# What Therapists Don't Talk About and Why

## UNDERSTANDING TABOOS THAT HURT US AND OUR CLIENTS

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Chapter

# 1

# Questioning Myths, Taboos, Secrets, and Uncomfortable Topics

Our education takes shape not just from what's in textbooks, graduate programs, and internships but from what's missing—what we don't see, acknowledge, or talk about. The relative silence about so many of the topics in this book is part of our education. We learn what topics are to be ignored, treated as secrets, denied, discounted, or examined no longer than you would hold a hot potato.

We go to our careers unprepared to address these topics realistically. We learn the processes of avoidance, masking, and minimization and begin to model them for our colleagues, our clients, our students, and the public.

This is a book of exploration, discovery, and learning. It was created to help therapists and therapists-in-training explore topics that are taboo, that receive only superficial treatment, or that provoke anxiety, discomfort, and confusion. They put us at risk in some way. We can avoid, mask, or minimize them so effectively that they become invisible to us.

The 1993 edition of this book focused on taboos around therapists' sexual feelings, arousal, and fantasies. This second edition explores a wider range of topics, including feelings of incompetence; therapists' blunders; fee disasters; hatred for a patient; therapists getting sick, growing old, and dying; confusion about disability and accessibility; *prayer with patients as part of therapy;* boredom; patients with terrible body odor; therapists' fears and

terrors; sexual orientation and self-disclosure; vulnerability; therapists' shame and guilt; silence about research data that are influential but faked; difficult aspects of race and ethnicity; anger at patients; the experience of being fired; confusion about what to do; and betrayal of ourselves, our profession, and our values to get ahead or just survive.

Like the original 1993 book, this new edition avoids imposing "right" answers and clinging to traditional, "politically correct," "emotionally correct," or "psychologically correct" approaches. As described later, the book's model of learning encourages a mindful awareness of the complex, messy situations that occur in real life, of how we respond to them, and of the need for openness, honesty, courage, and constant questioning. The book has been created for use by individual therapists or in courses, workshops, peer-consultation, or study groups (please see chap. 3).

## Basic Myths About the Psychotherapist

Why is it so easy to avoid these topics and so hard to talk about them openly, honestly, and realistically? Part of the answer may lie in the myths we have constructed about psychotherapists.

Where do these myths come from, and why do we live by them? There are as many reasons as there are myths. It's tempting to create an idealized version of ourselves to hide our flaws, mistakes, and vulnerabilities. Some clients hold flattering images of us, and we take the bait. Clinging to myths can make us feel safe when the world or our work scares us or makes us feel insecure. Myths comfort us when what happens in therapy makes us feel sad, frustrated, enraged, aroused, or hopeless. Most myths look like time-savers: If money will take care of itself, for example, there's no reason to waste time studying business principles, discussing how to set fees, or learning how to market a practice.[1]

The myths map out taboo areas and turn us away from them. If, for example, a myth denies therapists' sexuality or competi-

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[1]See chapters 2, 7, and 9 of Pope, K. S., & Vasquez, M. J. T. (2005). *How to survive and thrive as a therapist: Information, ideas, and resources for psychologists in practice.* Washington, DC: American Psychological Association.

tiveness, it can produce the emperor's new clothes in reverse: We don't see them when they're there. Or if we see them, we keep quiet about them.

Do we actually believe these myths? Hard to say. Most make us laugh if we give them a moment's thought. But we act as if we believe them. We set up training curricula, guide classroom discussions, provide resources, plan careers, and evaluate our progress as if the myths were true.

Although it is likely that all of us have been vulnerable to at least some of these myths, they represent unrealistic thinking about who we are as psychotherapists. As we recognize and come to terms with these errors in thinking about psychotherapists, we prepare ourselves to talk more frankly about topics that tend to be taboo. Part of this book's purpose is to provide tools—see particularly chapters 5 and 7—that will be helpful in identifying myths and taboos and avoiding rationalizations, fallacies, and evasions in examining them and their implications.

Here are just a few of the myths that afflict our training and practice. It is almost certain that every reader of this book could extend this list, and we encourage classes, workshops, and study groups not only to question whether the myths listed here have influenced their own settings but to identify influential myths that don't appear here.

