending on their training and experience. Some ask the addict to reveal broad general outlines and others ask him to get very specific regarding types of sexual activity that took place, the financial outlay, number of times the particular activity occurred, the time frames, and the lies the addict told to cover the behavior.

Sometimes the therapist asks the addict only to disclose sexual behaviors that took place since the couple knew each other whereas other therapists may encourage disclosure of relevant information of their entire sexual history. This may be an area that can be quite shameful for the addict and very painful for the partner. Consider the addict who may have had sexual contact with a younger sibling and is afraid to tell his partner for fear the spouse may think he will abuse their own children. It is also a dilemma for therapists practicing in a state that has laws requiring the therapist to report sexual abuse, no matter what the time frame. This is true, for example, of Texas, yet the Texas criminal code sets the statute of limitations as 10 years after the victim is 18. What should the therapist do ethically in the face of these different statutes?

We believe that, barring unusual circumstances, disclosing past sexual behavior will not only enlighten the partner but additionally, give them the information they need to accurately process the information. For example, when a person learns that their partner is a sex addict, the person will usually

ask if the addict might be a child molester. It is best to deal with this directly. Another area of concern is the disclosing of same-sex addictive behavior, which can be another area of resistance for the addict. The partner has a right to know about this, since this could be indicative of a struggle with the addict's sexual preference. It is another question that the partner usually asks and once again, it is best to discuss this openly.

In the context of addictive sexual disorders, there are two unique factors that significantly impact the disclosure process:

1. The sexual acting out has been repetitive and the betrayal and lying egregious. Even when the presenting problem is a single affair, there generally is a hidden history of other affairs or additional sexual acting out.
2. The most widely used model of recovery from addiction, based on the Twelve Steps of Alcoholics Anonymous, is confusing. On the one hand, the program requires "rigorous honesty." Disclosure is often an aspect of making amends, beginning the process to right wrongs. Yet, step nine cautions against making amends to those who have been harmed "when doing so would injure them or others." (Alcoholics Anonymous, 1953). Thus, it would seem that at times honesty is not the recommended course. (Corley & Schneider, 2002a).

Addiction authors have generally supported disclosure, but the ethical issues remain. For addiction counselors, the key ethical issues facing the therapist who learns of a client's secret are:

- Effect on the clients if the secret is revealed
- Effect on the clients if the secret is not revealed
- Effect on the therapist and on the therapeutic process if the secret is not revealed.

### Effects on Clients if the Secret is Revealed

Disclosure is understandably a very stressful process for both sex addicts and their partners. Addicts report initial worsening of the couple relationship, guilt and shame, anger from the partner, loss of trust by the partner, a cessation of the sexual relationship, and damage to other relationships such as with children, parents, or friends. Partners report initial worsening of the couple relationship, depression and even suicidal thoughts, attempts to compensate for the pain with acting-out behaviors such as drug and alcohol use and sex, loss of self-esteem, decreased ability to concentrate and/or function at work, feelings of shame and guilt, distrust of everyone, anger and rage, fear of abandonment, physical illness, and lack of sexual desire (Corley & Schneider, 2002b).

At the same time research shows that over 80% of partners and more than 60% of addicts report that at the time of disclosure they felt it was the right thing to do. With additional time in recovery, 96% of addicts and 93% of partners concluded that it was the right thing to do. (Schneider, Corley, & Irons, 1998). This was true even though a majority of partners threatened to leave at the time of disclosure. Positive outcome of disclosure for addicts included:

- Honesty
- End to denial
- Hope for the future of the relationship
- A chance for the partner to get to know the addict better
- A new start for the addict, whether in the same relationship or not
- Decrease in stress

For the partner, the most significant positive outcomes from disclosure were:

- Obtaining clarity about the events of the relationship
- Validation that they are not crazy
- Hope for the future of the relationship
- Finally having the information necessary to decide about one's future

Most therapists agree, however, that there are times when it's better for the client not to reveal the secret to the partner. Sometimes there are gray areas, and one therapist may differ from another on whether disclosure (full or partial) would be appropriate. Some such situations might be:

- When the spouse is physically or mentally ill and the therapist agrees that the spouse would be unable to utilize or deal with the information.
- When the secret would cause great damage, such as the potential for physical violence, or if the affair involved a close family member such as the spouse's sister and disclosure might destroy the extended family. (Each decision regarding family members must be considered cautiously. There are times when disclosure is advisable, and times when it would be extremely detrimental)
- When the behavior occurred long ago, the client has worked it through, the current relationship was not affected, and the information would be very upsetting to the spouse.
- When the spouse's religious or other beliefs would preclude any willingness to reconcile if such information were divulged.

Disclosure vs. nondisclosure is a very difficult topic. We believe there are only a handful of situations where nondisclosure would be the best course of action. In general, the addict is likely to use every excuse not to tell, and the therapist must be able to discern legitimate concerns from the addict's

generalized need to maintain secrecy. A decision not to disclose needs to be thoroughly evaluated, the client's motivation assessed, and the likely outcomes considered.

### Effects on the Sex Addict Client if the Secret is Not Revealed

Part of the disease of addiction is the tendency to lie and keep secrets. This can become such an integral part of the addict's behavior that he or she may lie even about things that don't matter. Recovery, therefore, urges "rigorous honesty." The general principle is that for the addict's recovery, it's a good idea to disclose secrets. If the addict decides not to reveal a particular secret to the partner, the therapist and addict need to discuss the effects on the addict of not revealing the secret. Does the addict feel shame about the nondisclosure? Is the secret like the "elephant in the living room" of the couple's relationship, something that is not discussed but which clearly affects the couple?

When the secret involves remote events, the therapist should discuss the context with the client. But, what will be the consequences of *not* telling? Is the addict going to feel remorse by withholding something from the spouse? Ask the addict what he or she thinks about the disclosure. What will be the consequences of disclosure, and of nondisclosure? Clarify with the addict, and then decide whether to do it. As one therapist explained,

I usually do encourage the addict to disclose. I make the point that this is a disease, it's not about the spouse at all, and it gives the spouse a chance to see how big a problem this has been all along. It's not just about her, or him, and he or she gets to make a decision on the basis of the truth, not just on part of the story.

### Effects on the Spouse if the Secret is Not Revealed

Over the duration of the sex addict's disease, the spouse has usually been the recipient of multiple lies. Co-addicts become very reactive about being lied to. In recovery, Schneider & Schneider (2004) advise the addict, "Be honest in the small things on a daily basis, and your spouse will be more likely to believe you about the big things." (p. 116). For spouses to rebuild trust in the addict, rigorous honesty—day after day—is essential. When couples in recovery go to marriage counseling, rebuilding trust is usually a major issue.

Staggered disclosure can be a big obstacle to rebuilding trust. When the addict claims initially to reveal all the relevant facts but actually withholds the most difficult information, such as an affair, partners report great difficulty in restoring trust (Schneider, Corley, & Irons, 1998). When the affair eventually is discovered or disclosed, as it most likely will be, partners report feeling betrayed and victimized all over again, and the gains made in rebuilding trust will vanish. It is much more beneficial for the addict to risk disclosing initially the broad outlines of all his or her acting out behaviors.

Additionally, it is likely that the truth will eventually come out, either in therapy or at home. When that happens, the deceived spouse will feel betrayed and victimized by the therapist, and the result may be a fatal compromise of the therapist's ability to counsel her at all.

### Effects on the Therapist and the Therapeutic Process if the Secret is Not Revealed.

Significant ethical issues arise for the couple's counselor who colludes with one member of the pair to keep a secret from the other. Brown (1991, p. 56) writes, "I believe that the integrity of the therapeutic process with couples depends on open and honest communication. Nowhere is this truer than with affairs. The therapist cannot be effective while beginning to collude with one spouse over the other. If a spouse tells her couple counselor that she suspects her husband has been unfaithful, and the therapist knows that this is in fact the case but is bound by confidentiality issues, the therapist may be able to do nothing more than ask, 'What makes you think that?' and advise the partner to focus on herself instead of her partner. The ethical therapist is likely to find this an extremely uncomfortable, if not untenable, position."

### Do I See Them Separately, Together, or Both?

Different therapists have different strategies to avoid the triangulation that results from holding a secret with one client against the other. Some therapists decline to have any telephone or personal conversations with only one partner. Others are willing to do this, but announce up front that any information divulged in these individual conversations will not be kept confidential from the spouse and will be open to discussion in the couple session. The advantage of such a stance is that the therapist avoids having to hold a secret given by one partner. The big disadvantage is that the efficacy of the conjoint therapy may be less than optimal because the therapist may be missing a large piece of relevant information, such as that one partner has an ongoing affair, or that one partner is not committed to working on the relationship.

