A Critical Look at 11 Myths & Faulty Beliefs in Psychotherapy & Counseling

Instructor: Ofer Zur, Ph.D.
www.drzur.com

Handout for 9/25/2021

Presented by:

Myth 1: The Inherent Power differential
Once a client—Always a client
Therapists' power in perpetuity

From the first day in graduate school in psychology, we psychotherapists-in- training have been instructed to pay great attention to the "inherent power differential" in psychotherapy. We were taught to be aware of the imbalance of power between therapists and clients, and repeatedly warned against inadvertently abusing or exploiting our vulnerable and dependent clients. The idea of power, as an attribute possessed exclusively by the therapist in the client- therapist relationship, has been largely left unchallenged. Our professional newsletters and advice columns on ethics and risk management present a similar unified message about therapists' unilateral power and clients' inherent vulnerability. Many psychotherapy clients and those who are mandated to undergo different types of forensic evaluations, are very vulnerable because the power differential, indeed, exist in these professional relationships. They may be distressed, young, impaired, traumatized, psychotic, anxious, and/or depressed. However, there are also clients who function highly, emotionally, and psychologically, and are powerful and effective in these and many other ways. They may be wealthy investors, powerful CEOs, established artists, forensic psychologists, or simply very centered, solid human beings who seek therapy to find meaning, seek their highest potential in a certain arena, or perhaps find a closer relationship to God. They are neither depressed, nor traumatized, nor vulnerable. As therapists we must know the difference: we must remember that not all clients are created equal.

Resources:

Zur, O. (2008). Re-Thinking the "Power Differential" in Psychotherapy: Exploring the myth of therapists' omnipotence and patients' fragility. Voices: The Art and Science of Psychotherapy, 44 (3), 32-40.

Zur, O. (2009). Power in Psychotherapy and Counseling: Exploring the "inherent power differential" and related myths about therapists' omnipotence and clients' vulnerability. Independent Practitioner 29, (3), 160-164.

Myth 2: Risk Management is Inherent Part of the Standard of Care

- **Risk Management's Don't:**
  - ❖ Touch
  - ❖ Leave the office
  - ❖ Give or accept gifts
  - ❖ Barter
  - ❖ Self-disclose
  - ❖ Engage in dual relationships
  - ❖ Make home visits

- None of the above "Don't" are inherently below the standard of care for psychotherapy

- Risk management is promoted, primarily, by insurance companies to reduce their potential liabilities

Resources:

- Risk of risk management: https://drzur.com/risk-management/
- The Ethical Eye: Don't Let "Risk Management" Undermine Your Professional Approach: https://drzur.com/risk-of-risk-management/

Myth 3: Physical Touch in psychotherapy is unethical and . . . leads to sex

"Among all the senses," Montagu states, "touch stands paramount."

We have been told by ethics experts, attorneys, continuing education instructors and supervisors never to touch our clients beyond a handshake. Touch has been increasingly perceived as a risk management issue to be avoided rather than as one of the most powerful ways to connect with and heal our clients. The paranoid notion that non-sexual touch is likely to lead to a sexual relationship, is countered by greater understanding of the importance of touch for human connection and bonding and in reducing stress, anxiety, and depression. Despite a half century of extensive knowledge on the emotional, relational, physiological, and behavioral benefits of touch, many therapists still shy away from appropriate non-sexual touch due to fear of boards, attorneys, and lack of training. Even though most therapists touch their clients by patting them on the back, holding a hand or giving an appropriate hug at the end of sessions, they do not write or talk much about it. The good news is that more clinicians are open to looking at the benefits of touch. Even though US culture tends to sexualize all forms of touch, clinicians are increasingly aware of the importance of touch with those who are depressed, anxious, and stressed, as well as clinically appropriate touch with children and women who were sexually abused.

Resources:

Zur, O. & Nordmarken, N. (2021). To Touch or Not to Touch: Rethinking the Prohibition on Touch in Psychotherapy and Counseling, Clinical, Ethical & Legal Considerations. Online publication by O. Zur, Ph.D.