**MYTH:** Therapists learn therapy and practice in organizations free of competition's influence.

OK, you can stop laughing now. No, really, you'll get the hiccups. It seems strange that a myth could flourish that is so at odds with reality. The system of grading puts us in competition with each other from our earliest years. Grading on the curve intensifies the process: A grade of 60% might be excellent or failing, depending on how well the other students did on the test. Many of us remember being asked, at the end of a test, to pledge in writing that "I have neither given nor received help on this test." We compete—with our grades, GRE scores, letters of recommendation, interviews, and other criteria—for admission to graduate school. Once in graduate school, we continue to compete—for grades, for teaching and research assistantships, for letters of recommendation, for internships, and so on, as well as for the intan-

gibles, such as "to be the most [insert desired quality—such as intelligent, well-prepared, wise, competent, articulate, likable—here] student in the class." We learn from professors who are also competing—for tenure, office space, grant money, promotions, raises, and, at least sometimes, attention, prestige, and popularity. This competition can lead to interesting behavior. In more than one graduate program, a reference book put on reserve before an exam, so that every student can check it out only for an hour, has gone mysteriously missing. Students may start circulating rumors about their competitors, rumors that are creative, plausible sounding, reputation destroying, and false.

The degree to which we are competing in so many ways with each other in a system that fosters competition provides a context in which opening up, failing to mask our weaknesses, allowing ourselves to be vulnerable, speaking frankly, acknowledging our mistakes (especially when no one else has discovered them), and engaging in genuine exploration and discovery may be a handicap, ready for skillful exploitation by those who see taking down others as a way for them to advance in the competition.

Some of the greatest difficulties seem to occur when the history, context, and process of competition are not acknowledged, when everyone acts as if learning and practicing therapy occur in settings free of competition's influence. This can make people feel a little crazy, everyone assuming that only he or she feels that way. It can isolate people and throw them off stride. It can make people mistrust their own feelings, perception, and judgment.

This myth is *not* about whether competition per se is helpful, hurtful, mixed, or "it depends." It is about the degree to which the presence and influence of competition may have become invisible, unacknowledged, unexamined, and unspoken.

**MYTH:** If you're a good therapist, the money will take care of itself.

The effects of this myth can be seen in the number of therapists who finish their graduate training without any education in fundamental business principles. So many of us know nothing of how to construct a realistic and effective business plan, how to budget for an office and other expenses, how to market our practice, or how to anticipate the financial seasons of a practice.

The myth also makes itself felt in the relative lack of attention that many graduate programs pay to therapy fees. It is as if there were a belief that fee setting, fee collection, what to do about late payments, what to do about people who refuse to pay their bills, and so on were either irrelevant to the therapy or so easy that we therapists need little or no training in that area.

The difficulty acknowledging the role that fees can play both in the therapy itself and in the therapist's attempts to make a living has deep historical roots. Large volumes that reviewed psychotherapy research tended to ignore the topic completely, prompting one author to comment,

> As a footnote, I would like to remark that if a Martian read the volumes reporting the two psychotherapy conferences and if he read all the papers of this conference it would never occur to him that psychotherapy is something done for money. Either therapists believe money is not a worthwhile research variable or money is part of the new obscenity in which we talk more freely about sex but never mention money. (p. 539)[2]

Nobett Mintz[3] once termed fees a "tabooed subject," suggesting that various factors "functioned to inhibit therapists from inquiring too closely into the financial side of psychotherapeutic practice and the actual effects it may have on the therapeutic enterprise" (p. 37). Tom Gutheil[4] noted that little had changed in this regard in his 1986 chapter in Krueger's book, *The Last Taboo: Money as Symbol and Reality in Psychotherapy and Psychoanalysis.*

**MYTH:** Therapists are invulnerable, immortal, and ageless.

A colleague of one of the authors had worked for years at a hospital and community mental health center. One day, a docile

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[2]Colby, K. (1968). Commentary: Report to plenary session on psychopharmacology in relation to psychotherapy. In J. M. Schlein (Ed.), *Research in psychotherapy* (Vol. 3, pp. 536–540). Washington, DC: American Psychological Association.

[3]Mintz, N. L. (1971). Patient fees and psychotherapeutic transactions. *Journal of Consulting and Clinical Psychology, 36,* 1–8.