In the ethics workshop, two counselors explained why working with only the information obtained from the client is a disadvantage:

We only know what the client tells us. More than once, after the couple counseling was finished and the couple went through a divorce, I learned from the legal deposition that I hadn't been aware of some very relevant information about the addict's acting out that would have changed the way I would have counseled them.

I've had clients where if I'd treated them without the outside information I obtained; it would have been no treatment at all. In the end, it's helpful to know.

Other therapists do meet individually with each partner, seeking to obtain as much information as possible. The advantage of this stance is that you are more likely to know the real story. The disadvantage is that you may find yourself holding a secret that you are ethically unable to reveal without the client's permission. This situation is fraught with the most difficult ethical dilemmas the therapist will encounter. You will then need to be very careful in the way you counsel the couple in order not to reveal the secret. You will need to have a constant observer in your head, monitoring everything you say. The situation can quickly become very complex. You will need to devote a great deal of energy to having an inner observer who monitors what you say to the couple and what you can do with every piece of information you have. Where did you get it? Are you breaking confidentiality? Can I say this or that? It takes an enormous amount of concentration.

Some therapists who see individuals together and separately explain to them that if any secrets are told in the individual sessions, then the therapist will work with the client individually with the goal of facilitating disclosure to the partner. Some put a time frame on the individual work—perhaps three or five sessions. One of the authors (BL) explains:

I do not put such a short time frame on this. There are times I do not give a time frame to the spouse in order not to put undue pressure on the addict before a therapeutic relationship can be established. I usually ask the spouse to write the questions they have for the addict so I can know what the specific concerns are. If the addict refuses to reveal something that is of concern to the spouse, then I would continue to work with the co-addict and may even have the addict tell the partner that he is not ready to do a full disclosure. This way, I am able to keep a relationship with both parties and support them in their individual therapy. If at some point the co-addict does not want to continue the relationship, I then help the addict to deal with the bigger ordeal, telling the truth or the breakup of the relationship.

If the secret-holding client is unwilling to disclose, then the therapist will decline to continue conjoint counseling. In the ethics workshop, one of the authors (BL) detailed how she deals with this situation:

I'm known in the community for working with sex addiction. A typical scenario is that a woman will phone and say, "I found my husband doing this or that. What do I do?" I talk to her before I see them, to be sure there's no conflict of interest. Then I ask the woman to bring in her husband. If they come in together, I ask the wife to describe what's been going on, I ask the husband to give his perspective. Then I tell them about the treatment I favor, which is a combination of individual, family, group, couple, and COSA and SAA.

I tell them that I will meet with them individually and that in those individual sessions there may be things that they may feel uncomfortable

divulging in the joint session. After that we'll make a decision about how to proceed. I tell them I work two ways: There are times when I'll see everybody and do everything, and there are times when I refer the co-addict out—usually I keep the sex addict. I tell them that the good news is that when I see both the couple and the individual, that I know everything. And the bad news is that I know everything. So you have to make a decision—If you opt to see me together, then complete honesty is the golden rule. If you want to see me as a couple and you tell me something your partner doesn't know and you say you're not going to tell her, I'll work with you for a period of time, but honest open communication is what I strive for. If a reasonable time passes and you are not willing to disclose any acting out or slips, I will stop the couple's therapy and tell you that I believe individual therapy is better at this time. To that end, we'll have a disclosure contract before you even tell me any secrets. One of the reasons I'll decide to stop couples therapy is if one or both or you has a secret. Do you want to see me under these conditions?

This automatically puts the patient in a therapeutic double bind. If the addict says he will not agree to this, then the wife is suspicious from the beginning. If he states that this is fine with him I then may say that a polygraph could be given in certain situations

All this is very time-consuming. I spend a lot of time on rules and structures, making sure, for example, that if one patient tells me the other told her that I said something in the individual session, I don't validate her statement or take sides. That's triangulating. It takes a lot of time if you're seeing people separately, making sure this doesn't happen. I do it because it lets me know everything.

I usually see them individually first and do an assessment and get a relationship with each. I usually don't start couples therapy immediately. I also have a group for men and women, and I might put each in a group immediately. If the couple is in a real crisis at first and can't contain themselves, then I'll do some couples therapy and give them information. I do a lot of didactic work, explaining sex addiction, educating about anger, and trying to support the spouse while not shaming the addict. Usually there is a lot of anger coming from the addict and a lot of denial. If this occurs, the therapist faces the dilemma of not alienating the patient, yet holding him accountable. I try to get a commitment from the co-addict to go to COSA [or S-Anon]. This is difficult, because she often says 'It's not my problem,' so I have to do a lot of education. Once I start couple therapy, I usually see them individually one week and as a couple the next.

Another therapist reported,

I've worked similarly, and I found it's really helpful because in individual therapy sometimes I've gotten one idea about the client, and am really supporting them in ways that are not helpful, because they're showing me a very different part of them than they showed to their partner... I think I should put something in writing that they sign in order to protect myself.

To avoid holding secrets, a therapist who sees clients both individually and as a couple needs to set up the rules in advance. Of course the rules may end up limiting the amount of information he gets.

Another therapist stated,

What I normally do at the very beginning is tell the two partners that our individual sessions are not really confidential from the partner, that the information I get I would hopefully use with discretion and bring back to the couple session. They still sometimes tell me, and then I have discretion on how to use that in the couple counseling. So I try to set it up to where I don't get into a triangle of withholding information from a partner. If it happened and I felt the partner needed to know, I'd say, Either you tell them or I will. Usually if they've told me, it's because they wanted to get it out.

A therapist who sees clients together and also separately takes a slightly different twist, putting the responsibility squarely on the client:

I tell them right from the beginning, If and when I meet with either of you individually, you need to know I'm not going to be the go-between. I'm not going to relay things for you or against your will. If I see something that hasn't been addressed in the couples' session and needs to be, I'll tell you it has to be addressed, and then you have to deal with the fallout.

For example, I'll say to the person [who has disclosed to him an ongoing affair], "I can't work with you if in the couple session. You say, 'I'm done with the affair and I want to restore trust,' but all the while you're still seeing the other person. If they refuse to disclose, then I might say to that client during the couple session, "It seems like you're not on board. What's going on?" And I'll see where it goes from there.

This therapist seems to be walking a fine line, hinting in the couple session at things that were disclosed individually, hoping to precipitate more honesty.

After listening to these explanations, a therapist commented,

I've avoided working with couples. I see only sex addicts, and I don't know that I have the energy for everything that's been described, in terms of the ethical dilemmas which are inherent in it.

Another way of minimizing these conflicts was reported by a counselor who said:

I have a good setup in town. I refer the co-addict to another therapist who likes to work with co-addicts. I usually see the addict and refer

the co-addict. I have group and individual for the addict, and she has group and individual for the co-addict, and we co-therapize the couple. Four people. It's expensive for the couple, but it keeps things really clear.

What about the situation where the therapist has done individual counseling with a client who then seeks couples counseling from the same therapist? One psychologist reported:

I generally do not see a couple if I have seen one of them for individual therapy. But if I do, I make it very clear that by choosing me to provide couples therapy, they are forgoing their confidentiality, and that anything they have said in individual therapy can be brought up by me in couples therapy, especially if they contradict what they said in individual therapy. If they cannot agree to this, then I would not provide couples therapy.

What is clear from the above comments is that despite the different approaches taken by various therapists, all are aware that confidentiality and other ethical issues complicate the work of couple's therapists, especially those who see clients both individually and together. Therapists need to consider all these issues carefully in advance, before deciding on their therapy style and rules. In particular, they need to give careful thought to the benefits and costs of allowing a client to divulge sensitive information to them, and if they do not wish to put themselves at risk of possessing such information, how to minimize the chance that they will be caught in the middle. We believe that no matter what the therapist's style, the therapy will be adversely affected if the therapist holds a secret that is relevant to the couple relationship and does not address it.

b. Client Discloses Behavior That has Harmed, or May Harm, Another Person: A Minor; Positive HIV Status; or a Client or Patient in the Course of a Fiduciary Relationship

#### CHILD PORNOGRAPHY

In contrast to the previous item, the responsibilities of the therapist who learns of actual or potentially harmful behavior are governed by laws (which often differ from state to state) as well by regulations of one's professional licensing board. It behooves all helping professionals to become familiar with the laws and regulations relating to mandated reporting of various behaviors. In this section, however, we will focus on the ethical considerations of such disclosures rather than the legal implications.

