Examing Ethical Boundaries in Therapy Checklist

Compiled by Bernadine Fox

Examining Ethical Boundaries in Therapy:

Therapy Abuse and Exploitation

A Checklist

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Exploitation and Therapy Abuse

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The material in this list is derived from personal experience, consultation with other survivors, and two lists posted on the TELL website (www.therapyabuse.org) "Psychology: The Good, The Bad, and The Dangerous" by Ilana W. Rosen, MSW and "Is There Something Wrong or Questionable in Your Treatment" by Estelle Disch, PhD

In a healing relationship, there is an inherent and indisputable imbalance of power that is imperative for effective therapy. Therapists or helping professionals are likely members of an association, society, or college that outlines ethical boundaries to which they must adhere. A good therapist will advise clients of which organization they are a member. More information on what good therapy looks like can be reviewed at TELL. It is important to recognize that while some of the infractions below are, in and of themselves, a profound transgression (i.e., sex with clients) others are ambiguous. For instance, having the last session of the day is not, in and of itself, a transgression. Whether it signifies a component of an unhealthy therapeutic involvement can only be determined after taking stock of the healing relationship.

So, what does exploitation in therapy abuse look like? Outside of those who work with or support victims of therapy abuse, this is an issue fraught with misperceptions. Confusion around what therapy abuse is can leave us wondering how to separate the serial offender who preys on clients from the therapist who might have made a mistake in the services they offer.

To start, let us examine what is not therapy abuse. In my opinion, it is not therapy abuse and exploitation if a client is unhappy with their progress or is experiencing a personal conflict. While it is malpractice when therapists work beyond their skill level, make poor clinical decisions, and then fail to correct that mistake with consultation, acknowledgement, and action, by this definition, is not therapy abuse. A therapist who falls in love with a client has not committed therapy abuse. One who acts on those feelings and has sexual contact with that client is, by definition and unequivocally, committing therapy abuse.

Therapy abuse is about exploitation. It is using patients to fulfill the needs and desires of the offending therapist while pushing the best therapeutic interests of the client aside. Offenders groom their victims with the intent to exploit them financially, emotionally, psychologically, physically, and/or sexually with a direct benefit for the professional.

Offenders often have more than one victim. Therapy abuse and exploitation follows patterns of grooming and coercion seen in other forms of abuse, to induce the victims' compliance, secure their silence, and, if necessary, ensure a means to discredit disclosure.

In the mid-80s, we learned how child molesters groom their victims with flattery, the employment of 'secrets,' labeling the relationship as special, insisting that no one would understand, and encouraging role reversals: victim as caregiver and protector of the offender, i.e., "If you tell I will go to jail." We know child molesters use employment to gain access to victims, including daycares, schools, camps, and churches. In intimate partner violence, we learned how batterers groom and isolate their victims using a cycle of abuse to maintain control. For battered spouses, the most dangerous time is when they leave. Since the #metoo movement emerged, we have been confronted with a shocking number of adults who have been emotionally coerced into sexual activity by those, such as employers, with authority.

As with teachers, priests, daycare attendants, it offends our sensibilities to see how therapists, who are assumed to be helpful and compassionate, might use their power and authority over vulnerable clients to exploit them for their own needs or benefit. Unfortunately, this profession is not free

from being used by serial offenders. Lack of resources, knowledge, and expertise, along with long-held social norms, have left survivors largely silenced. That is changing.

Those who are trauma-informed will recognize the phases of therapy abuse:

The **Grooming Phase** in therapy abuse and exploitation is well defined. It may start within the first few sessions but can begin as early as the first consultation. It can go on for many years. The grooming phase mirrors that of child molesters including calling the victim special, giving gifts, creating a sense of financial indebtedness (e.g., misuse of pro bono), pushing boundaries around contact and touch, solidifying the victim's sense of responsibility for the perpetrator's well-being ("You must keep this secret."), creating a profound dependence on the therapist, setting up covert forms of communication, and isolating the victim from family and friends.