[4]Gutheil, T. C. (1986). Fees in beginning private practice. In D. Krueger (Ed.), *The last taboo: Money as symbol and reality in psychotherapy and psychoanalysis* (pp. 175–188). London: Brunner-Routledge.

and somewhat confused day-treatment patient asked for directions to the office of someone who would be conducting a psychological assessment. The colleague, who was headed toward that wing of the center, offered to escort the patient to the office.

As they walked down one of the corridors, the patient pulled a knife, forced the colleague into a deserted room, and, locking the door behind them, held her hostage. The patient began to hallucinate and threatened to kill her. Although the center's staff noticed the therapist was not showing up for her appointments, no one knew where she was. Hours later, she was able to talk the patient into giving up his knife and letting her go.

In the weeks and months after this harrowing experience, the therapist tried to understand why she had ignored the warning signs that became clear in retrospect and had made herself vulnerable to such risks with no backup plans about how to handle them. In part, she thought, it was because she'd come to feel safe in "her" center and ignored risks and warnings that she'd be alert to if she were walking down the street or even visiting in another facility. Feeling safe and secure—although this feeling reflected a myth—in her familiar work setting had become an unexamined part of her identity.

The myth of the invulnerable, immortal, ageless therapist is reflected in the number of therapists who complete their training without learning how to set up a practice office with an eye toward safety—how to screen new clients, what to do if a client pulls a weapon during a session, how to secure a therapy office and waiting room in light of potential violence, what arrangements to make to summon help in the event of violence or the immediate threat of violence, and so on.

The myth is reflected also in the number of therapists who practice without an adequate professional will and other arrangements. It is difficult to acknowledge in a real and practical way that any of us could at any moment experience a stroke, a heart attack, an accident, a criminal attack requiring hospitalization, or any of the other diverse illnesses, disorders, incidents, and misfortunes that can prevent us—temporarily or permanently—from functioning as therapists.

Imagine the consequences when a therapist in individual or group practice suddenly dies without having made a professional

will.[5] Colleagues may not only be coping with their shock and grief over their sudden loss of a friend but also be forced to scramble to find the keys to their friend's therapy office and filing cabinets, the passwords to their Palm Pilot and computer, where schedules and contact information are stored, the code to retrieve answering machine messages, and so on; during which the friend's clients—some of them in crisis—are showing up at the office for their appointments and leaving messages, some of them urgent, on the friend's answering machine.

The myth's influence can be seen also in the number of therapists who continue to practice when Alzheimer's disease or other age-related factors have impaired their ability to function adequately as a therapist.[6] We tend to avoid planning for the contingencies of aging. We don't want to monitor ourselves and ask trusted colleagues to attend to any signs that we are losing our competence.

**MYTH:** With their extensive education and training, therapists have a firm grasp of logic and, whatever the limits of their knowledge, do not fall prey to basic logical fallacies.

Courses in the various forms of logical reasoning seem relatively rare in graduate psychology programs, continuing education programs, and workshops. The myth seems to assume either that psychologists have an inherent grasp of logical thinking or that we somehow pick it up along the way.

Few myths grant us as much power as this one. Faced with a devastating critique of our own pet hypothesis, one that brings empirical data and sound reasoning to show that our falsifiable hypothesis is in fact false, we can easily dismiss the critique with an argumentum ad logicam, argumentum ad ignorantiam, or straw person argument. Or we could dismiss the person who wrote the critique with an ad hominem attack or *tu quoque* response.

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[5]Pope, K. S., & Vasquez, M. J. T. (2005). *How to survive and thrive as a therapist: Information, ideas, and resources for psychologists in practice.* Washington, DC: American Psychological Association.

[6]Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling: A practical guide,* (2nd ed.). San Francisco: Jossey-Bass.

Lapses in logic unfortunately find their way into classroom discussions, peer-reviewed journal articles, and especially the polarized debates of controversial topics. Because logically flawed statements can sound so convincing—at least when used to support something that we ourselves value, believe in, or hope for—they blend in and are easy to miss. They have worked their way into so many forms of our discourse that it is worth pausing here to look at some of the most common forms of errors in reasoning. Here are some logical missteps that can trip up most of us at one time or another.[7]

## Ad Hominem

The *argumentum ad hominem,* or *ad feminam,* attempts to discredit an argument or position by drawing attention to characteristics of the person who is making the argument or who holds the position.

