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A PHILOSOPHY OF THERAPEUTIC CHANGE

Allen E. Bergin*

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Approaches to therapeutic change are necessarily a melange of philosophy, science and art; and are not yet proximal to the applied science that we have tried to achieve. Consequently, a comprehensive view of positive change must include more than empiricism. Such a view should have the following characteristics: It should be, first of all, eclectic, because there is no one method for all people and conditions. It should also be, of course, *Empirical*, and then *Psychological, Sociological, Physiological, Moral, Spiritual*, and *Educational*. Consider first the Eclectic and Empirical aspects of a comprehensive approach.

Eclectic and Empirical

The empirical and eclectic go together in that the more empirical one is the more obvious it is that there is merit in a number of approaches; however, neither empiricism nor eclecticism have been popular until recent years. I recall how negative Albert Bandura's response was to my essay outlining an eclectic system for his graduate seminar in 1959; and also the skeptical reaction of behavioristic colleagues at Temple University to my lecture on multiphasic therapy in 1967, with the notable exception of Arnold Lazarus who has left that camp to become a leading eclectic systematist. It was equally surprising to me how resistant practitioner colleagues in the New York area were to empirical findings during my eleven years there. However, it seems, that many of these longstanding resistances have been crumbling all through the 1970s; so it is timely to reassert principles that have endured and which show promise to become basic assumptions for the behavioral helping professions.

It is essential to good practice that professional therapeutic interventions have supporting data from empirical studies. Although methods continue to proliferate without good scientific roots, they will gradually fade away from the ethical therapy scene unless verification of efficacy is forthcoming. This is equally crucial for both secular techniques and the spiritual ones that many of us are experimenting with.

Coincidentally, I was impressed recently by the fact that the Missionary Training Center in Provo conducted an experiment to determine the preferable mode for memorizing 100 essential scriptures. Traditional memory drill exercises were compared, in a controlled test, with two presumably superior methods based upon sophisticated mnemonic systems. The traditional method proved superior and was retained. It is perhaps no accident that this study took place at a religious center headed by a member of our AMCAP Board of Governors, Joe J. Christensen. May we go and do likewise in our own practices.

This is all the more important today in our consumer-oriented society, where funding is increasingly tied to evidence of positive effects. The impact of empiricism is perhaps best illustrated in the decline of traditional psychoanalysis (dropped from 41% preferring the orientation in 1961 to 19% in 1974) and the rise of behavior therapies. Supportive evidence is rare in the one case and relatively abundant in the other. This is not to say there is no merit in psychodynamic therapy but that its relative merit has declined.

Empirical results have also affected practice in another way--namely, to increase the tendency of practitioners to become eclectic in their orientations. A variety of studies show that more than one technique is effective, and that there is no such thing as one superior method. Ardent allegiances to single approaches are thus breaking down, with the exception of a few entrenched classical Freudians, operant conditioners, and primal screamers. For instance, Garfield and Kurtz (1974) found, via a national survey of 865 clinical psychologists, that 55% considered themselves to be eclectics. A subsequent study of this subsample of eclectics (Garfield and Kurtz, 1977) revealed that they pragmatically adapt a variety of techniques to the needs of each specific client, even though half of the therapists (49%) had previously adhered to a single viewpoint. It is interesting that, consistent with my own approach, psychodynamic and behavioral approaches are the ones most commonly woven into the substrata of these eclectic systems even though they seem to contradict each other, as well as the assumptions of the humanistic and interpersonal methods they are often merged with!

To give you a flavor of the attitudes of this group of eclectics and their melding of empirical and eclectic philosophy, let me quote some of their own words as they articulate the kind of viewpoint I am espousing and which I think is the trend of the future. The next generation of therapists may, I hope, be taught that such thinking is essential to good practice.