Therapists all too often face ethical dilemmas when they learn of behaviors that can potentially harm others. How do you balance your responsibility

to the patient and the need for confidentiality, versus the potential harm if you do nothing? Whether or not the behavior is illegal, the ethical issues are real.

One of the most common issues faced by sex addiction therapists concerns clients who disclose sexual feelings and behaviors related to children. In some situations the activities are illegal and must be reported; in others there is no mandate to report, but ethical dilemmas persist. For example, possession of child pornography is a felony that can lead to a prison sentence, but viewing child pornography is not. Downloading or transmitting child pornography is a serious crime, but viewing it on a website is not a crime. Where does this leave the therapist who learns from a client that he spends many hours viewing child pornography? One therapist reported,

I had a client who'd been viewing child pornography and had pedophilic interests. He told me he had just gotten a job at a group home for children. This seemed to me to be a clearly dangerous situation for the children. Nothing had happened yet, so I couldn't call the police, but I called the supervisor of the program and indirectly said, you may have hired someone recently who may be a high risk for children. I can't be more specific than this, but I'm warning you. So there may be an indirect way you can let the word out without violating confidentiality. It's a risk. My lawyer friend said I should document everything carefully, what I did and why. I assume the program director acted on it. In some states you're mandated to report only if a child comes before you, or if a specific child was abused, but not if someone is at risk. In other states it's different.

One of the authors (BL), who is experienced in working with sex offenders, commented,

I do not know if this is appropriate to do. I believe that some therapists without the proper training in this area may put themselves and the patient in jeopardy.

When a patient comes to me because of thoughts or fantasies about children I do a very careful assessment. If the therapist does not have specific training in the area of deviant arousal or sexual offender assessment, the ethical thing to do would be to refer the client out. If the patient is coming to you and in the course of history taking you discover that he is frequenting child porn sites, then the client must be told of the dangerousness of this activity and the possible legal ramifications. If the patient is in denial and does not want to stop the behavior, then the therapist may have to weigh different options. Is this patient at risk for offending behavior? Is the patient having fantasies that are ego-dystonic or ego-syntonic? Does the patient work or do activities that are high risk? Has the behavior increased in intensity?

I am working with such a patient at this time. He was referred by another patient who is sponsoring him in a twelve-step S program [for

sex addiction]. This man was going to internet sites and looking at child porn. He has an extensive history of interest in young girls and has come close to inappropriate behavior. I made a contract with him and got him to agree to stop all activities with children in his target age group. He is a teacher, but now only a substitute and he works with older age students. He is reluctant to stop teaching altogether. The dilemma is that he has not done anything that is reportable.

I am continuing to work with him intensively. I work with his sponsor indirectly, by insisting that he share WITH THE SPONSOR EVERYTHING and get his feedback. I know the sponsor and trust that he will back up what I am telling the patient. I also told the patient that if I thought he was escalating, I would do what I needed to keep the community safe and that I would tell him before I would report him. I spent at least 2–3 sessions going over with him what I would report and what would be questionable. I had the patient sign the informed consent and other paper work that I use with a sex offender population before I told him I would take him on as a patient. I also told him under what circumstances I would discharge him.

During the assessment I obtained information that makes it likely that a diagnosis of Pedophilia is appropriate. He has never had sex with an adult and is solely aroused by female children between the ages of 9 and 13. He loves children; he finds no other joy in life. He wants to be a youth counselor at a church. However, has been asked to resign from that position at two churches because of questionable behaviors. When he asked if he could ever teach, I replied, “You might not ever be able to do that.” He got very depressed and we began dealing with his depression as well as helping him in developing adult relationships.

It is very difficult to decide when to report if there has been no crime. One must assess the level of risk to the community and decide whether confidentiality takes precedence of community safety. These are difficult dilemmas for the therapist and one must take all possible consequences into consideration before taking action. One cannot operate in a vacuum. Asking for input from other professionals is essential.

For this client, I would try to get him into inpatient treatment right away. Because of the addictive nature of the computer, and the high-risk situation, I’m not going to tackle it on my own. I’d leverage it the best way I can. I’d tell him, you’ve got to go inpatient, buy some time. Get a treatment team to lay out the parameters for long-term recovery.

Referring out is an excellent idea for a counselor who feels that a particular problem is beyond her depth.

Another case created a similar ethical dilemma:

A client had been accessing child porn sites. I did an assessment, and he told me he was having obsessive thoughts about children. Meanwhile, his wife’s sister was a drug addict so CPS had placed their three children with him and his wife in their home. The oldest one, a girl, was his target

age. His obsessions had increased since the children were in the home. He hadn't done anything with the girl—yet. Well, he doesn't have the children now. I did talk to CPS. He was very angry. But when it was all done, after the raging, he came back and said, I want to thank you, because I would have abused her.

The consensus seems to be that there are times when concern for the safety of others supersedes the therapist's concern for client confidentiality or loyalty to the client. And in the long run, the outcome of the therapist's action may in fact be in the best interest of the client, as in the above example.

#### LONG-AGO BEHAVIORS

A therapist presented the following dilemma:

A client tells you that 30 years ago, when he was 16, he abused his 9-year-old sister. In the state of Texas the family code says you have to report any suspected child abuse or neglect, and it doesn't give a time frame. Do you report that, and to whom? If you call CPS, they'll tell you it's not relevant to them, he's out of the house; if you call the police they'll laugh at you.

A colleague, who works with sex offenders, responded:

This is an interesting situation. I've encountered it several times. One reason for this kind of open-ended reporting is to provide a basis for maintaining a record of possible history of abuse, for a given individual, in different jurisdictions, accessible now by computerized data bases. Additionally, knowing that many offenders continue to offend, reporting sexual abuse that was committed in the past brings up the question of the client's current access to children. A possible intervention here could be to offer the client the option of phoning CPS himself and reporting his own criminal behavior.

One must take everything into consideration. The questions to be asked are "Is he having obsessive thoughts about teenage girls now? What was the initial reason for the assessment? Is he involved in a current relationship? Does he now have children? Is there any suspicion of child abuse? One cannot take any rule of thumb and apply to all cases. There are many situations where sexual activities between siblings have occurred. If we report every time any such activity occurred, then patients would be very reluctant to tell us their innermost secrets.

Consider, if you will, what you might do if a 24-year-old elementary school teacher came in complaining of anxiety and difficulty with her husband. Upon further inquiry, you ascertain that the husband has inhibited sex drive. After several sessions with both the husband and the wife, you find out that she was sexually abused by a babysitter when she

was 4 and the female sitter was 12. You later learn that she touched her sister when she was four and the patient suffers from extreme feelings of shame and guilt. Is this a case would you report to CPS or the police. I hope not!

#### POSITIVE HIV STATUS

Nondisclosure of positive HIV status to the spouse or other sexual partner leads to another ethical dilemma for the therapist or healthcare professional. Here too, state laws differ. Some, citing the Tarasoff ruling (1976), mandate notification of sexual partners; others don't. As summarized by the HIV Criminal Law and Policy project, 24 states have adopted statutes that criminalize exposure or transmission of HIV generally or specifically by at least some form of specific behavior such as spitting, donating blood, or sexual intercourse. (see <http://www.hivcriminallaw.org/laws/hivspec.cfm>.) For example, Florida's Title XXIX, Chapter 384, states

2) It is unlawful for any person who has human immunodeficiency virus infection, when such person knows he or she is infected with this disease and when such person has been informed that he or she may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease and has consented to the sexual intercourse.

What, then, does the therapist or health professional do who learns that a client or patient has not disclosed their HIV status to their sexual partner? If the client is on probation and his treatment with the therapist is mandated, the course of action is more straightforward. The treatment plan consists of full disclosure to whichever family members the provider believes it necessary to inform. The treatment plan at the outset can also specify no unprotected sex or high-risk sex. If the client violates the treatment plan, then it's rational to report him to the probation officer and notify the spouse or partner. Because offenders are very rarely honest, nor do they report when they are in violation of their treatment contract, the therapist needs to be very alert to signs of lack of follow through.

The situation is even more complex in the more typical therapy situation. One of the presenters (JPS), a physician, said,

I believe that if someone is in danger, you have to act. What I'd first do is try to persuade the patient to disclose, to get the patient to use safe sex, and to get the partner tested. If the patient refuses, I tell him that he has a choice—either he tells the spouse or partner, or I will. I do understand that in some states counselors cannot tell, and that's a real

problem for them. It's also a challenge if the HIV-positive person doesn't have a steady partner and is just out there having unsafe sex. In that case you have to try to get the client to change their behavior. I also believe that if the state considers it a felony for an HIV positive person to have unprotected sex with an unknowing partner, the therapist may indeed report this. The informed consent forms should clearly state that this will be disclosed.