**Example:** "The research and reasoning that supposedly support (or that supposedly discredit) this intervention are a joke. The researchers are people who are not methodologically sophisticated, and there have been rumors—I have no idea whether they're true or not—that they faked some of the data. The advocates (or opponents) of this intervention are the worst kind of sloppy thinkers. They are fanatical adherents who already have their minds made up; they've become true believers in their cause. They make arguments only a stupid person would accept, and mistakes in reasoning that would make an undergrad psychology major blush. These are not the kind of people who deserve to be taken seriously."

## Affirming the Consequent

This fallacy takes the form of

If $x$, then $y$.
$y$.
Therefore, $x$.

**Example:** "People who are psychotic act in a bizarre manner. This person acts in a bizarre manner. Therefore, this person is psychotic."

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[7]This section is adapted from "Falacies and Pitfalls in Psychology" © Ken Pope, available at http://kspope.com.

**Alternate example:** "If this client is competent to stand trial, she will certainly know the answers to at least 80% of the questions on this standardized test. She knows the answers to 87% of the test questions. Therefore, she is competent to stand trial."

## Appeal to Ignorance (Ad Ignorantium)

The *appeal to ignorance* fallacy takes this form:

There is no (or insufficient) evidence establishing that $x$ is false.
Therefore, $x$ is true.

**Example:** "In the 6 years that I have been practicing my new and improved brand of cognitive–humanistic–dynamic–behavioral–decontructive–metaregressive–deontological psychotherapy (now with biofeedback!), which I developed, there has not been one published study showing that it fails to work or that it has ever harmed a patient. It is clearly one of the safest and most effective interventions ever devised."

## Argument to Logic (Argumentum ad Logicam)

The *argument to logic* fallacy takes the form of assuming that a proposition must be false because an argument offered in support of that proposition was fallacious.

**Example:** "This new test seemed so promising, but the three studies that supported its validity turned out to have critical methodological flaws, so the test is probably not valid."

## Begging the Question (Petitio Principii)

This fallacy, one of the fallacies of circularity, takes the form of arguments or other statements that simply assume or restate their own truth rather than providing relevant evidence and logical arguments.

**Examples:** Sometimes this fallacy literally takes the form of a question, such as, "Has your psychology department stopped teaching that ineffective approach to therapy yet?" (The question assumes—and a "yes" or "no" response to the question affirms—that the approach is ineffective.) Or, "Why must you always take

positions that are so unscientific?" (The question assumes that all of the person's positions are unscientific.) Sometimes this fallacy takes the form of a statement such as, "No one can deny that [my theoretical orientation] is the only valid theoretical orientation" or "It must be acknowledged that [whatever psychological test battery I use] is the only legitimate test battery." Sometimes it takes the form of a logical argument, such as, "My new method of conducting meta-analyses is the most valid there is because it is the only one capable of such validity, the only one that has ever approached such validity, and the only one that is so completely valid."

## Composition Fallacy

This fallacy takes the form of assuming that a group possesses the characteristics of its individual members.

**Example:** "Several years ago, a group of 10 psychologists started a psychology training program. Each of those psychologists is efficient, effective, and highly regarded. Their training program must be efficient, effective, and highly regarded."

## Denying the Antecedent

This fallacy takes the form of

If $x$, then $y$.
Not $x$.
Therefore, not $y$.

**Example:** "If this test were based on fraudulent norms, then it would be invalid. But the norms are not fraudulent. Therefore, this test is valid."

## Disjunctive Fallacy

This fallacy takes the form of

Either $x$ or $y$.
$x$.
Therefore, not $y$.

**Example:** "These test results are clearly wrong, and it must be either because the client was malingering or because I bungled the test administration. Taking another look at the test manual, I see now that I bungled the test administration. Therefore, the client was not malingering."

## Division Fallacy

The division fallacy or decomposition fallacy takes the form of assuming that the members of a group posses the characteristics of the group.

**Example:** "This clinic sure makes a lot of money. Each of the psychologists who work there must earn a large income."

## False Analogy

The *false,* or *faulty, analogy* fallacy takes the form of argument by analogy in which the comparison is misleading in at least one important aspect.

**Example:** "There were wonderful psychologists who passed away several decades ago. If they could be effective in what they did without reading any of the studies or other articles that have been published in the last several decades, there's no need for me to read any of those works to be effective."