> By eclectic, I mean whatever frame of reference seems to best fit a particular client....
>
> ...each client is unique and his situation or reason for coming for help is unique....
>
> Different strokes for different folks. Learning theory to influence behavioral problems. Psychodynamic approach to motivational conflicts. Group process orientation to people with interpersonal difficulties.
>
> I found that Rogerian methods worked with one type of patient, Sullivanian with another, rational-emotive with still another....I found I could combine hypnotic methods with my behavior modification techniques.
>
> In view of the concept of individual differences...it is theoretically probably nonsense that any one system of therapy is or can be applicable to every problem.

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> Because all schools of psychotherapy claim successes, and yet all have their failures, the best bet...is that different patients...need different treatment experiences.
>
> I am no longer interested by or supportive of adherence to "big" theory. I am much more persuaded by empirical results and sometimes find a small theory or piece of a big theory helpful to explain and organize a problem. My orientation is pretty pragmatic and technique oriented.
>
> I find that I can understand emotional process best using psychoanalysis and many aspects of molar behavior best by using constructs from social learning theory.
>
> No theory or set of theories is presently adequate to explain the range of behaviors confronting a clinical psychologist. Each theory suggests particular dimensions of relevance for the fuller description of the complex world of human behavior, but no one—or any combination of them--describes the whole story. Eclecticism is the acknowledgement of the truthfulness and usefulness of multiple perspectives and the present inadequacy of single perspectives. (From Garfield and Kurtz, 1977)

There are, of course, many eclectic systems going back to those of Adolph Meyer and Frederick Thorne (1950) and up to Arnold Lazarus' (1981) newest book this year. It was surprising to me to observe the enthusiasm with which our symposium (Garfield, Strupp, Goldfried, Frank, Waskow, and Bergin) on eclecticism was greeted at the American Psychological Association meetings in Los Angeles this past August. There, six leading persons in psychology and psychiatry unanimously endorsed eclecticism without a dissent from a crowd of several hundred persons. A trend, and possibly a movement, has grown up.

The next steps in empirical work are to (a) compare the effeciveness of such eclecticism with narrower approaches, and (b) to specify the precise conditions under which one method should be prescribed over another. Even though there is currently some confusion over how to put such a package together and do good tests of efficacy, we are far better off empirically than we were in the days when it was unclear whether any therapy did anyone any good.

The remainder of this essay is devoted to a consideration of further elements of a complete system. I do not consider these to be original but I do consider it rare to put all of these pieces together. I think they provide a comprehensive scaffolding for a complete system that is evolving as a result of the work of many people. Let me deal first with some psychological elements.

Psychological

It is my view that there are four strong psychological traditions of value. No *one* is exclusively correct, and all will be superseded by an approach that utilizes the valuable trends each has fostered; but first, "What have been the essential contributions of each that should be recognized by all practitioners?"[*]

The Dynamic Tradition. Unconscious processes. Psychodynamics of communication and interaction, including transference and countertransference. It is my opinion that no one can fully understand another human being nor fully help that person without comprehending how unconscious and psychodynamic factors operate in behavior and being able to manage such factors during the therapeutic transaction. Thus, to be good at any other form of therapy, the therapist must be a good psycholanalyst.

The Humanistic Tradition. Definition of the kind of relationship

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[*]This section is derived from a lecture delivered to the Dutch Psychotherapy Society in Amsterdam and to be published in *Tidschrift voor Psychotherapie,* 1982, in press.

that has healing effects, which liberates the person from inhibiting self-concepts and frees the person to explore life, form deep affective ties, and make new choices based upon self-determined values. This capacity to form a trusting, understanding and freeing relationship is also fundamental to all other therapies. Thus, one cannot become a good analyst nor a good behavior therapist without being a good humanistic-relationship therapist. If a relationship of deep trust and empathic communication is not established, then exploration of dynamics is impeded, knowledge of cognitive structures is limited, and understanding of the circumstances under which conditioned responses may be elicited cannot be ascertained.