The **Exploitation Phase** may take financial, physical, emotional, and/or sexual forms. The financial exploitation of a victim may include but is not limited to buying property together, accepting financial gifts, borrowing money, being designated as beneficiary of estates and/or insurance policies, or accepting free services such as legal or administrative work. Physical exploitation may include free labour such as renovating therapists' home or office, babysitting, running errands, and even serving as surrogates for in vitro fertilization. Therapists employ role reversal and exploit clients emotionally depending on them as sounding boards or for support. Sexual exploitation, the most obvious and easiest to define, is any sexual interaction and includes talking about the therapist's own sex life to sexual touching and intercourse. Many forms of exploitation may take place concurrently.

The **Termination Phase** generally occurs when the offender's interests wane, when the victim is asking for change and/or confronting them on the exploitation, or when the offender feels at risk of exposure. In the same way battered spouses are most at risk when leaving, so too may therapy abuse survivors find themselves in precarious positions. In this phase, perpetrators may initiate a pre-contrived defense strategy. Where other molesters or batterers might rely on threats of physical harm, abusive therapists primarily employ emotional coercion or threats. This may start with

soliciting a victim's agreement to protect them with silence and the mutual destruction of evidence of transgressions including but not limited to texts, emails, photos, gifts, therapy notes, etc. If they fear being formally reported, whether to police or licensing boards, offenders rely on having groomed their victim to take responsibility for their well-being while positioning themselves as the real victims. ("I only did this because of you." or "My working with you has cost me.")

Perpetrators may plead for forgiveness and offer promises to reform. They may incessantly call, text, email, or show up at their victims' homes or work hoping that access will help them regain control. If all that is unsuccessful, they may turn to emotional violence to enforce their victims' silence. Their assaults use the clients' secrets, vulnerabilities, and confidences disclosed in sessions to inflict fear and grave emotional harm. The love and acceptance they once offered is now replaced with intentional triggering of shame, guilt, abandonment, rejection, and threats of exposing secrets. Offenders may work to break up clients' support systems. Those who offered pro bono arrangements may use it to disprove a professional counseling relationship or claim consensual affairs. And if all else fails, they may assign a new diagnosis, such as borderline personality disorder, to undermine their victims' self-confidence and discredit their disclosures.

The damage done to victims of therapy abuse is likely catastrophic. During the grooming and exploitation phases, healing is actively undermined, and victims are often faced with new issues such as insomnia, depression, suicidal ideation, and anxiety. In the termination phase, victims struggle to regain a sense of self and may end up losing friends, family, and partners/spouses. Emotionally overwhelmed, victims may be unable to work and thus risk losing jobs, homes, and even child custody.

Victims often experience PTSD and the impact of Stockholm Syndrome while fielding both individual and institutional victim-blaming. Potential healing relationships become triggering in ways that subsequent mental health professionals may not understand victims may be accused of being vindictive, dangerous, and/or lying. Add to that a popular culture which incorrectly depicts a sexual relationship between therapist and client as 'romantic,' victims are often left grappling with what is and is not real. It is

no wonder that therapy abuse survivors engage in self-harm and are ten times more likely to attempt or commit suicide than the general public.

Given this definition, it is easy to differentiate between the therapist who has made a mistake or has misjudged the needs of their patient and the serial offender who grooms and then exploits their victims. Because therapy abuse offenders exhibit the same patterns as child molesters, batterers, and other offenders, those who are trauma-informed will recognize these patterns.

Most recently, social media platforms have provided spaces for survivors to find each other, compare notes, and get support. Websites, such as TELL, accessed by as many as 40,000 unique visitors every year, offer on-line resources and opportunities for networking for those concerned about their therapy. These resources for information and support are resulting in more survivors emerging empowered with knowledge and healing opportunities. Consequently, the known number of survivors appears to be increasing exponentially across the globe.