## False Dilemma

Also known as the *either–or* fallacy or the fallacy of *false choices,* this fallacy takes the form of only acknowledging two (one of which is usually extreme) options from a continuum or other array of possibilities.

**Example:** "Either we accept the findings of this study demonstrating that this new intervention is the best to be used for this disorder, or we must no longer call ourselves scientists, psychologists, or reasonable people."

## Golden Mean Fallacy

The fallacy of the *golden mean* (or fallacy of *compromise,* or fallacy of *moderation*) takes the form of assuming that the most valid con-

clusion is that which accepts the best compromise between two competing positions.

**Example:** "In our psychology department, half of the faculty believes that a behavioral approach is the only valid approach; the other half believes that the only valid approach is psychodynamic. Obviously, the most valid approach must be one that incorporates both behavioral and psychodynamic elements."

## Mistaking Deductive Validity for Truth

This fallacy takes the form of assuming that because an argument is a logical syllogism, the conclusion must be true. It ignores the possibility that the premises of the argument may be false.

**Example:** "I just read a book proving that book's author can do much better than any psychological test at determining whether someone is malingering. The book's author reviews the literature showing that no psychological test is perfect at identifying malingering. All have at least some false positives and false negatives. But the author has a new method of identifying malingerers. All he does is listen to the sound of their voices as they say a sentence or two. And he included in the book a chart showing that by using this method, he has never been wrong in hundreds of cases. This proves his method is better than using psychological tests."

## Naturalistic Fallacy

The *naturalistic* fallacy takes the form of logically deducing values (e.g., what is good, best, right, ethical, or moral) based only on statements of fact.

**Example:** "There is no intervention for victims of domestic violence that has more empirical support from controlled studies than this one. It is clear that this is the right way to address this problem, and we should all be providing this therapy whenever victims of domestic violence come to us for help."

## Post Hoc, Ergo Propter Hoc (After This, Therefore on Account of This)

The *post hoc, ergo propter hoc* fallacy takes the form of confusing correlation with causation and concluding that because $y$ follows $x$, then $y$ must be a result of $x$.

**Example:** "My new sport psychology intervention works! I chose the player with the lowest batting average based on the last game from each of the teams in our amateur baseball league. Then I gave each of them my 5-minute intervention. And almost all of them improved their batting average in the next game!" (Note: This example may also involve the statistical phenomenon of regression to the mean.)

## Red Herring

This fallacy takes the form of introducing or focusing on irrelevant information to distract from the valid evidence and reasoning. It takes its name from the strategy of dragging a herring across the path to distract hounds and other tracking dogs and to throw them off the scent of whatever they were searching for.

**Example:** "Some of you have objected to the new test batteries that were purchased for our program, alleging that they have no demonstrable validity, were not adequately normed for the kind of clients we see, and are unusable for clients who are physically disabled. What you have conveniently failed to mention, however, is that they cost less than a third of the price, are much easier to learn, and can be administered and scored in less than half the time compared with the tests we used to use."

## Straw Person

The *straw person,* or *straw man,* or *straw woman* fallacy takes the form of mischaracterizing someone else's position in a way that makes it weaker, false, or ridiculous.

**Example:** "Those who believe in behavior modification obviously want to try to control everyone by subjecting them to rewards and punishments."

## Tu Quoque (You Too!)

This fallacy takes the form of distracting attention from error or weakness by claiming that an opposing argument, person, or position has the same error or weakness.

**Example:** "I have been accused of using an ad hominem approach in trying to defend my research. But those who attack me and my research are also using ad hominem. And they started it!"

**MYTH:** Learning ethical standards, principles, and guidelines, along with examples of how they have been applied, translates into ethical practice.

It is difficult for many of us to let go of this myth. When the subject is ethics, so many licensing exams, graduate courses, and workshops focus almost exclusively on knowledge of formal ethics codes, their history and evolution, their relation to legal standards, and figuring out which code sections might be applicable to specific situations.

It is as if the answers to our ethical questions were already there in the code, waiting to tell us what to do, if only we were sufficiently familiar with it and could open ourselves up completely to it and listen intently and passively receive its wisdom without static or interference. However, what the code says is the beginning, not the end, of ethical consideration, of an ethical response to a situation.[8,9]

It is important not only to understand the nature and complexity of the considerations that are informed, but not determined, by the code but also to become aware of and appreciate the subtle ways in which all of us are vulnerable to cognitive strategies that allow us to evade ethical responsibilities while protesting, sometimes a little too loudly, that we are upholding the highest ethics and that anyone who disagrees or questions our reasoning is wrong, stupid, naive, and probably an all-around bad person. We may become indignant and accuse these others of be-

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[8]See footnote 6, this chapter.