The American Medical Association's *Code of Medical Ethics* (150th edition) for physicians states (p. 62).

Exceptions to confidentiality are appropriate when necessary to protect the public health or when necessary to protect individuals who are endangered by persons infected with HIV. If a physician knows that a seropositive individual is endangering a third party, the physician should, within the constraints of the law, (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.

The American Psychiatric Association's *Practice Guideline for the Treatment of Patients with HIV/AIDS* states,

If a patient refuses to change behavior that places others at risk for HIV infection or to inform individuals at ongoing risk, or if the psychiatrist has good reason to believe that the patient has failed to or is unable to cease such behaviors or to inform those at risk, it is ethically permissible for the psychiatrist to notify identifiable individuals at risk or to arrange for public health authorities to do so. (p. 370).

The Canadian Psychiatric Association (Chaimowitz & Glancy, 2002), in their 2002 position statement, "The Duty to Protect," stated,

The CPA takes the position that its members have a legal duty to protect intended victims of their patients. This duty to protect may include informing intended victims or the police, or both, but may more easily be addressed in some circumstances by detaining and possibly treating the patient. . . . A duty to protect (warn, or inform) exists

- In the event that risk to a clearly identifiable person or group of persons is determined
- When the risk of harm includes severe bodily injury, death, or serious psychological harm
- When there is an element of imminence, creating a sense of urgency . . . The imminence could be interpreted as 3 years in the definitive Canadian case.

In the United Kingdom, the guidelines are not definitive. In 2000, a report from the UK stated,

How far should a doctor go in attempting to protect others from HIV risk from his patient? Many clinicians are very uncomfortable with knowing that an HIV-positive patient is continuing to have unsafe sex with a person whom the patient is unwilling to inform. After attempting to influence the patient's behaviour or willingness to discuss his HIV status, the clinician may be left either unable to act further because of confidentiality, or feeling obliged to breach confidentiality to protect the third party. General Medical Council guidance allows either, so long as the clinician is able to justify his actions. Each case has to be judged on its particulars (Pinching, Higgs and Boyd, 2000).

As the previous report shows, in some situations the legal requirements and constraints on reporting may differ from the ethical. In the author's opinion (JPS), it is unethical for a health care professional to knowingly permit one person to endanger another and to do nothing about it. It may be different for a licensed counselor or therapist, as some state laws and licensing board regulations specifically prohibit the professional from disclosing a client's HIV status, even in cases of a duty to warn. One therapist's solution is to routinely strongly encourage both addict and spouse to get STD testing, "because someone may have done something they're not disclosing."

The American Psychological Association's Code of Ethics (2002) states,

4.05 Disclosures (b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm;

The National Board of Certified Counselors, in its 2002 revision of the Code of Ethics, states,

Section B: 4. When a client's condition indicates that there is a clear and imminent danger to the client or others, the certified counselor must take reasonable action to inform potential victims and/or inform responsible authorities. Consultation with other professionals must be used when possible. The assumption of responsibility for the client's behavior must be taken only after careful deliberation, and the client must be involved in the resumption of responsibility as quickly as possible.

Although HIV infection is no longer a quick death sentence, AIDS remains a serious and potentially fatal disease whose containment requires life-long treatment with drugs that are expensive and have major side effects.

Significant stigma exists for this disease, and infection with it can be an adverse life-changing event. Therapists' opinions on their duty to warn is variable (Burkemper, 2002). Helping professionals need to take very seriously the consequences to other people who are in a sexual relationship with the seropositive client.

#### PROFESSIONAL SEXUAL MISCONDUCT

Another ethical dilemma concerning patient confidentiality versus harm to others occurs when the therapist learns of sexual misconduct by a professional. A therapist related,

While obtaining a sexual history from an impaired physician, I asked about frottage and he answered affirmatively. I thought he was going to tell me about an elevator incident or something similar, but apparently he had had sexual contact with patients while they were under anesthesia. I said, stop! Because this was a situation I'd have to report, but he'd already told me, so it would be too late. I asked him, "Did you read the informed consent?" (In which I'd listed the types of disclosure that mandated reporting). He said, "No, not really." This taught me a lesson, and now I review every line of the informed consent form with a client at the very beginning.

What did I do? I reported it, fully expecting that the client would then experience some negative consequences. He already had a mentor because he was being monitored by his licensing board for chemical dependency. So I called the mentor and told him, and the mentor reported it to the Committee for Impaired Physicians. I then called the patient's treating psychiatrist, who agreed that this should be reported to the medical licensing board.

This report highlights several issues that may come up regarding disclosure. One is that clients may not realize the risks of certain disclosures, even if they have signed informed consent forms. The therapist needs to go over the forms with them to be sure they understand them. Sometimes even if they fully understand the reporting laws, they may still disclose reportable material to the therapist. A counselor who worked for the Post Office recalled,

A client may say, "I have something really heavy to tell you." I usually respond, "Wait—time out. Remember that paper you signed that listed the three things counselors can't hold confidential. They are if there's any criminal activity, or any child abuse, or if you're a threat to yourself or others." Through the years I've had people say, "I don't care. I want to tell you anyway." For example, a client who's a mail carrier told me he'd exposed himself. Not on the job, but of course I couldn't be sure he'd be safe on the job and not expose himself there. So I told him, you

have to tell Labor Relations. Either you do, or I will. So he told them. I think they fired him. It was quite a few years ago.

Regarding this therapist's comments to his client about the areas that the counselor can't hold confidential, it's important for the counselor to be specific about the kinds of criminal activities that must be reported.

Another point that the story of the impaired physician demonstrates is that a lack of understanding of the significance of a client's behavior may result in the client *not* experiencing the natural consequences of his behavior. As another therapist commented,

I want to underline that when offenders come for treatment, they are there to get treatment and, if necessary, to experience consequences. Consequences are part of treatment. You're not coming here to get absolution.

Another therapist added,

Sometimes offenders want to get caught. If you say "Stop!" You're in a sense taking the power away from them, you don't allow them to share their secret. So I think it's okay to say, "Stop! I'm letting you know that anything you say to me, if it's harmful to someone else or yourself, I'm going to have to report that, and records could be subpoenaed, but if you still want to tell me, go ahead." That keeps the power with them, to get it off their chest.

When a client discloses behavior with another person with whom they are in a fiduciary position, and the therapist believes there is a significant risk of harming others, we believe it is the therapist's ethical duty to disclose the behavior to the professional association, licensing agency, or other appropriate body.

### c. Client Discloses Illegal Behavior

There is, of course, overlap between the dilemmas involving illegal behaviors and those discussed in the previous sections. Some illegal behaviors may have endangered or are likely to endanger others. In such cases, the legal and ethical concerns are congruent and reporting feels like the right thing to do. Following is one counselor's query:

In the course of giving his sexual history, my new client disclosed that he was going online for sex, and that his compulsion has progressed to where he's now looking at child pornography, downloading it, and masturbating to the images. He has children the same age as the images

he's downloading. He hasn't had a hands-on crime, but it's clear to me that his addiction is progressing. What do I do?

Although viewing child pornography online is not a crime, downloading it is a felony, subject to long imprisonment. This doesn't mean, however, that the therapist is *required* to report this activity to the FBI. The real issue here is whether there is a significant risk of danger to the client's children or other children. In this situation, the therapist decided that the risk to the children was real enough that she reported the client's behavior.

In another scenario, a client discloses viewing child pornography online as well as downloading it. He also views and downloads adult pornography. He spends hours per day on the computer, but has not had any real-life sex with anyone but his wife.

This man, too, is committing a felony, as he's downloading child pornography, but most sex addiction therapists would probably not report him. He would be counseled urgently on his legal risk and attempts would be made to motivate him as strongly as possible to maximize his treatment and recovery work.

#### d. Client Discloses Acting Out with Another Therapist

A therapist ("A") who works at an inpatient/outpatient sex addiction treatment center related:

I'm counseling a client who disclosed that he relapsed and was acting out with a new partner. He wouldn't tell me who the partner is. Eventually I learned it's another therapist ("B") in the same facility, someone who was formerly my client's therapist. The client is having sex with this other counselor. My client doesn't want me to talk with the other therapist. I don't feel I can continue working with therapist B. What should I do?

Most therapists at the workshop agreed that doing nothing (other than continuing to work with the client) is not an option. Therapist B has behaved unethically, causing harm to the client. Future clients of therapist B are also at risk of being harmed. Therapist A's professional relationship with B has been damaged. The institution where both work is now at risk of being sued. Finally, various professional associations and licensing bodies mandate that their members report professional misconduct of a colleague or risk being liable themselves. These considerations override the client's request of confidentiality. Clearly, something must be done.