Zur, O. (2020). Risk Management: Touching is not Always a Violation. The National Psychologist, Spring, p.6.

Myth 4: Dual relationships in counseling are always unethical, constitute ill-advised boundary violations and…are likely to lead to…sex

Dual relationships, or multiple relationships, in psychotherapy refer to any situation where multiple roles exist between a therapist and a client. Examples are when the client is also a student, friend, family member, employee, or business associate of the therapist. A dual role of therapist and expert witness is likely to constitute an ethical violation, due to the therapist acting outside his/her scope of practice, unavoidable conflict of interest, or due to engaging in unethical multiple relationships. Psychotherapists making custody recommendations (i.e., engaging in a dual role of therapists & experts) is one of the most common reasons for psychotherapists to be disciplined by licensing boards. Clearly, forensic psychologists who conduct forensic evaluations, such as sanity to stand trial or custody evaluations should avoid dual or multiple relationships of any form. Non-sexual dual relationships are not necessarily unethical or illegal. Sexual, exploitative, and harmful dual relationships are unethical and can be illegal. Most of the major professional associations' codes of ethics state that multiple relationships should be avoided if they could reasonably be expected to impair the therapist's effectiveness or cause harm. There are several kinds of dual relationships: Dual relationships can be avoidable, unavoidable, or mandated; consecutive or sequential; expected or unexpected-accidental; initiated by therapists, clients, both or a third party and they can be of low, medium, or high intensity. Dual relationships are often unavoidable in rural and small communities, the military, forensic settings, church and LGBTIQ communities and among people with HIV/AIDS, Hispanics, African American, Asians and other minority communities. Almost all ethical guidelines do not mandate a blanket avoidance of dual relationships. All guidelines do prohibit sexual dual relationships with current or recently terminated clients and prohibit exploitation of clients.

Resources:

Free online resources; https://drzur.com/favorite-articles/#dual-relationships

Zur, O. (Ed.) (2017). *Multiple Relationships in Psychotherapy and Counseling: Unavoidable, Common and Mandatory Dual Relations in Therapy*. New York: Routledge

Zur, O. (2010) Forensic Psychology Dual Relationships: Is it Kosher for a Psychotherapist to Serve as an Expert Witness? Online publication.

Zur, O. (2006). Therapeutic Boundaries and Dual Relationships in Rural Practice: Ethical, Clinical and Standard of Care Considerations. Journal of Rural Community Psychology. V. E9/1 (Online Journal)

Zur, O. (2005). On law-imposed dual relationships. Online Publication.

Zur, O., The Truth About the Codes of Ethics on Dual Relationships

Myth 5: As the slippery-slope argument predicts, boundary crossings inevitably lead to boundary violations.

The baseless and paranoid idea of the "slippery slope" has been with us for too long and, when followed, results in substandard care. It is idiotic to assert that non-sexual touch is likely to lead to sexual touch, that simple gift-giving results in social relationships, or that bartering inevitably ends in exploitation.

Resources:

- Boundaries in Therapy – Summary Brochure: https://drzur.com/media/boundariesbrochure.pdf
- Zur, O. (2004). To Cross or Not to Cross: Do boundaries in therapy protect or harm. Psychotherapy Bulletin, 39(3), 27-32.
- Zur, O. (2007). Boundaries in Psychotherapy: Ethical and Clinical Explorations. Washington, DC: American Psychological Association - APA Books.

Myth 6: “Don’t blame the victim” - Victims are always 100% innocent.

Psychotherapists and attorneys are in the forefront of those who fuel the “Victim Industry” in the U.S. “Don’t blame the victim,” has become a moratorium on exploring situations where victims bear responsibility. As a result, we have become a nation of victims. In reality, some victims are 100% innocent (i.e., abused children) and others are willing and relentless participants in their own (repetitious) victimization.