Mental health organizations, colleges, and licensing boards require their members to adhere to a Code of Conduct or Ethics and/or Bylaws. Many of these include a standard or principle that allows for a sexual relationship between therapist and client two to three years after termination. While such allowances, along with their qualifying conditions, may seem, on the surface reasonable, those of us who work with survivors know how these clauses too often open doors for opportunistic abusers. In addition, promises to a therapy abuse survivor of a future love relationship, after the waiting period, allows offenders to move on with their lives while victims are left in limbo, kept from forming healthier and appropriate relationships, and entrapped.

Given what we know about the enormous dangers and damage done to victims, many educated, and trauma-informed mental health professionals and organizations have recognized that the power imbalance between therapist and client is akin to that of parent and child, and that it is life-long. Any sexual activity is, therefore, unavoidably abusive. They recognize that there is no good reason for this type of permissive principle or standard to be included in the codes of conduct/ethics or bylaws and are removing and

replacing them with ones that specifically preclude any sexual contact between therapist and former or current clients. Changing these standards or principles in our mental health organizations goes a long way towards making the mental health field a safer place for clients. The catastrophic damage that they suffer behooves these institutions, if they haven't already, to do this as soon as possible.

There is no known way for clients to prevent therapy abuse from occurring. We can, however, arm them with information that helps.

- Learn to recognize the red flags of therapy abuse
- Go over the checklist of therapy abuse to recognize experiences of therapy that appear abusive. This will also provide information on proper boundaries in therapy
- Check reviews or disciplinary actions about the therapist and/or organization
- Know where the therapist was trained and where they are licensed
- Ask the therapist straight up what they know about therapy abuse and dual relationships and assess how it aligns with this definition.

In and of itself, understanding what therapy abuse is, recognizing how mental health organizations might enable it, and knowing the steps clients can take to protect themselves won't, overall, prevent therapy abuse. However, they will raise awareness for clients and warn an abusive therapist that they are not dealing with a client who can be naïvely coerced into taking part in transgressions or an organization that will look the other way. Together, it may go a long way to interrupt therapy abuse from beginning or help clients extricate themselves earlier. (definition from https://www.therapyabuse.org/t2-therapy-abuse-what-is-it.htm)

The checklist that follows is meant only as a guide to facilitate conversations (even if that is a private one). It is not all-inclusive. Nor would one necessarily check off every item in any problematic healing relationship. Nor should someone conclude that they have experienced exploitation in therapy abuse because they have checked off a few items.

The Grooming Process

Sessions

The therapist may:

- moves sessions to the last appointment of their day.
- determines the length of sessions.
- leaves the length of sessions casual.
- keeps clients waiting.
- decides how many times per week to schedule sessions without client's agreement.
- schedules sessions when no one else is in the office.
- allows sessions to be interrupted by phone calls or other activities.
- gives their home phone number and encourages calls.
- creates informal sessions i.e., conducted over dinner or dinners/lunches before, after, or in lieu of sessions.
- outside of sessions, calls frequently to check on how client is doing.
- shows up at client's home outside of session times.
- conducts sessions in the client's home and, at time, the client's bedroom.
- provides and/or encourages clients to use substances and/or prescription drugs and/or alcohol during or after sessions with them that is not part of the treatment modality.
- includes therapeutic techniques (i.e., hypnosis) that client has not agreed to and/or is uncomfortable around.
- disallows access to information about what happened in sessions (hypnosis, dissociation).
- appears drugged or intoxicated during sessions.

Money as Control

The therapist:

- sees client for a low fee or at no cost but then redefines it as a 'gift' and/or uses it as leverage for other requests.
- allows client to pay later for sessions and/or carries large accounts receivable for client.
- ignores the client's discomfort around issues such as owing money.
- barters with clients to reduce their counseling bill by having them perform tasks or services.

Isolating Client

The therapist:

- disapproves of client's current friends and discourages new friends or relationships.
- makes disparaging remarks regarding the client's partner or family members.
- encourages estrangement from others in the client's social network even when client disagrees.
- requires secrecy around the therapeutic process especially around transgressions.
- discourages the inclusion of other practitioners.
- encourages and/or demands secrecy around any inappropriate behavior (i.e., sexual contact) thereby impacting on other personal relationships for the client.