Some suggested options for therapist A were:

- Encourage the client to report B to B's licensing board or to a supervisor at the treatment facility. [In this case, the client was asked but emphatically refused.]

- Have a talk with B to assess the credibility of the client's information.
- Discuss this information with other members of the client's treatment team, and together decide what to do. [It is generally permissible to discuss client information with other members of the treatment team.]
- Report B's behavior to A's supervisor or the CEO or other person in charge of the facility.
- Report B's behavior to B's professional association or licensing body.

Some institutions have written guidelines governing situations such as this; those that don't should. This is a predictable situation that should not be left to the individual therapist to handle. In the medical profession, when there is knowledge of a physician's problem—such as chemical dependency or inappropriate behavior—some states have in place physician health associations to assist the professional in a manner that doesn't involve reporting him to the licensing board. The errant physician is confronted by at least two colleagues and offered treatment. Only if the physician refuses is he or she reported to the licensing board. If therapist A does not want to risk B's career without obtaining further information, it's highly desirable that several therapists confront B, not A alone. In fact, A may choose not to be involved at all.

Resolution of the situation requires clarification of therapist A's goals. Do these include helping the client through the relapse? Getting therapist B to stop the behavior? Getting therapist B some help? Keeping other clients safe? Decreasing the institution's legal exposure? This is why it's critical for treatment agencies to have clear-cut, written ethical guidelines which include detailed information for therapists about how to handle this type of situation.

Another situation included a probationer and a probation officer. A female probationer told the therapist that the probation officer made inappropriate advances to her. The therapist, who had known the probation officer for some time, was quite disturbed by this. The probationer had a history of lying, exaggeration, and making false allegations against other care providers. The therapist called the officer and told him of the allegations and stated that she was going to write up an incident report and turn it into his supervisor. There was an investigation and the officer was removed from the case and another assignment was made. A therapist must report all allegations of sexual abuse about a care provider when reported to that therapist whether or not the therapist believes them to be true. Only those in higher authority can make that determination.

#### e. Another Person Wishes Information Disclosed by a Client Who is Now Deceased

What happens to a client's information if the client dies? The American Psychiatric Association is clear about this. Its *Ethics Primer* (p. 43) states,

Finally, in this incomplete list of potential confidentiality problem areas, comes death. Confidentiality of psychiatric information about patients remains ethically in force after the death of the patient and after the death of the psychiatrist. With only a few exceptions (e.g., those involving court orders, heirs, or executors) and despite the wishes of biographers and historians, it is important for the protection of past, present, and future patients that confidentiality does not end with their or the psychiatrist's death.

This is, in essence, the *legal* position of the American Psychiatric Association, and perhaps of other counseling and psychology agencies. Nonetheless, ethical dilemmas arise in which it may be in the best interests of another person for the counselor to reveal some information. The counselor must decide in each case what the ethical thing to do is. A therapist reported,

A self-identified sex addict came to see me. I saw him for an initial session, and he gave me his sexual history. He was also depressed. I asked him to bring his wife in to the next session. The day before the next appointment, he committed suicide. A few weeks later the wife came to see me. She wanted therapy to deal with the suicide, and she had found his [sex addiction] Step One on his computer. I treated her like any other co-sex addict. We read the disclosure together. I went through it with her and we talked about it. I helped her through the disclosure, explained what the sex addiction was. But what should I have done had the wife *not* found the husband's first step? What if all she knew was that he was a sex addict?

Had the wife been unaware that her husband was a sex addict, the therapist's course of action would have been more difficult, as she would have had to decide whether to disclose this to the wife. The therapist's ethical decision was made even easier by the wife's discovery of the man's First Step, so that the wife already had quite a bit of information before she consulted the therapist. The therapist's job then became to help the wife process information she had already learned, in contrast to having to disclose to her.

Another counselor's experience:

The mother of a 21-year-old client came to see me after her son's suicide. She wanted to see the record. I didn't give it to her, but we did sit down and talk about what was behind his suicide. They had no clue, they knew nothing about what was wrong with their son, and then all of a sudden he was dead. She was very angry. I spent a lot of time debriefing that with her, and she seemed to feel good about it.

A psychologist related,

I had a situation where a client I'd been treating for years was killed by a train. His family called me and wanted to know was he suicidal—

to explain how this happened. My inclination was to say no, it wasn't suicide, and to come to his defense. But I realized I needed to get some advice, so I called my lawyer and my state professional association, and I found that in my state, confidentiality extends beyond the grave. Without a written consent or court order, you can't say anything.

Losing a spouse or child to suicide is devastating. The survivors usually spend years trying to understand what happened and assessing (all too often unrealistically!) what they did wrong and how they could have prevented it. Knowing that a therapist possesses information about the suicide but will not disclose it can keep the survivors from experiencing closure for many years.

Leaving aside the legal issues, if you decide that ethically you are going to disclose some information to the survivor, you need to realize that what you say may stay in that person's brain for many years. Will the survivor be better off receiving upsetting information about which he or she can do nothing? What you tell should depend on what the therapist's ongoing relationship is going to be with the survivor, and what they want to do with the information. Ideally the survivor will become a client with whom you will have an opportunity to process the information at length, and the outcome will be increased peace of mind for the survivor.

Regarding the first case in this section—the surviving spouse of a sex addict who killed himself—his therapist gave this follow-up:

I made my decision to see her based on the circumstances of his death and the fact that she had found him dead. I did not believe that the treatment session, per se, was the cause of his death and knew that she had known about his sex addiction. I believed that she was coming in to find answers for herself and to try to understand his decision to kill himself. My decision to share his history with her came about in the first session when she had found his First Step disclosure on the computer. She was having the reactions any spouse would have after finding out about her husband's addiction in depth. She also stated she wanted her own therapy to deal with all of this and to understand her part in the marriage. I believed her request was genuine and needed help to understand what she had found.

Another counselor opined:

I would have taken the surviving spouse and given her a lot of information about sex addiction. Remember, this is a brain disorder, and trauma is the key. Whatever was in the guy's First Step, was because of his brain disorder and his trauma. I'd do a lot of empathizing with her and how sad I was that he and I didn't get to work with the trauma, but certainly *you've* been traumatized by this, so let's work with you. When I work with sex addiction clients and they tell me their history, I do a lot of

empathizing with them, and I always try to remember to say how very sorry I am that that happened to you. I've had clients say to me, "Nobody ever said that to me." Horrible things have happened to these people! They turn around and do it to other people, which doesn't make it right, but the treatment has to involve going back to the trauma.

## II. INFORMATION ORIGINATING WITH A THIRD PARTY (ANOTHER CLIENT, ANOTHER THERAPIST, LAW ENFORCEMENT, 12-STEP PROGRAM)

Occasionally information may come to the therapist from outside sources, with a resultant dilemma about what to do with the information. For example, your client, Steve, reports that at a meeting of Sex Addicts Anonymous (SAA), Joe, who also happens to be your client, disclosed he was continuing to have an affair. Until now, you were not aware of Joe's relapse.

There are several issues here. First of all, Steve should not have reported this to you, and the question is why he did. Steve is well aware of the 12-step slogan, "What you learn here stays here." Steve's motivation needs to be discussed with him in therapy.

As for the relationship with Joe, you cannot break Steve's confidentiality and directly confront Joe. One of the authors (BL) describes her approach in this situation:

After learning about Joe's current affair, I'm in couple therapy with Joe and his wife, and his wife says she's suspicious he's having an affair. He begins to get angry. He gets very angry. He tells the wife he hasn't acted out in 18 months. Anger is a defense. Joe's reaction makes me suspect that indeed he's lying. I can't simply say what I now know about Joe, but I can't just ignore the information I've learned and pretend I never heard it. What I can do is challenge his anger. I would say to the couple, "I know from experience that when someone gets as angry as you are now, I get suspicious as well, so I can understand your suspiciousness. What else is going on in the marriage that is making you suspicious?" And I would work with that.

The ethical challenge here for the therapist is to make use of the information without breaking the other client's confidentiality.