Resource:

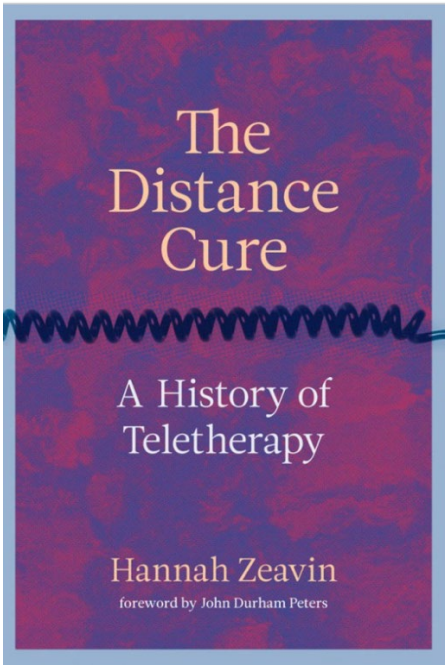
Zur, O. (1994). Rethinking "Don't Blame the Victim": Psychology of victimhood. Journal of Couple Therapy, 4 (3/4), 15-36.

Myth 7: 'Distance Care' is new: It started in the last decade – It started with the COVID-19 explosion

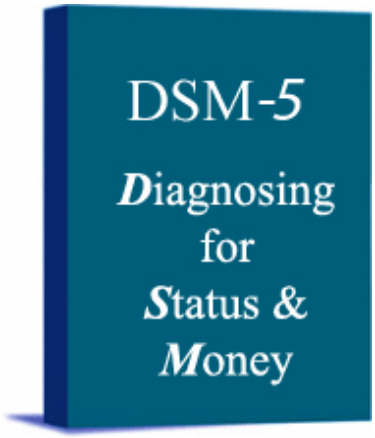
Distance Care (AKA Telemental Health) is NOT New

- Freud's letters w/ 'Little Hans' (1890) + 30,000 personal (self-analysis) letters
- Suicide Prevention, Domestic Violence & Crisis Hotlines/Lifelines
- Phone Therapy (since 1960)
- 'Warm Line' (855-845-7415)
- Dr. Phill – TV Therapy
- Telemental Health: "Dear Uncle Ezra" (1986 - Cornell Univ.)
- More recently:
  - **Covid-inspired Telemental Health explosion**
  - Social Media
  - Text Therapy (TalkSpace, BetterHelp, etc.)
  - Virtual Reality
  - **AI - Artificial Intelligence – The future is . . . here**

Hannah Zeavin's 2021 book:



Myth 8: The DSM is a scientifically valid, and reliable document.



Unlike what we were told in most graduate schools and assessment workshops, in my humbled opinion, the DSM is a politically and economically driven document more than a scientific one. My research and impressions have led me to believe that decisions regarding inclusion or exclusion of disorders are made by majority vote rather than by the review and acceptance of indisputable objective scientific data. One telling example: Homosexuality was listed as a mental disorder in the DSM until 1974, when gay activists demonstrated in front of the American Psychiatric Association Convention. The APA's 1974 vote showed 5,854 members supporting and 3,810 opposing the disorder's removal from the manual. Ever since, homosexuality has not been regarded as a mental illness. Voting on what constitutes mental illness is truly bizarre and, needless to say, unscientific. It is my impression that in recent years, the DSM has been primarily driven by the psychopharmacological industry, which reaps huge profits from each new diagnosis that can be treated with psychotropic medication

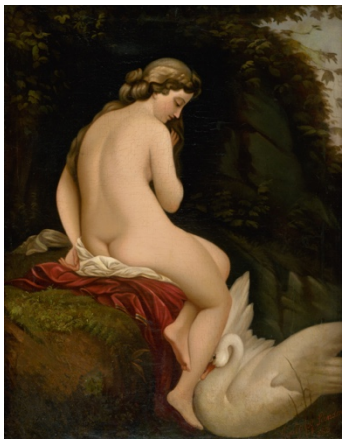
Resource:

DSM: Diagnosing for Status & Money

- https://drzur.com/dsm-critique/
- https://drzur.com/clinical-updates/dsm-5-diagnosing-for-status-and-money/

Myth 9: It is never ever ethical, legal, or OK for a psychotherapist to be naked with a client.