The Behavioristic Tradition. The first contribution is objectivity and precision in describing disorders and designing methods of treatment. This has been an essential addition to the subjectivity of the other methods. This approach has also insisted upon specificity of intervention which has produced acceleration of change over previous rates of change and has provided the client with specific and objective behavioral links to reality for feelings and thoughts that have been liberated and brought to the fore by good therapy. It has also revealed and exposed for all to see the powerful and often damaging and excessively controlling effects of environmental influences. By providing means by which the person can be freed from the domination of environmental stimuli (conditioned habits) and endowed with a new capacity to select self-chosen responses, this approach has provided a major addition to our therapeutic repertoire.

The Cognitive Tradition. This approach has provided us with a proper analysis of the role of ideas, beliefs, values, concepts and constructs in the modification of symptoms and the revision of habits, lifestyles and personal goals. It has shown vividly the possibilities for internal, conscious mental regulation and management of both feelings and behavior. It is built upon the others in that this rational aspect of self cannot function fully without the prior liberating effects of relief from unconscious forces, conditioned responses, constricted emotions and a damaging self-image.

A Multidimensional, Eclectic Approach. The foregoing assertions imply that an intergration of the valuable aspects of each method into a comprehensive, eclectic approach is reasonable, feasible and essential.

The idea, presented by some, that there are fundamental incompatibilities among these approaches come from the fact that our theories are too narrow and primitive.

A comprehensive conception of how the body works does not demand that every system or organ of the body operate according to the same principles. Thus, our view of how the circulatory system works is quite different from our view of the nervous system. The forces and actions of the human heart operate according to the principles of fluid mechanics, whereas the principles of electrochemistry apply to the transmission of nerve impulses through the neuron; yet, these two quite different processes occur in the same human body and are coordinated harmoniously despite their apparently disparate functions.

Similarly, human personality operates in accordance with a complex interaction of seemingly disparate processes that act together, though each differently and

in its own sphere. Thus, it is entirely conceivable that the same individual may suffer at one time from a repressed conflict, a conditioned response, an incongruent self-image, and irrational cognitions; and that each of these dysfunctions may operate in semi-independent systems of psychic action which are amenable to rather different interventions, each of which is compatible with the system to which it is being applied.

Eclecticism and Psychopathology. The success of therapeutic intervention is dependent upon an accurate view of what is wrong; however, theories of pathology vary according to therapeutic traditions. In my opinion, the same progress will occur here that is occurring in psychotherapy, namely, that we will have a systematic, eclectic approach to pathology. In the future, diagnosis will determine the locus of disorder according to which portion or portions of the multisystem psyche is involved. Treatment will then be selected for its relevance to that locus. For example, cognitive therapy for cognitive disorders, self-control therapy for impulse-control disorders, and several therapies for a multidimensional disorder, an approach consistent with the prescriptive emphasis of several contemporary innovators (Beutler, 1979; Garfield, 1980; Goldfried, 1981; Goldstein and Stein, 1976; Hammond and Packard, 1976; Lazarus, 1967, 1981).

We are also gradually learning which disorders are influenced mostly by sociological factors and therefore respond best to a familial, community or political approach as opposed to traditional psychotherapy.

It is also important to recognize that in addition to disorders where the client has been a victim of pathological psychosocial or familial conditions, there are many others wherein the client is a perpetrator of negative effects and must accept guilt for harmful consequences. Treatment in such cases requires moral reform rather than ordinary psychotherapy because the cause is violation of moral principles. This assumes that immorality can have pathologizing effects.

Thus, analyses of "what is wrong" or what "causess" pathology include not only a multidimensional, eclectic synthesis of secular approaches, but also an assessment of the client's values and how those values and value-related behavior may be factors in the disturbance.

The role of the therapist's values in guiding and managing change also obviously has much prominence, especially in light of the fact that technique alone is often one of the weaker variables in effecting change when compared with the personal characteristics of the therapist.

Physiological

Next, we need to consider human biology and its place in the clinical scheme of things. While this may seem to be a parenthetical aspect of our training and practice, it needs to become more fully included in our repertoires.