### Polygraph

Whenever a therapist obtains information from outside sources suggesting that the client is lying, the question arises of how to handle this information. The dilemma is typically that described previously—how to use the information without violating some else's confidentiality. Therapists who treat mandated sex offenders have another tool at their disposal—the polygraph, which

is often a part of the treatment contract for sex offenders. For nonoffenders, simple mention of a polygraph can be informative. In the pain medicine and addiction medicine practice of one of the authors (JPS), if I have concerns that a patient who is taking prescribed pain medications is concealing illicit drug use, I sometimes say, “I’m thinking of having you obtain a urine drug screen today. If I do, am I likely to find anything in it other than what I’ve prescribed?” At that point, the patient who’s being using illegal drugs is likely to admit it, whereas the patient who’s “clean” will not have a problem with the request. Most of the time, I don’t end up ordering the test. Similarly, the therapist who strongly suspects a client is continuing to lie may ask, “Would you be willing to take a polygraph test?” Those who have nothing to hide are more likely to assent.

A counselor reported,

I was referred a couple where the wife was highly suspicious that the husband was continuing to have sex with other women. Although he’d been in 12-step for 3 years and appeared to me to be sincerely committed to recovery, his wife could not get over her suspicions. The husband was running out of patience at the recurrent confrontations. The treatment plan we worked out included an agreement by the wife to begin serious involvement in a 12-step recovery from co addiction. But in addition, the husband agreed that whenever his wife was strongly suspicious of him, he’d assent to take a polygraph test. Knowing he was willing to do this was very comforting to the wife.

### III. INFORMATION ORIGINATING WITH THE THERAPIST

Years ago when the reigning paradigm for psychological treatment was psychoanalysis, the therapist was ideally a blank slate who revealed nothing about himself to the client. Modern therapists are less rigid about occasional self-disclosure when doing so is in the interest of the client and will further the therapy. Counselors who themselves are in recovery from addiction will often disclose this in a general way, as it may increase the comfort level and the trust of the client. Some professionals may have no choice about this—for example if they have written books or articles in which they talked about their own addiction recovery. Especially with sex addiction, however, it’s a good idea to avoid giving details of your own sexual acting-out history. Clients are also likely to ask how you got into the type of professional work you do, and this too may involve therapist disclosure about addictions.

Here’s what some seasoned counselors said about self-disclosure:

Counselor 1:

What I do depends on my relationship with the client, and on my goal for the disclosure. If I want to make the client more comfortable sharing about some past issues, I might share about past issues that I had, and

identify with the client. I would not disclose anything of a personal nature regarding a specific act or specific fantasies.

Counselor 2:

This just came up for me with a client I've worked with for a couple of years. She has very good recovery, and we're working on her developing healthy sexuality. She asked me, which she'd never done before, "Why did you go into this field?" "Why do you do what you do?" I felt it was very appropriate to say a couple of things about where I'd come from, and a couple of things personally, without disclosing anything major. It helped with the connection. It's as though she was asking me, "Can I trust you to lead me down this path?" On the other hand, another patient who I've worked with for years asked me recently who I'm going to vote for president, and I said, "I'm not going to tell you." I don't keep any political information anywhere in the office. I think you have to pick and choose those kinds of things.

Counselor 3:

I work with offenders, and when I have a new client I disclose why and how I came to work with offenders, my personal experiences with people who are sex offenders, to give them a sense of who I am and why they should tell me their frightening secrets and why they should trust me with it. I think it's important for them to know that I'm not a victim. It turns out that many of the people I knew early in my life *were* offenders, and that's where I come from. It sets the stage for the work I do with them.

We believe that therapists working with sex offenders should avoid disclosing anything personal about themselves. Many offenders are manipulative, if not psychopathic. Therapists may want to believe they are in a relationship with the offender; however, only the therapist may be in the relationship. Offenders may use any information about the therapist to their own advantage. One must be extremely cautious when doing any disclosure with a sex offender.

Treatment with an offender is very different than with other patients. Gerald Blanchard's book, *The Difficult Connection*, (1995) is an excellent resource in this regard. Although he writes about establishing a relationship, the relationship is one of respect for the individual and not about disclosing any information. Any personal information about the therapist is unnecessary. One of the authors (BL), explains:

When patients enter into my office I have a biographical introduction outlining my profession training and experience. That is the only thing that I share. Personal pictures, any information regarding any personal

hobbies or information is not displayed in my office. My sex offender patients do not even know if I am married or single. The therapy is about them and not about me.

We believe it's important for the therapist to have appropriate boundaries. After that, each therapist needs to decide for themselves what they feel comfortable with. One of the authors (BL), who works with sex offenders, continued,

I have very strict boundaries and hardly disclose anything about myself. Since I was trained in Ericksonian techniques, I'll sometimes tell stories to make a point. For example, when talking about shame, I'll tell a story about how my parakeet died when I was 11. I let it out of the cage after my mother told me not to, and it broke its little head. I took the dead parakeet and put it back on its perch, leaning against the cage, and then my mother came home and said, "What happened to the parakeet?" and I said, "I don't know." But then because I was so full of shame I had to tell her what happened. And she was very nice, and we buried the parakeet together. So that's my story about shame. I'll tell that kind of information about myself, but not personal information. When my patients ask me if I'm in recovery, I say, "Yes, from life, so every day is a meeting for me."

Another counselor related,

I self-disclose by way of offering an example which I believe may be helpful to a client, in an attempt to normalize them or their issue, and with someone who is struggling with accessing feelings or situations from early childhood. I try to practice honesty in a general manner, without getting into much detail. I also self-disclose when a client specifically asks me—again, with honesty, but without indulging into my own story, taking up their time.

A psychologist self-discloses *any* information very judiciously. He said,

I don't self-disclose unless I am clear that it is in my client's best interests. I am cautious that my own needs don't sneak into self-revelation. I will answer a direct question about whether I am addicted, but I don't volunteer this information. When I use personal examples, I disguise my identity much like I disguise the identity of clients whom I use as examples.

A therapist described how she has changed from the early days, when she followed the analytic "blank screen" school in which she was trained:

These days, having abandoned the "blank screen" shield I hid behind, I thoughtfully disclose to clients when I feel it would benefit them. We are teaching and coaching our clients to take risks to be honest and real in

their relationships and it feels incongruent to be dishonest. For instance, if I have to cancel sessions because one of my kids is sick I will let the client know—knowing that some clients can better tolerate the knowing than make up a story that I don't care about them, that they're not important enough to make time for, or any number of other self-hating reasons they have at the ready.

In couple's sessions, partners seem to feel comforted by knowing I am in recovery as they struggle to understand their addict's frame of thinking—they can often take the difficult information from a trusted person in recovery (their therapist) that they find offensive coming from a spouse.

The work calls upon us to be more real—we have to be willing to bring down our walls, personas, and reveal ourselves (as appropriate, and with professional boundaries, etc.) in ways traditional therapists may not. Bill Herring, the co-leader of the ethics workshop held at the NCSAC conference in 2003, has given much thought to the complexities of therapist self-disclosure.

Over the years, I've become a lot more transparent than I used to be. What I mean is that I generally let people know much more about me than I formerly did. My well-established clients know things that are going on in my life. For example, with parents I talk about how my kids are doing, and almost everybody knows I have just moved my home. My clients as a rule are high-functioning even while having significant issues that bring them into treatment. (I probably wouldn't take such an open approach with sociopaths and sex offenders.) I don't try to impose information about myself on clients, and the vast majority don't ask any personal information about me.

In a noble quest to provide healthy boundaries to the client, it seems important to me that we not just define boundary issues as those which seem "too close" or transparent. Perhaps there is a risk on the other side by being too distant, emotionally detached or rigid.

We are providing a sacred safe space for a client to work through their issues. But we are also modeling life's complexities and at least one way to deal with them. If I share an anecdote from my life, I can make a case that I am being real, modeling the successful navigation of life's inevitable problems, and offering a strategy or response that my client can relate to and perhaps incorporate into his or her journey.

The client may get too "codependent" on how I am doing, becoming overly compliant and not stand up to what they see as me being too open. However, can't a similar result happen if I am too distant? The same client could grapple with "codependent" feelings about me, not stand up for wanting to know more about me, and be likely to think that I am able to live a life they can never reach. Sometimes my clients feel better about

themselves by comparing their character quirks with my own, as opposed to me hiding them as if they are neither present nor relevant.

I wonder that sometimes we refrain from a lot of withholding as being “safe” for the client when it is really our own safety that we seek to protect. This is a fine goal, but let’s be honest about it.

Just today a well-established client expressed anger at me after I described how I am encouraging my daughter to talk about her feelings moving to a new home and school. The client never had an opportunity to share her feelings safely in her family when she moved. She is jealous, it hurts, and she voices it. I encourage her to talk about her anger at what my anecdote represents, to be as safe as my daughter feels in telling me what she feels. It is an unprecedented moment of standing safely in her truth.