Sharing of Personal Information

The therapist:

- shares information about their family, marriage, sex life, or personal struggles without any clear indication of how this is relevant to client's therapeutic process.
- puts client in a position of observing and/or knowing personal physical information about them (i.e., attend medical

appointments, visits to hospitals, social situations like swimming, or attending the same physiotherapist and/or gym).
- solicits the client's help or advice.
- monopolizes entire session with their own issues while client becomes the listener.

Creating Dependency

The therapist:

- insists that the client must unconditionally trust them to effect change. There is often some threat of losing therapy or inability to heal if the client resists.
- promises to always be available for client.
- promises to never hurt client.
- initiates or allows daily contact via scheduled sessions, phone calls, and other activities.
- relaxes boundaries when client is in crisis.
- assumes the role of advocate and accompanies client as support to events or appointments.
- tells client that they are special or their favorite client.
- compliments or critiques the client about their appearance, clothes, work, intelligence or, otherwise, implying they are special.
- claims boundary infractions are okay because client is extraordinary or special.
- claims that they care about the client more than any other person in their life.
- disparages client's actions and decisions that will support or develop their sense of self-confidence (i.e., their job performance).
- becomes disapproving, angry, cold, distant, or punitive around infractions to their demands.
- cycles through abuse to caring which keeps client off balance as they try to appease the therapist.
- uses the dependency that is created to emotionally coerce clients to engage in ways they are uncomfortable or unsure.

- **Positions Themselves as The Expert**

The therapist:

- insists clients trust them.
- positions themselves as the only professional that will understand or be able to help the client.
- avoids discussions around and/or misrepresents their qualifications to do the work the client needs.
- discourages clients from bouncing issues from therapy off other professionals.
- claims family or friends won't understand the work client is doing and discourages sharing.
- insists that their education and experience provide them with greater insight into client's process.
- encourages compliance and insists the client accepts what they say without question.
- discourages questions about the therapeutic/treatment process or what to expect.
- dismisses client's concerns about how therapy is going (i.e., must trust them).
- makes unilateral decisions about the direction of therapy that the client is uncomfortable with and then dismisses concerns or labels as resistance to healing.
- identifies the client's unresolved issues, transference, or neuroses as the cause of difficulties in the therapist/client relationship.
- dismisses issues even though client identifies them as important.
- in healing relationships which become 'life-partnerships,' insists they know best how to
- develop a healthy partnership.

Gifts (Given and Received)

The therapist:

- offers gift(s) to client often defining it as a therapeutic act (i.e., client needs to learn they deserve this).
- accepts gifts from clients without a discussion about the meaning behind them and any potential impact on the therapeutic process.
- asks for or accepts for monetary favors such as products at reduced costs or engaging in mutual business ventures or loans.

Social (Dual Relationships)

The therapist:

- offers little to no real examination of dual roles, confidentiality, and boundaries when client and professional find themselves at the same professional, social, or personal event.
- provides transportation for client and/or client provides transportation for therapist.
- encourages or allows client to spend the night over at their home.
- travels to and attends events together with client.
- has dual relationships with clients or former clients who are:
- friends or colleagues
- family members or close friends of the family
- teachers, consultants, and/or supervisors.
- involves clients in a joint business venture (i.e., purchase of business property).
- hires clients or asks them to work at a discounted price or without payment (sometimes in exchange for therapy sessions.
- indicates client can be a friend after therapy is completed.
- borrows money from client.
- involves client in their family events.
- allows for or arranges social opportunities to occur where therapist and client attend the same swimming pool, spa and/or gym.

Breaking Confidentiality

The therapist:

- does not explain the confidentiality that they must adhere to in the therapeutic process and the situations in which they are mandated to report.
- inappropriately discusses other clients and their therapy and/or allows their information to be shared.
- declares their trust of a client warrants breaking the confidentiality of other clients so that they can elicit an opinion.
- shares details about client's therapy with other clients and/or people (i.e., family) without their permission.