In the past ten or twenty years, there has been restoration of the old gospel idea that the mental and physiological are part of a dynamically integrated entity. Opposed to the Descartesian dualism that has held sway for so long, the professional view now reflects the essence of Doctrine and Covenants 93:33: "...spirit and element, inseparable connected, receive a fulness of joy."

To approach any psychological problem from a purely psychological perspective, in light of modern research, seems naive. Advances in neuropsychology, behavioral genetics, developmental biology, etc. make a psychobiological perspective an imperative element of proper clinical practice.

The mere fact alone that the respective hemispheres of the brain conspire to dominate the way we perceive and respond to the world must give pause to every believing environmentalist. If individual infantile temperamental differences are even in part laid down in the genetic material and in the brain, we have to adjust our thinking about how disturbances are aquired and what the limits are of planned changes we may wish to implement. Systems of personal constructs are not merely mental but emerge from the interplay of perception with biologically given orienting dispositions and the action of one's agency. To omit the dispositional is to forget that we are material beings with long histories, and that one purpose of this life is to integrate that material with an effective lifestyle and moral direction, rather than to (naively and futilely) attempt to override that material.

One of the more significant evidences of the trend is that the category of psychophysiological disorders was dropped from the American Psychiatric Association's Diagnostic and Statistical Manual, 3rd Edition, in favor of the notion that psychological factors may contribute to any physical disorder and, by implication, vice versa. This is a simple but sweeping change in perspective, which is responsive to the holistic trends in both medicine and behavioral science. New treatment regimens thus are not only designed to modify psychological factors contributing to physical distress but there is a much broader emphasis upon modifying bodily conditions in order to improve mental states.

I am not referring here simply to the use of psychoactive drugs, with their checkered history, but rather to trends, consistent with gospel principles, that emphasize enhancing the health and vitality of the body by means of aerobic exercises, weight control, systemic purity, quality nutrition, etc. These trends pertain to broader lifestyle qualities that are consonant with the notion that there are ways of living that matter for physiological and mental health. To ignore these is to ignore a basic root of dysfunction and to err in many diagnoses; and it also means omitting the potentiality for powerful psychotherapeutic results from physical changes.

I was surprised, just this week, to receive a manuscript for editorial review concerning the relationship between brain structures and multimodal therapy that fits nearly perfectly with what I have said about multiple psychological systems. Consider this quotation from that paper:

"(It is postulated that) humans possess several major, semi-independent fuctional brain systems, including internal, behavioral, non-verbal, cognitive and 'symbolic processes' regulatory systems; each capable of influencing other

regulatory systems, each processing independent learning and memory and each programmable by a unique set of modification parameters."

I do not have the time or sophistication to pursue this in detail here; but this aspect needs to be an integrated part of all behavioral training, diagnosis, and intervention.

Sociological

No modern approach to change can, however, be left at the level of individual or interpersonal psychology or to psychophysiology, no matter how empirically sophisticated or eclectic. Without a sociological framework and methods for using and affecting social networks, individual changes, regardless of how dramatic they may be, are subject to severe limitations. It is no secret that we live in a complicated network of familial, communal, and societal influences and power structures. These can inhibit or facilitate individual change; and they can nullify or help to maintain therapeutic effects from whatever source they originate.

While I believe that individual psychology is as basic to behavioral science as physics is to physical science, it is not sufficient to leave our analysis at that level. The surge of competent research and practice in the marital and family area has to be recognized as a substantial contribution to both the diagnostic and therapeutic armamentarium. For psychiatrists and clinical psychologists to assume that the categories of DSM-III can stand on their own, independent of dysfunctions in the family system or the social network, ignores the proven potency of sociological factors in psychopathology, a good illustration being the high rate of marital-familial disress in cases of diagnosed affective disorder. The inclusion in DSM-III of psychosocial stressor axis partially recognizes the importance of such factors but it is insufficient in that, diagnostically, the *interaction* may be the problem to be treated, not the depression or other individual disorder. While in some cases, individual treatment or simultaneous individual and interactional treatment may be most effective, this does not diminish our responsibility to pinpoint sociological causality and deal with it whenever it is recognizable.