[9]Please see chapter 7, section entitled "The Legal and Ethical Framework."

ing unethical and of refusing to acknowledge our virtue and righteousness.

These cognitive strategies may rely on subtle rationalizations, appealing fallacies, doublespeak, or Alice-in-Wonderland maneuvers to make even the most selfish, thoughtless, harmful, or inhumane behavior come across as ethically ideal. Our awareness of the ways that each of us as individuals may be vulnerable—particularly at times of stress or fatigue, of great temptation or temporary weakness—to these cognitive strategies may be an important aspect of our ability to respond ethically to difficult and complex situations, particularly at moments when we are not at our best. Our ability to recognize these maneuvers as we are falling prey to them and to avoid, however reluctantly, their seeming rewards may be as influential to an ethical response as a knowledge of the ethics code.

What sorts of cognitive strategies are commonly used to justify unethical behavior as ethical? Here are a few. We encourage readers to expand the list.

1. It's not unethical as long as a managed care administrator or insurance case reviewer required or suggested it.
2. It's not unethical if we can use the passive voice and look ahead. If it is discovered that our CV is full of degrees we never earned, positions we never held, and awards we never received, all we need do is nondefensively acknowledge that mistakes were made and it's time to move on.
3. It's not unethical if we're victims. If we need to justify our victim status, we can always use one of two traditional scapegoats: (a) our "anything-goes" society, lacking any clear standards, that lets what were once solid rules drift and leaves us all ethically adrift or, conversely, (b) our coercive, intolerant society, tyrannized by "political correctness," that is always dumbing us down and keeping us down. Imagine, for example, we are arrested for speeding while drunk, and the person whose car we hit decides vengefully to press charges. We can show ourselves as the real victim by writing books and appearing on television pointing out that the legal system has been hijacked by a vicious minority of politically correct, self-serving tyrants who refuse to acknowledge that most speeding while

drunk is not only harmless but constructive, getting drivers to their destinations faster and in better spirits. Those who question our claims and reasoning are clearly intolerant, trying to silence us and destroy our right to do what is right.

4. It's not unethical as long as we can name others who do the same thing.
5. It's not unethical as long as there is no body of universally accepted, methodologically perfect (i.e., without any flaws, weaknesses, or limitations) studies showing—without any doubt whatsoever—that exactly what we did was the necessary and sufficient proximate cause of harm to the client and that the client would otherwise be free of all physical and psychological problems, difficulties, or challenges. This view was succinctly stated by a member of the Texas pesticide regulatory board charged with protecting Texas citizens against undue risks from pesticides. In discussing chlordane, a chemical used to kill termites, one member said, "Sure, it's going to kill a lot of people, but they may be dying of something else anyway" (p. 17).[10]
6. It's not unethical if we acknowledge the importance of judgment, consistency, and context. For example, it may seem as if a therapist who has submitted hundreds of thousands of dollars worth of bogus insurance claims for patients he never saw might have behaved "unethically." However, as attorneys and others representing such professionals often point out: It was simply an error in judgment, completely inconsistent with the high ethics manifest in every other part of the person's life, and insignificant in the context of the unbelievable good that this person does.
7. It's not unethical as long as no law was broken.
8. It's not unethical if we can say any of the following about it (feel free to extend the list):

   "What else could I do?"
   "Anyone else would've done the same thing."
   "It came from the heart."
   "I listened to my soul."
   "I went with my gut."
   "It was the smart thing to do."

[10]Perspectives. (1990, April 23). *Newsweek*, p. 17.

"It was just common sense."
"I just knew that's what the client needed."
"I'd do the same thing again if I had it to do over."
"It worked before."
"I'm only human, you know!"
"What's the big deal?"

