MAPS: Trust, Consent, Professional Touch, and Transference

Therapeutic Alliance and Trust

- We act in accordance with the trust placed in us by participants.
- We aspire to create and maintain therapeutic alliance built on trust, safety, and clear agreements, so that participants can engage in inner exploration and relational healing.
- We respect the inner healing intelligence of participants to guide their experience.
- We respect the autonomy of each participant to make decisions in their life and make meaning of their experiences.
- We acknowledge that the healing process is deeply personal, and each participant has unique needs for treatment and support.
- We prioritize the participants' therapeutic needs and treatment goals.
- We treat people receiving services or reaching out for services with respect, compassion and humility.
- We firmly maintain the responsibility of upholding clear professional boundaries.
- We acknowledge the inherent power differential between therapy providers and participants and act conscientiously in the service of participants' self- empowerment.
- We examine our own countertransference and unconscious biases.
- We avoid entering into dual relationships that are likely to lead to impaired professional judgment or exploitation. In cases where there is a dual relationship, we give special attention to issues of confidentiality, trust, communication, and boundaries, and seek supervision as needed.
- We use careful judgment about continuing interaction with existing or previous participants outside of treatment.
- When treating couples or families, we consider potential conflicts of interest, disclose policies on communicating information between family members, and discuss continued care and treatment plan.
- When working with participants in a research study, we strive to deliver therapeutic benefit while following scientific protocol.

Touch

- When using touch in our practice, we always obtain consent and offer touch only for therapeutic purposes.
- We only offer techniques, such as touch, if they are within our scope of practice and competence.
- When touch is part of our practice, we discuss consent for touch during intake, detailing the purpose of therapeutic touch, how and when touch might be used and where on the body, the potential risks and benefits of therapeutic touch, and that there will be no sexual touch.
- We obtain consent for touch prior to the participant ingesting medicine, as well as in the moment. Aside from protecting a person's body from imminent harm, such as catching them from falling, the use of touch is always optional, according to the consent of the participant.
- We discuss in advance simple and specific words and gestures the participant is willing to use to communicate about touch during therapy sessions. For example, participants may use the word "stop" or a hand gesture indicating stop, and touch will stop.
- We practice discernment with touch, using clinical judgment and assessing our own motivation when considering if touching a participant is appropriate.

Sexual Boundaries

- We do not engage in sexual touch with participants.
- We take responsibility for upholding clear professional boundaries.
- We do not engage in sexual intercourse, sexual touch, or sexual intimacy with a participant, former participant, their spouse or partner, or their immediate family member, at any point during treatment or following termination.

• We commit to examining our own sexual countertransference, to not act in ways that create ambiguity or confusion about sexual boundaries, and to seek supervision as needed.
• We respect the sexual identities and expression of participants and validate participants' processes that might relate to sexuality and sexual healing.
- As representatives of this work, we aim to uphold clear sexual boundaries and ethics in our daily lives.

Special Considerations for Non-Ordinary States of Consciousness

- We attend to special considerations when working therapeutically with participants in non-ordinary states of consciousness.
- Participants in non-ordinary states of consciousness may be especially open to suggestion, manipulation, and exploitation; therefore, we acknowledge the need for increased attention to safety, sexual boundaries, and consent.
- In therapy, both positively and negatively shaded kinds of transference may occur. "Idealized transference" describes when a patient assumes that the therapist has certain positive characteristics (such as wisdom). If the positive feelings are not too exaggerated, this form of transference may be useful for the therapist-patient alliance. Negative transference might be at work when a patient has feelings about the therapist, such as suspicion or anger, that seem to be based on experiences from past relationships.
- A patient's experience of sexual or romantic feelings about the therapist has been called sexualized transference. The concept dates back to Freud, who posited that some patients fall in love with their therapist because of the context of psychoanalysis, not because of the actual characteristics of the therapist. Later theorists distinguished between "erotic transference," which can involve sexual fantasies that a patient realizes are unrealistic, and "eroticized transference"—a more intense and problematic pattern that may include explicit sexual overtures from a patient.
- We do not engage in coercive practices or behaviors.
- In working with non-ordinary states that can evoke unconscious material for both the participant and therapy provider, we acknowledge the potential for stronger and more complex transference and countertransference. Therefore, we practice self-awareness and self-examination and seek supervision and guidance as needed.
- We approach participants' experiences with respect, curiosity and openness. We suspend our own beliefs and opinions and cultivate an expanded perspective that embraces extraordinary states.