I am asking my clients daily to take risks. By choosing disclosing to the extent that I do I am holding myself to the same standard. Consider that by not taking such personal risks I am saving myself (from being vulnerable) while robbing the client of an opportunity for true human connection.

Having said all that, I do have some guidelines for my personal disclosure. For instance, I don’t share personal information about a problem or struggle that is currently going on with me. I try to stick with past-tense situations. I carefully evaluate the impact of disclosure and process this openly with the client. I don’t dominate the discussion.

Am I meeting my own needs by this approach? To some extent, yes. But I hold that we all meet our own needs every session. We meet them by getting paid, by feeling good about ourselves for what we are doing, by having people trust us, by enjoying the company of interesting, courageous and vibrant people who come into our rooms. In my opinion there is nothing inherently wrong with a therapist demonstrating to a client how to get their own needs met in an ethical, genuine and interactional manner. Have clients left therapy because of discomfort with this approach? I hope not, but it probably happens. Do other therapists experience client drop-outs because of what clients perceive as an unnecessarily rigid and non-forthcoming approach? I think so.

Finally, please don’t think that just by not having pictures of your family or not talking about your church or politics or whatever, that you are not bringing your history, and your values, and your perspective into the room. They are there. You don’t have to talk about them for them to be present, and by withholding your more authentic self you run the risk of having these influences remain beyond the range of conversation where they cannot be named, much less explored. When we do not *expose* our personal baggage and history, we are likely to *impose* their residue.

As Herring points out, the reality is that therapists, like other employed people, do inevitably get some needs met through their work. At the same

time because so much of the therapist's work is based on his relationship with the client, the therapist must be very conscious of the impact of his actions, including self-disclosure of one form or another, on the patient. We must constantly ask ourselves whether we are doing it for the client or for ourselves. Many therapists have had patients tell them that one of the reasons they didn't stay with their last therapist was that they always seemed to talk about themselves. Some of that may be the patients' distortion. However when therapists describe disclosures they have made to their clients, sometimes it appears they think that boundaries may have been crossed.

One of the authors (BL) related,

When I am out I tell my patients I am going to be out. If it is appropriate I may tell them I am going to a conference. If I am going on vacation and they ask where I am going I do not tell them. There are certain patients I might tell, but as a rule I do not tell them, especially the sex offenders.

Ideally, therapists do not disclose their personal baggage but, if indeed this happens in the course of therapy and countertransference, then the therapist must be authentic and reveal themselves and take responsibility. This can be done if the therapist is always listening to themselves and exploring their own feelings. It is in this type of genuine care that therapists can make their greatest contribution.

A physician added,

I use personal disclosure where I think the patient may benefit. The biggest part of my recovery journey is in Bipolar Illness. I have written a chapter about my illness and recovery which I will occasionally offer to patients where I think it would improve their chances of success to know about me. I often recommend Marnie Ferree's book *No Stones* to women struggling with the concept of sexual addiction and get excellent results. And, of course, the before, during, and after story of Bill Wilson forms the backbone of the disclosure interventions.

According to Marnie Ferree, a sex addiction therapist,

I totally agree that our clients benefit by our prudent, past tense disclosures. I am extremely open about my personal recovery from sex addiction; so many clients are already familiar with my identification as one of them. I don't volunteer a lengthy telling of my story, but I do answer questions and share brief personal examples when it seems helpful. (And when is it "helpful"? When my clinical hunch says it probably will be. Isn't that the basis for much of what happens in our offices? We take our best shot based on the intersection of our theoretical model and our client's presentation.)

I see disclosure of my own status as an important part of the joining process. When I tell a new client simply, “I, too, am a recovering sex addict, and I remember how frightening it was to admit this problem,” I sense he/she immediately relaxes into this safe space. Trust grows with honesty and transparency—on both sides.

On another level, I believe we do our clients a disservice by withholding our personal recovery identity. More specifically, I believe we shortchange our field, which is in desperate need of more openness about this problem. How can I expect a client to take the risk of exposing her addiction to her partner or daring to attend a 12 Step meeting when I personally hide behind a professional persona? Is that not failing to practice what I preach?

I wonder sometimes if our collective reserve is more about fearing what our colleagues may think of us instead of how our clients may react. We, too, are subject to the stigma of sexual addiction.

A somewhat different perspective was presented by clinical social worker Roy Berman:

I rarely do self-disclosure in my clinical practice. I do it only when I feel it would benefit the client. For example, I might share how I handled a situation which a client is struggling how to handle, if I feel by doing so it might motivate the client into taking some positive action to resolve the situation, to share with him that there is a way to resolve the situation successfully and here is a pragmatic or emotional way to resolve it and I am living proof that it can be resolved—and by doing so I am letting the client know that the kinds of problems he faces other people face as well and that there are solutions to these seemingly irresolvable problems.

Most of the time I do not do self-disclosure because the focus of a psychotherapy session should be on the client and I think we therapists have a tendency to shift that focus onto us for our own unconscious reasons to get our own gratification and to meet our own needs. We have to always remember that professional counseling is not twelfth-stepping; this is not a self-help process, this is professional treatment and it is our duty to help them disclose to us in a safe and unthreatening environment.

My response to a client who asks me if I'm in recovery is to ask them why this is important to them. I use the question to get to know my client better and to explore his underlying biases, issues, feelings, and possible misconceptions of the therapy process, such as who can or cannot help him. By prematurely disclosing too much myself I prevent the client from further examining himself and his underlying reason for asking the question in the first place.

When considering self-disclosure, it's important for the therapist to ask themselves each time about the purpose of revealing the information. It needs to

be for the benefit of the client and not the therapist. It can be helpful to address the client's motivation. As one therapist reported,

When the client probes the therapist with question about themselves, it can be useful to ask the client how this information will be important to them in the therapy. Sometimes this will lead to another whole discussion and the client will not return to his original request. So it wasn't so much about what I disclosed, or even *if* I disclosed, really it was about what they're looking for, which may be totally different from the information about the therapist.

Clients sometimes complain that the therapist spent too much time talking about themselves. Also consider that any information you disclose about yourself may be used in various ways by the client—including, if the relationship sours—to try to discredit you. So be discreet. A therapist at a treatment center related,

We have a personnel policy that no one is to talk directly about their recovery so as not to give patients chance to split between staff members who are in recovery as better as or worse than those who are not addicts. We have had too many occasions in the past when patients have used the information against staff members (who were or were not in recovery)—we now “choose” to keep that information private while at work. Everyone is free to talk about their own recovery strength, hope and experience when not at work.

Richard Blankenship, M.Ed., M.A., focused on issues of the professional consequences of self-disclosure:

I supervise a number of therapists for licensure. Most of the newer graduates have been trained against disclosing personal information to clients. They have been frightened by stories of proceedings from ethics and licensure boards.

In some cases, therapists who are in recovery may still carry the stigma with them and hide behind a professional persona. Others may have concerns for clients (I've seen the damage that can be done with inappropriate disclosure to vulnerable clients), or for the market in which they practice. I recall seeing an excellent therapist lose his credibility (and many of his referral sources) by disclosing his struggle with sexual addiction in a public setting.

Whether it is therapists, clients, or people in recovery, we need more people willing to share their stories in appropriate forums.

An addiction-trained therapist who was employed by the Post Office related that over the years he'd had opportunity to speak with many employees, to learn what therapy models had worked for them and what spoke to them

overall during their therapy: “The number one answer I heard all the time was ‘what really helped me was that my therapist seemed real’.” For addiction treatment, being real means some self-disclosure about the addiction. An experienced sex addiction therapist who does disclose that he’s a recovering sex addict added,

I tell clients very little about the specifics of my own addiction history and recovery. I’ve never talked specifically about my sexual activities, but I have many times talked about the kind of thinking that led to the decision to recover, what it was like to work with a sponsor, etc.—when it served the client. I might also tell them about the stressors and the kind of thinking that led to acting out. Everything *around* the behaviors that could serve, and inspire them wherever possible.

As other therapists have reiterated, the goal of self-disclosure needs always to be to help the client. Self-disclosure can make the therapist seem more real to the client and may increase the client’s trust. The client may think, “She’s been through the same thing, so she can really understand me.” It can model a willingness on the therapist’s part to be honest. But there are times when it would be better for the client to have the therapist not reveal early on about some issue, or indeed not disclose at all. One example might be the therapist with a history of sexual abuse who is treating a sex offender; knowing of the therapist’s prior victimization might make the offender hold back some feelings or facts out of fear of being judged by the therapist. It might be wise for the therapist to withhold such disclosure until late in the therapeutic relationship, if at all.