It is all about Context:



Most, if not all, therapists, understandably, are likely to respond with a "Hell no!" as they probably connote this situation with a sexual encounter. Obviously, sex with clients is ALWAYS unethical, counter-clinical, and illegal in most states, but then imagine a situation in which a therapist is stepping out of the shower stall in the local gym when, to his or her or great surprise, a client (equally naked) steps out of the next stall. This is called an "incidental contact," "chance occurrence," or what I call an "out-of-office experience" that takes place in the community, outside of the treatment room. Such nude encounters have been reported to have taken place between men and women at nudist beaches or at the hot tubs in Esalen. This vignette is an example of how therapists and ethicists must first understand and comprehend the specific context of each and every situation BEFORE they cast uninformed, 'instinctive' judgment.

The appropriate meaning and applicability of boundaries can only be understood within the context in which therapy takes place. **The context of therapy consists of the following five components**:

- *Client factors:* Culture, age, gender, acculturation, language, history of trauma, sexual/physical abuse, presenting problem, severity of mental disturbances, class, personality, social support, etc.
- *Therapy factors:* Individual vs. family vs. group therapy; short term vs. long term; frequency; child vs. adult psychotherapy; psychoanalysis vs. humanistic vs. group therapy vs. body psychotherapy; etc.
- *Setting factors:* Outpatient vs. inpatient vs. day program; solo practice vs. group practice; office location (e.g., home office, hospital); locality (rural, urban, reservation, university, military base, prison); elective vs. mandated; voluntary hospitalization vs. involuntary; In person (f2f) vs. Telehealth, etc.
- *Therapeutic relationship factors*: Quality/nature of therapeutic alliance; length, phase in therapy; idealized/transferential relationships vs. egalitarian relationships; familiarity and interactivity in community vs. only in office; presence or absence of dual relationships; etc.
- *Therapist factors:* Culture, age, gender, sexual orientation, experience, training, etc.

Resources:

- Brochure: https://drzur.com/media/boundariesbrochure.pdf
- Articles: https://drzur.com/favorite-articles/#dual-relationships

Myth 10: Malpractice Lawsuits against psychotherapists and counselors are common and therapists should be very concerned

We have been indoctrinated to fear lawsuits and our licensing boards. The simple fact that social workers, MFT's and counselors pay about $300-$400 a year for malpractice insurance and psychologists pay about $1,400 a year while many cardiologists, anesthesiologists and Obstetricians pay $50,000 or much more a year clarify the level of risk between psychotherapists and these physicians. The percent of complaints to licensing boards is not as high as many attorneys and "ethicists" lead us to believe. Even when charges are brought, most complaints are dropped without any charges being filed.

Myth 11: TeleMental Health significantly reduces the risk of therapists violating boundaries or sexually engaging with their clients

- **Texting into the night**
- **Blurring personal vs. professional**
- **The online disinhibition effects**
    - **Excessive self-disclosure**
    - **Loose Boundaries**

Suler, J.: The Online Disinhibition Effect:
http://drleannawolfe.com/Suler-TheOnlineDisinhibitionEffect-2004.pdf

ABSTRACT

While online, some people self-disclose or act out more frequently or intensely than they would in person. This article explores six factors that interact with each other in creating this online disinhibition effect: dissociative anonymity, invisibility, asynchronicity, solipsistic in- trojection, dissociative imagination, and minimization of authority. Personality variables also will influence the extent of this disinhibition. Rather than thinking of disinhibition as the revealing of an underlying "true self," we can conceptualize it as a shift to a constellation within self-structure, involving clusters of affect and cognition that differ from the in-person constellation.