A related aspect of such treatment is the growing evidence that natural therapeutic events and relationships already exist in the social environment and can be mobilized for therapeutic gain. These include nonprofessional helping relationships that occur in the familial, social and institutional contexts, such as formal voluntary helping. Empirical studies indicate that such helping has an average effect that is substantial; consequently, the mobilization of such supportive personnel or networks of support is an intergral part of a complete approach to therapy.

In an LDS context, this means utilizing family councils, home and visiting teaching, interviews, blessings, and church assignments in a far more explicit and systematic manner. To do so would yield a gain in economy of treatment, magnitude of positive effect, and duration of change. Indeed, it is very likely that appropriate innovation in diagnostic assessment could tell us which cases could be treated primarily by such systemic intervention, given modest professional consultation.

This is of course, the present intent of the stake welfare committees, but their potential is yet to be realized. Nonetheless, it is worth pointing out that the gospel model of change, to the extent one is decipherable, is eminently sociological and communal. Healing processes are envisaged as becoming optimal inside of a viable community of believers who love and care for one another. If we were to take this model more seriously, we would do a lot less psychotherapy and help people do a lot more church work of the caring kind as opposed to the busy-work kind. The structure is nicely laid out for this, but the processes of change that should take place therein are too frequently weak or nonexistent. There is probably no other system in existence more ideally suited to gaining the confidence and acceptance of a general population for change-inducing interventions.

Also, in this connection, the special pertinence of cultural anthropology requires mention. Familial, kinship, and societal value structures vary considerably within and between societies. Even in Utah we have a variety of cultural patterns, and we must adapt to the schemes therein to be fully effective. All therapy interactions probably involve some degree of cross-cultural differences.

Moral and Spiritual

Sociological considerations bring us directly into the realm of moral issues. Whatever happens in therapy, though it may proceed in private, has consequences within the social networks in which the person or persons being treated exist. As Perry London put it: "Every aspect of psychotherapy presupposes some implicit moral doctrine." Subjective value decisions underlie the choice of techniques, the goal of change, and the assessment of what is a "good" outcome. Clinical interventions that ignore this aspect of individual behavior are seriously isolated from the moral and societal realities that surround the treatment situation. My point is to emphasize that behavioral technology cannot substitute for morality, and that every therapeutic action entails moral choices.

All I wish to say here about morality and psychotherapy is that attempts to help people should be guided by the well-defined moral principles and standards of the Church. Any method that violates spirituality, moral purity, integrity, or interferes with true love of the Lord and His children must be avoided. Any methods that enhance these things are to be embraced, for:

...every thing which inviteth and enticeth to do good, and to love God, and to serve him, is inspired of God. But whatsoever thing persuadeth men to do evil, and believe not in Christ, and deny him, and serve not God, then ye may know with a perfect knowledge it is of the devil;...(Moroni 7:13,17)

Consequently, it seems that moral guides for evaluating theories or techniques include the scriptures and the criteria by which we select church officers and

missionaries, or by which we issue and receive temple recommends. If a therapy in any degree reduces one's capacity to serve in the Church or to enjoy the spirit of the temple, it should be shunned; whereas, any approach that strengthens these divinely established functions should be sought after.

Since therapy involves the moral and spiritual, or in other words "what is good," the Lord is very relevant to it. This relevance can be vivified by using inspirational methods that enhance a client's convictions regarding what a fruitful life style is like, and which strengthen one's conviction that he or she is an eternal personality and the offspring of God. I was pleased to note that Frederick Thorne, in his 1950 book on an eclectic approach to counseling, included the need for spiritual support in his treatment. He also referred to the importance of divine providence, faith, grace, free will, salvation, sanctification, conversion, regeneration, repentance and love. When such concepts and their associated actions and feelings are incorporated into our therapeutic orientation, the full sense of what a human being is and may become comes into view. Our aspirations for the client and for ourselves are magnified and more inspired; and we can begin to realize more clearly that there is a fundamental link between the true aspects of therapeutic change and the divine law of eternal progression.