Suicide

The therapist:

- minimizes or dismisses client's discussions around suicidal thoughts.
- suggests that suicide may be a solution to problems.
- ignores client's intention to commit suicide.
- indicates that the client would not survive without their assistance.

Sexual Misconduct

The therapist:

- states or acts in a manner that clearly demonstrates a sexual attraction to the client:
  - makes sexually loaded compliments of the client's body.
  - tells clients sexual jokes.
  - has a voyeuristic interest in client's physical body including breasts or genital areas.
  - repetitively asks about client's sex life.
  - makes comments that admits or announces the sexual attraction.

- declares their love for client (i.e., direct statements, valentines, and love letters or gifts).
- suggests that after therapy they could enter a sexual relationship.

- after therapy terminates invites client on a date.
- sexualizes the therapeutic process:
  - touch with unclear intentions.
  - questions about touch are unanswered.
  - no discussions around boundaries with regards to touching.
    - touching that becomes inappropriate:
    - hugging or touching too long
    - touching that feels like a caress
    - touching that feels sexualized
    - touching that doesn't relate to a therapeutic intervention
    - seems to be purposefully hurtful without warning or discussion
    - therapist appears angry around touch
  - encourages client to disrobe during sessions.
  - encourages client to masturbate during sessions as part of their healing process.
  - includes information about the therapist's sex life.
- redirects therapeutic process towards sexual content.
- uses what they define as therapeutic touch but which is uncomfortable and inappropriate (i.e., pressing on client's chest/breasts during memory work).
- suggests that the only way to heal from sexual trauma or deal with sexual problems is to engage in sexual activity with therapist including sensual touch, mutual masturbation, and sexual intercourse.
- directs client to engage in sexual activity (i.e., masturbation, use of sex toys, etc.) outside of sessions that have no clear therapeutic value. Asks client to describe that activity, in next session.
- uses physical force and/or emotional coercion, to push a client into overt sexual activity with or without actual penetration.

After

Maintaining or Regaining Control Over Client

There is a distinct difference in the before and after in the unhealthy relationship between therapist and client. When the relationship ends and/or the client begins to disclose what transpired within the healing relationship, the predatory therapist may make obvious attempts to regain control over the client. Just as the Grooming Process has striking similarities to that of child molesters, the attempts to maintain control over clients who are leaving mimics that of spousal batterers. Some of what is outlined below may occur before the client breaks away.

The therapist:

- terminates therapy suddenly without the standard sessions to process.
- refuses to refer client to another professional.
- becomes angry or punitive if client does not comply with therapist's requests and/or demand.
- belittles and/or reprimands the client on their failings in an angry, cruel, or vicious manner.
- insists the sexual contact be kept secret to protect their professional reputation or avert disciplinary actions by their professional organization.
- threatens to tell others the client's confidential material from therapy.
- weaponizes sensitive therapeutic issues to create targeted insults (gender, sexual orientation, medical history, psychiatric history, personal failings, and/or regrets).
- suddenly applies a different diagnosis to the client that will inspire suspicion around disclosures i.e. Borderline Personality.
- to regain ground, they may become angry and abusive as they lose control.
- at times the therapist seems to purposefully cause emotional pain for client.

- will apply financial control over the client as punishment or to attempt to thwart disclosures.
- in relationships that developed into 'marriages' or 'life-partnerships,' will apply forms of control similar to that of a batterer: restrict access to financial assets, take away children, pets, access to other love ones, kick out of home, isolate by involving others in their dispute often using lies, etc. If physical or emotional abuse was a part of this relationship, those will intensify.

Note:

These guidelines pertain to talk therapy. Other issues may arise for clients seeing massage or other bodywork therapists (click here for more information).

If you have questions regarding this list, please do not hesitate to contact **Bernadine Fox** (bernadinefox@outlook.com) using subject line "Questions regarding Checklist".