9. It's not unethical if the American Psychological Association, the American Psychiatric Association, the American Counseling Association, the National Association of Social Workers, or a similar organization allows it.
10. It's not unethical as long as we didn't mean to hurt anyone.
11. It's not unethical even if our acts have caused harm as long as the person harmed has failed to behave perfectly, is in some way unlikable, or is acting unreasonably.
12. It's not unethical if we have written an article, chapter, or book about it.
13. It's not unethical as long as we were under a lot of stress. No fair-minded person would hold us accountable for what we did when it is clear that it was the stress we were under—along with all sorts of other powerful factors—that must be held responsible.
14. It's not unethical as long as no one ever complained about it.
15. It's not unethical as long as our clients' condition (probably borderline) made them so difficult to treat and so troublesome and risky to be around that they elicited whatever it was we did (not, of course, to admit that we actually did anything).
16. It's not unethical as long as we don't talk about ethics. The principle of general denial is at work here. As long as no one mentions ethical aspects of practice, no course of action could be identified as unethical.
17. It's not unethical as long as we don't know a law, ethical principle, or professional standard that prohibits it. This rationalization encompasses two principles: specific ignorance and specific literalization. The principle of specific ignorance states that even if there is, say, a law prohibiting an action, what we do is not illegal as long as we don't know about the law. The principle of literalization states that if we cannot find specific mention of a particular incident anywhere in legal, ethical, or professional standards,

it must be ethical. In desperate times, when the specific incident is unfortunately mentioned in the standards and we are aware of it, it is still perfectly ethical as long as the standard does not mention our theoretical orientation. Thus, if the formal standard prohibits sexual involvement with patients, violations of confidentiality, or diagnosing without actually meeting with the client, a behavioral, humanistic, or psychodynamic therapist may legitimately engage in these activities as long as the standard does not explicitly mention behavioral, humanistic, or psychodynamic therapy.

18. It's not unethical as long as there are books, articles, or papers claiming that it is the right thing to do.
19. It's not unethical as long as a friend of ours knew someone who said an ethics committee somewhere once issued an opinion that it's OK.
20. It's not unethical as long as we know that legal, ethical, and professional standards were made up by people who don't understand the hard realities of psychological practice.
21. It's not unethical as long as we know that the people involved in enforcing standards (e.g., licensing boards or administrative law judges) are dishonest, stupid, destructive, and extremist; are unlike us in some significant way; or are conspiring against us.
22. It's not unethical as long as it results in a higher income or more prestige (i.e., is necessary).
23. It's not unethical as long as it would be really hard to do things another way.
24. It's not unethical as long as no one else finds out—or if whoever might find out probably wouldn't care anyway.
25. It's not unethical if we could not (or did not) anticipate the unintended consequences of our acts.
26. It's not unethical as long as we can find a consultant who says it's OK.
27. It's not unethical as long as the client asked us to do it.
28. It's not unethical as long as we don't intend to do it more than once.
29. It's not unethical as long as we're very important and can consider ourselves beyond ethics. The criteria for importance in this context generally include being rich, well known, extensively published, or tenured; having a large

practice; having what we think of as a "following" of likeminded people; or having discovered and given clever names to at least five new diagnoses described on television talk shows as reaching epidemic proportions. Actually, if we just think we're important, we'll have no problem finding proof.

30. It's not unethical as long as we're busy. After all, given our workload and responsibilities, who could reasonably expect us to obtain informed consent from all our clients, keep our chart notes in a secured area, be thorough when conducting assessments, and follow every little law?

## The Nature and Reality of Myths, Taboos, Secrets, and Uncomfortable Topics

What do these myths suggest about the implicit image of the therapist we try to live up to or grow into, plan our training and practice around, and measure ourselves against?

One possible response to that question is that this image represents an invalid, unrealistic, and downright wrong standard for us, our development, and our work. We seem to be trying to hold ourselves to a standard requiring us to be immortal, invulnerable, ageless therapists, unaffected by competition, to whom the principles of business, finance, and logic come so naturally that we need no formal training in them and for whom ethical behavior is mainly a matter of knowing the ethics code and examples of how to apply it.

The purpose of this short book is to invite exploration and discussion of such myths; the taboos, secrets, and uncomfortable topics they foster; the errors in thinking they represent; and their implications for our development and work. As will become apparent in the following pages, this book's model of exploration, discovery, and learning depends in part on the reader's ability and readiness to be relentlessly honest about topics, experiences, and responses that most of us find it difficult to acknowledge. The process invites us to go beyond stances, views, and words that are safe and familiar, that are socially acceptable, that seem clearly right or at least clear. It is relatively easy for many of us to