As Dr. Collins demonstrated so well this morning, the implications of the gospel for good counseling are numerous and specific. To incorporate these with valid learning from the world of research and clinical innovation is to approach the psychology of change with a more complete understanding of human nature and its possibilities for growth, if the conditions of growth are provided.

This brings me to my next point--the educational function in change.

Educational

A basic element of positive change is proper instruction in the nature of man and the moral rules that effect growth. Personality change must be linked with character development and, to the extent that it is, the whole repertoire of sound educational principles is relevant. As I stated before, much positive change can be achieved outside of the clinical mode and in the communal or social mode. A comprehensive change model, like the gospel model of change, is not at all restricted to the clinical setting or modalities. The educational or instructional mode, when added to the communal one, provides additional potency to the potential for clinical change and much of it can be done outside of the consulting relationships and at less cost.

To me this would mean an experiential-didactic system for informing people in a host of basic concepts, both from the profession and from gospel teachings. These would provide cognitive restructuring and utilize principles of cognitive psychology that could be linked with affective relearning and behavior modification, which might be simultaneously in process in the clinical relationship. The interpersonal relations lab at BYU does an integration of these along the lines I am thinking of, and it is effectively done in groups. Indeed the group setting enhances the learning.

Incidentally, while I have mentioned the importance of family approaches, I have said nothing about groups. Some of the most powerful and fruitful change

processes are affected in group settings, which are difficult to duplicate in any other way. Instruction, particularly, is suited to the group mode, and it is efficient and economical. I assume, from all I know about the Church and the gospel, that the divine model of change also includes the valid principles of group psychology. It is group systems that link the community, familial and instructional facets of the complete change model.

To return to the educational mode, consider its importance by comparing what is achieved by clinical work alone vs. educational approaches. The 600 members of AMCAP may help a few thousand people per year using traditional clinical methods; whereas benevolent effects could be distributed among millions if the right instructional means were employed.

Training

A final educational consideration pertains to clinical training. It is obvious that I think clinicians in training should be educated in an eclectic philosophy and technology. Training of the practitioner must, therefore, be broad and not confined to one specialty. The psychological specialties, psychiatry, social work, and marriage and family therapy are all too narrowly based. An eclectic clinician has to be trained in psychology, psychobiology, sociology, anthropology, family and group approaches, education, and moral and spiritual traditions. To my mind, this requires a professional school that is multidimensional and not controlled by any one specialty. Consider medicine, for instance. Medical education is not dominated by the department of physiology or anatomy or biochemistry or genetics or radiology, but they unite in the goal of mutually shaping the competency of a multimodal professional who is alert to multiple biological systems and their interactions. My dream is that someday we will have comparable training and comparable proficiency and credibility within the human behavior domain.

Unlike medicine, however, we cannot assume that our field will become an applied science dominated by technology. While behavioral technologies have already earned a place and will continue to grow, we need to recognize that the moral and spiritual are supreme variables in human behavior. These cannot be reduced to equations, technologies or other mortal modes. They are as ineffable as those invisible and increasingly miniscule atomic particles, yet even more powerful. Introducing them unflinchingly, yet systematically, into the curriculum is a task for the future, and I view it as an urgent one.

Perhaps an excerpt from the concluding remarks in one of my recent papers, delivered at the 1981 American Psychological Association Convention, will best convey my view in this matter:

In light of the pervasiveness of religious cognitions, emotions and behaviors, as documented here, it seems essential to lift the taboo on training potential clinicians in the cultural content of the religious worldviews with which most clients come for help, rather than denying their importance and coercing clients into linguistic and conceptual usages that are alien to them. Such an exercise in consciousness-raising could have beneficial effects upon the *religism* in our profession. Part of this trend would include attending to the suppressed religious impulses of clinical students and practitioners themselves. Spiritual tendencies are comon among us but they are symbolized and expressed under many aliases. Despite the fact that practicing psychologists rate themselves as religious less often than the general public, it is surprising that a *majority* consider themselves to be believers