### Sexual Orientation

Disclosure of the therapist’s sexual orientation is another issue that comes up often enough in sex addiction treatment. How counselors respond depends on their own comfort level, on whether or not they have a high public profile in the community as a gay or lesbian therapist, and their concern about appropriate boundaries. One gay therapist doesn’t volunteer the information but it’s clear to most people that he is gay. If asked directly, he says he’s gay. A gay therapist explained,

First of all I always follow the cardinal rule of therapy and all ethical therapists which is, “Disclose only that which is in the service of the client and only when it is in the service of the client.”

With gay clients I don’t disclose much about my sexual orientation unless I think it would be helpful to them. An example is the client who is fearful of homophobia and wants reassurance that I will not judge him for being gay or is concerned that I will challenge his sexual behavior with men because, because he is gay . . . once *I understand his motivation for wanting to know more about me then* I might disclose my orientation

to reassure him. Most gay men will know my orientation intuitively by my dress, presentation etc... I don't have to announce anything. Also much depends on where we are in therapy. I give away *much less* in the beginning than later in the process, particularly with sex addicts, particularly with gay sex addicts, until I know where the client is coming from (internally and externally) and what he is going to do with the information he is gaining about me. With more stable gay sex addict clients, who I have seen for some time, I do speak about my relationship, long term aspects, recovery, communication etc., using it to offer hope, inspiration, and encouragement.

I rarely speak of my sexual orientation to heterosexual clients; they never ask in the beginning, sometimes later. I do wear a wedding ring; they assume what they may.

### What About Therapists Going to the Same 12-step "S" Meeting as Their Clients?

Most therapists who are themselves recovering from sex addiction use the Twelve Steps in their recovery, and many continue to attend 12-step meetings. Such therapists routinely recommend 12-step meeting attendance to their recovering clients. Unless they live in a small number of large cities in the U.S., most sex addicts do not have a wide choice of "S" meetings to attend. Are recovering therapists comfortable attending the same meetings as their clients? We posed this question to sex addiction professionals on an e-mail discussion group. Twelve experienced clinicians responded: ten said no, and two said maybe or it depends. Because this is such an important and recurrent issue, we have quoted some of the respondents. Here are several responses from the first group:

Therapist #1: It is psychologically problematic for clinicians to go to the same meetings as their clients. The clients end up feeling inhibited sharing and are being tempered by the therapist's needs, no matter how comfortable the situation may seem superficially. This is something I hear about over and over again. The solution for the recovering therapist is attending meetings in a neighboring town, creating and attending closed meetings (for professionals only), or asking their patients to avoid one particular meeting in their town so that they may comfortably attend.

Therapist #2: I have avoided 12-step meetings because I have too many current and former clients in those settings. They don't need to know about my struggles at home with children and marriage. It simply doesn't benefit them to have this type of a dual relationship with me. I've also seen the harm done to clients by therapists who have engaged in this type of a dual relationship.

Therapist #3: While I'm quite open about being a recovering addict, for years I haven't attended 12-step meetings because all contain clients or former clients. To share my experience, strength and hope isn't the issue

for me. That information can be conveyed in session with some brief example.

The problem is the ethics of sharing any current information, even that not related to acting out. My clients don't need to know I'm having to take my own inventory around a fight with my husband or admit my powerlessness, about a tough situation with my employer. I agree it's an important ethical issue concerning a possible harmful dual relationship.

Therapist #4: I do not attend 12-step meetings where I may run into clients. I believe it is setting up a dual relationship between client and therapist. I certainly would not feel free to share my experience, strength, and hope in a setting that my clients attended and I believe they would not feel free to do so either. Talk about disclosure! While I have revealed that I am in recovery, my clients know that I will not be seeing them at 12-step. I know some therapists shared that they do attend the same meetings, I believe that it would set up all kinds of countertransference and transference issues for me. I have to keep that boundary for myself as well as for my clients.

Therapist #5: Even though there are many 12-step meetings in my city, I do not attend the meetings where clients may be present. The SAA fellowship has a couple of Sexually Addicted Helping Professionals Anonymous meetings in Houston that require prospective members to submit their name and a mini-first step, and members vote on allowing the new person to attend. In that way therapists are protected from the possibility of a client joining the group.

There is a 12-step retreat that I attend that is open to all "S" group members. If I find out a client is at the retreat, I let the client know that should we both end up in the same break-out session I will move to another group so that he is able to share more openly.

Therapist #6 [a psychiatrist]: I think that attending 12-step "S" meetings with a client would not be acceptable in today's climate. I feel this is more of a unique issue with sex addiction recovery than with chemical dependency. I currently do not attend "S" meetings in my area because of the boundary issues. The majority of my issue comes from doing more psychodynamic psychotherapy, where my relative neutrality is a major issue. I do not hide the fact that I am in recovery, but do not speak directly of my issues or the "kind" of recovery. I cannot imagine that I could go to a meeting and be open and maintain my integrity as a therapist. Furthermore, I feel it could severely contaminate the therapeutic alliance to go to a meeting in a rough spot and actually seek to get my needs met. As I have taken on a more visible role, this has been more sensitive.

Two respondents gave less definitive replies.

Therapist #7: I think the core issue is that there are two therapeutic needs that must be considered in deciding about attending 12-step meetings that your clients attend. One is the need of the client. The other is the need of the therapist. There's no simple answer to the question . . . With individual

clients, I've come down on both sides. Sometimes it seems to be helpful and necessary for us to go to separate meetings or alternate meetings so that we are not there at the same time. This can either be because the client needs a separate place to talk without his therapist being present, or more often because I need a place where I can open up without my client hearing all the details of my own issues.

Therapist #8 [psychiatrist]: I do go to 12-step meetings with patients and former patients. I even take patients to meetings on occasion. When I do, I do not expect anything but "fellowship" for myself at those meetings. I utilize sponsorship and service to meet my needs.

The consensus of experienced therapists is clear: For a therapist and client to attend the same meeting is likely to complicate the therapeutic relationship. It is virtually impossible to prevent blurred boundaries and information learned by both parties at the meeting from affecting into their professional relationship. Even more problematic, the presence of both at the meeting is likely to inhibit one or both from sharing current struggles and asking for help. Even the minority of therapists who believe it's occasionally okay to attend the same meetings recognize that they are not likely to get real help during those meetings. The professional will be reluctant to share his challenges; a relapse would be an even bigger problem and might risk his own recovery. And if the meeting contains several clients, there's always the temptation of becoming the guru in the meeting.

If separate meetings are not available, consider starting a professional's meeting, find a meeting in another town, or attend a 12-step group that focuses on recovery from your other addiction, if you have one. Strengthen your relationship with your sponsor. Find on-line meetings. One therapist related that in lieu of attending local meetings, "I joined the NCSAC [now SASH] Board of Directors and found the company of other professionals, some of whom were in recovery, all of whom understood this addiction, a wonderful substitute."

## Sponsorship

Clients who learn that their therapist is also in 12-step recovery from sex addiction may ask their therapist to be their 12-step sponsor. We believe this to be a bad idea. The role of a sponsor differs from that of the therapist, and it is best to keep them separate.

Sponsorship and therapy have very different roles. The sponsor guides the person through the steps and is not the therapist. The therapist's role is to not only help the person with his or her sex addiction, but to confront if necessary and explore deeper issues. The sponsor is often an advocate for the patient and if transference happens with the therapist who is also acting as the sponsor, then recovery may be dropped entirely. Sponsors may often share their own faith, hope and experience; it may be appropriate for therapists to share their own experiences about their recovery, but inappropriate to

share about current struggles. Very often the patient needs to develop a support group and the sponsor is often instrumental in helping the addict do this. If the therapist is also the sponsor, the therapist runs the risk of having the patient enter into their own support system and therefore increase the risk of further boundary violations.

## CONCLUSION

The purpose of this article was not to give all the answers to all the ethical dilemmas that may arise, but to offer some suggestions and avenues for further discussions. The ethical choices we all have to make in our work sometimes come with ease but more often with much thought and consideration. The decisions we make today can affect our patients' lives and our own for years to come. We owe it to our profession and to the others who come after to set precedent and make the difficult choices. We must never take our responsibilities lightly or glibly. Seeking out consultation and the ability to ask for help are essential to this endeavor.

Each day can bring new dilemmas, and the way in which we deal with what is given to us builds our strength, hope and courage. We often have to make decisions that are difficult and can leave us feeling alone and questioning ourselves. The day we think we have all the answers is the day we fail ourselves and our patients. We must always strive to do the Next Right Thing. If our decisions do not always yield the results we thought they would, hopefully we can move on and learn from our mistakes. It is not a shame to fail, but it is, not to try.

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