(Marx and Spray, 1969) and ten percent of a random sample of APA members hold positions in religious organizations (Ragan, Malony and Beit-Hallahmi, 1976). One would never know this by content analyzing professional conversations or publications. This strong level of interest and participation has obviously been compartmentalized because the language of academic training and of personality, psychopathology and psychotherapy is strictly non-spiritual. Thus, the religious inclinations of clinicians are subjected to aversive consequences by a form of ideological coercion--that is, naturalism, mechanism, and secularism prevail, and one gets degrees and certification by emitting such terminology at the right times and places.

A proper re-education could begin with a selection of readings from among the references at the end of this paper.

A correlated educational experience would be to encourage more research in this domain among students at both predoctoral and dissertation levels.

In addition, teachers, research mentors and clinical supervisors need to be involved in student education who have sympathies with and experience in correlating the psychological and the religious.

Practitioners generally need to make efforts to tune into healthy religiosity as opposed to the unhealthy kind they tend to dwell upon (Salzman et al., 1965). When a client's religious values create difficulties for the therapist, consultation or referral are in order. The unethical practice of automatically interpreting values one disagrees with as having pathodynamic origins needs to be curtailed (Menninger, 1973).

In addition, practice needs to more assiduously include collaboration with the religious leaders and subcultures from which clients come. Practitioners need to broaden their horizons enough so that they can have a more complete empathy for persons who approach life from a spiritual perspective. (Cited from Bergin: "Religiosity and Mental Health: A Critical Reevaluation," APA, Los Angeles, August, 1981).

Finally, before concluding, let me make reference to some case material.

Case Illustrations

I have experienced several successes with a multidimensional approach and have published a few relevant cases; but none fully exemplify the orientation I have outlined. It seems that I can convey my point best by listing several cases that failed to improve properly due to ignoring one or more of the facets outlined here. Perhaps, if you can identify with some of these experiences, then the relevance of a comprehensive eclecticism will become more persuasive.

I have done a modest amount of therapy for 24 years, beginning in the fall of 1957, so I have my share of tales to tell. Let's assume in the cases reported here that the technique I used was administered competently, but that the defects involved had more to do with omitting additional methods. That is the main thrust of my presentation.

Case 1:

Sociological Failure. This was a case of so-called antisocial personality, with both schizotypal and borderline features, in a young Puerto Rican male in NYC. My approach was a fairly standard combination of supportive therapy combined with structure, firmness against manipulation, guided behavioral assignments, and avoidance of psychodynamic interpretations. My failure here consisted of (a) Not recognizing that what I perceived as loose thought, recurrent illusions, and cognitive disorganization was more a function of the subculture than of his personality disorders. Superstition, magical thinking, visions, etc., are part of

the milieu. Consequently, I misdiagnosed this aspect and did not tune in to the deep cultural meanings he was expressing. (b) As a result, our therapeutic alliance lacked strength, so the next time a key relationship became estranged, he attempted suicide rather than turning to me. In my pseudo-sophistication, I interpreted this as a manipulation and handled it with medical assistance but with minimum sympathy. This turned out to be mistaken also because the attempt was a manifestation of real desperation more than manipulation, for I had not fully perceived the extent to which his antisocial acting out was subcultural rather than psychopathological. He ultimately broke off contact.

I could add other examples here that startle me upon reflection in that I have been more anthropologically naive than I believed, despite my classes in the subject and my exposure to various groups. Getting inside the real worldview of people who do not share our specific heritage requires a sizeable effort. Indeed, this is the very same point I have been emphasizing to secular colleagues who seem unable to capture the essence of a client's spiritual perspective, and consequently, they make the same mistakes over and over again with religious people.

Case 2:

Psychological Failure. This was a case of rampant conflict in a family consisting of mother, father, and two children. I approached this with a combination of marital and family sessions; and then watched the tensions increase and family members become more threatening to one another. Eventually, I discovered that the mother's individual disturbances were the key to the disruption. A program of systematic desensitization of her ubiquitous fears and training in child behavior management via homework assignments and reinforcements brought about considerable improvement; but by then one daughter was quite estranged.

Such cases are not too common but they illustrate the point that family systems intervention is not necessarily sufficient, even when the presenting problem appears to be familial.

On the other hand, I suspect that there are more cases of the opposite, in which individual treatment drags on because familial dynamics that maintain the pathology are being ignored. I have noticed this in a number of cases of depression that were treated by a combination of drugs and psychotherapy. I was involved in such an instance with a single student wherein symptoms seemed to remit and then to return. Only when we insisted on the parents' becoming involved did we begin to see the real parameters of the depression, and then more fundamental progress began to occur.

Case 3:

Physiological Failure. I saw a case of depression in which several psychological modes, as well as spiritual techniques, were utilized with no progress. Subsequently, after making a referral, a medical regimen without psychotherapy produced positive results. There are probably too many instances in which psychologically oriented therapists are slow in recognizing the physical bases of mental symptoms.

On the other hand, I have also seen case after case in which medical therapists ignored either psychological factors in a physical disorder, or in which medications were administered with disregard for mental side effects. I recently saw a case in which I requested that medication for a physical problem be stopped, and as a result a disturbing set of psychological problems cleared up and, as a bonus, the physical symptoms continued to improve too.

The overuse of drugs is a continuing problem. Medications are prescribed routinely with minimal patient contact and inadequate diagnoses. Administration of drugs for depression and anxieties is too casual, too often obscures non-biological sources of disorder, creates medical dependency, and is associated with relapses. Reflexive prescribing needs to be replaced by thoughtful multidimensional assessment.

Case 4:

Moral Failure. This was not one of my cases, but it was presented at our weekly clinical case conference at Columbia. An inhibited, single young woman was treated by means of analytic therapy. Through appropriate analysis of her dynamics and by resolution of the transference with her male analyst, she was emerging from her cocoon. She was dating and becoming capable of mature affection and intimacy. Her therapist indicated that treatment would be considered fully successful when she was able to have a gratifying series of sexual encounters with a male friend.

While achievement of this goal would certainly indicate major improvement in her psychological functioning, at the same time it would be a moral failure. I so expressed this view to the therapist and assembled students and faculty. A vigorous debate ensued. My point was and is that a technical success can be nullified by ignoring moral consequences. To evaluate outcome on the basis of immediate and individual criteria is too narrow. Quality of results must also be assessed in terms of social effects and duration of effect.

In this case, encouraging a self-oriented behavior as a measure of positive results set the client up with a hedonistic ideal--a value that leads to temporary relationships, negative consequences for other persons, and eventual disappointment. To have incorporated the good clinical work within a more comprehensive schema for change could have resulted in positive effects on criteria ranging from the individual to the societal, and from immediate to long term.

Moral values intervene in such cases because the goodness of eventual consequences to the individual and to others is at stake and must be evaluated morally rather than simply technically. Unfortunately, this particular case presentation was all too typical of clinical practice, for so often such practice is competent but not moral. Widespread treatments for some common problems, like guilt-related depressions, marital disorders and sexual dysfunctions, have the appearance of being straightforward technical interventions. But they are overlaid and undergirded by a host of moral assumptions, many of which lead people into moral confusion and subsequent failure of constructive self-regulation.

A positive philosophy of change must incorporate the moral dimension so that both treatment process and outcome are guided by the highest principles and by an abiding social consciousness.

Conclusion

And so, I hope for a system that harmonizes the many means of producing positive change that derive from diverse orientations, modalities and cultural forms, but which are embraced within a mature and divinely inspired moral framework. And, I pray for the openness of thought and spirit that allow us to endorse the view expressed in Doctrine and Covenants 88:40: "...intelligence cleaveth unto intelligence; wisdom receiveth wisdom; truth embraceth truth; virtue loveth virtue;..."

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