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PSYCHOTHERAPY AND RELIGIOUS VALUES

By Allen E. Bergin *

Presented at Values and Human Behavior Institute, Brigham Young University

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Brother Bergin expresses gratitude to Victor Brown, Truman Madsen, Spencer Palmer, Jeff Bradshaw, and Karl White for their helpful suggestions. He also indicates that he does not take credit for these ideas, but recognizes that they are inherent in the Gospel. He also expresses the feeling that the reason his lectures have been so widely and favorably received is that so many people everywhere respect these values. We are grateful to him for expressing them so clearly and eloquently!

—Ed

The importance of values, particularly religious ones, has recently become a more salient issue in psychology. The pendulum is swinging away from the naturalism, agnosticism, and humanism that have dominated the field for most of this century. There are more reasons for this than can be documented here, but a sampling illustrates the point:

1. Science has lost its authority as the dominating source of truth it once was. This change is both reflected in and stimulated by analyses that reveal science to be an intuitive and value-laden cultural form (Kuhn, 1970; Polanyi, 1962). The ecological, social, and political consequences of science and technology are no longer necessarily viewed as progress. Although a belief in the value of the scientific method appropriately persists, there is widespread disillusionment with the way it has been used and a loss of faith in it as the cure for human ills.

2. Psychology in particular has been dealt blows to its status as a source of authority for human action because of its obsession with "methodolatry" (Bakan, 1972) its limited effectiveness in producing practical results, its conceptual incoherence, and its alienation from the mainstreams of the culture (Campbell, 1975; Hogan, 1979).

During a long period of religious indifference in Western civilization, the behavioral sciences rose to a crest of prominence as a potential alternative source of answers to basic life questions (London, 1964). Enrollments in psychology classes reached an unparalleled peak, but our promises were defeated by our premises. A psychology dominated by mechanistic thought and ethical naturalism has proved insufficient, and interest is declining. A corollary of this trend is the series of searing professional critiques of the assumptions on which the field rests (Braginsky & Braginsky, 1974; Collins, 1977; Kitchener, 1980; Myers, 1978).

3. Modern times have spawned anxiety, alienation, violence, selfishness (Kanter, 1979), and depression (Klerman, 1979); but the human spirit appears irrespressible. People want something more. The spiritual and social failures of many organized religious systems have been followed by the failures of nonreligious approaches. This seems to have stimulated renewed hope in spiritual phenomena. Some of this, as manifested in the proliferation of cults, magic, superstitions, coercive practices, and emotionalism, indicates the negative possibilities in the trend; but the rising prominence of thoughtful and rigorous attempts to restore a spiritual perspective to analyses of personality, the human condition, and even science itself represent the positive possibilities (Collins, 1977; Myers, 1978; Tart, 1977).

4. Psychologists are being influenced by the forces of this developing Zeitgeist and are part of it. The emergence of studies of consciousness and cognition, which grew out of disillusionment with mechanistic behaviorism and the growth of humanistic psychology, has set the stage for a new examination of the possibility that presently unobservable realities — namely, spiritual forces — are at work in human behavior.

Rogers (1973) posed this radical development as follows:

There may be a few who will dare to investigate the possibility that there is a

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lawful reality which is not open to our five senses; a reality in which present, past, and future are intermingled, in which space is not a barrier and time has disappeared. ...It is one of the most exciting challenges posed to psychology. (p. 386)

Although there has always been a keen interest in such matters among a minority of thinkers and practitioners (Allport, 1950; James, 1902; Jung, 1958; the pastoral counseling field, etc.), they have not substantially influenced mainstream psychology. But the present phenomenon has all the aspects of a broad-based movement with a building momentum. This is indicated by an explosion of rigorous transcendental meditation research, the organization and rapid growth of the American Psychological Association's Division 36 (Psychologists Interested in Religious Issues, which sponsored nearly 70 papers at the 1979 national convention), the publication of new journals with overtly spiritual contents, such as the journal of *Judaism and Psychology* and the *Journal of Theology and Psychology*, and the emergence of new specialized, religious professional foci, such as the Association of Mormon Counselors and Psychotherapists, the Christian Association for Psychological Studies, and so on.

These developments build in part on the long-standing but insufficiently recognized work in the psychology of religion represented by various organizations (e.g., Society for the Scientific Study of Religion, American Catholic Psychological Association), journals (e.g., *Review of Religious Research*), and individuals like Clark, Dittes, Spilka, Strunk, and others (cf. Feifel, 1958; Malony, 1977; Strommen, 1971); however, the newer positions are more explicitly proreligious and are not deferent to mainstream psychology.

The trend is therefore also manifested by the publication of straightforward religious psychologies by academicians such as Jeeves (1976), Collins (1977), Peck (1978), Vitz (1977), and Myers (1978) and of more wide-open values analyses (Feinstein, 1979; Frank, 1977). Even textbooks are slowly beginning to introduce these formerly taboo considerations. In previous years basic psychology texts rarely mentioned religious phenomena, as though the psychology and sociology of religion literature did not exist. But the new edition of the leading introductory text (Hilgard, Atkinson, & Atkinson, 1979) contains a small section called "The Miraculous". Although the subject is still interpreted naturalistically, its inclusion does mark a change in response to changing views.

Values and Psychotherapy

These shifting conceptual orientations are especially manifest in the field of psychotherapy, in which the value of therapy and the values that preclude its processes have become topics of scrutiny by both professionals (Lowe, 1976; Smith, Glass, & Miller, in press; Szasz, 1978) and the public (Gross, 1978).

In what follows, these issues are analyzed, as they

pertain to spiritual values, in terms of six theses.

Thesis 1: Values are an inevitable and pervasive part of psychotherapy. As an applied field, psychotherapy is directed toward practical goals that are selected in value terms. It is even necessary when establishing criteria for measuring therapeutic change to decide, on a value basis, what changes are desirable. This necessarily requires a philosophy of human nature that guides the selection of measurements and the setting of priorities regarding change. Strupp, Hadley, and Gomes-Schwartz (1977) argued that there are at least three possibly divergent value systems at play in such decisions — those of the client, the clinician, and the community at large. They stated that though there is no consensus regarding conceptions of mental health, a judgment must always be made in relation to some implicit or explicit standard, which presupposes a definition of what is better or worse. They asked that we consider the following:

If, following psychotherapy, a patient manifests increased self-assertion coupled with abrasiveness, is this good or a poor therapy outcome? ... If ... a patient obtains a divorce, is this to be regarded as a desirable or an undesirable change? A patient may turn from homosexuality to heterosexuality or he may become more accepting of either; an ambitious, striving person may abandon previously valued goals and become more placid (e.g., in primal therapy). How are such changes to be evaluated? (Strupp et al., 1977, pp. 92-93).

Equally important is the fact that

in increasing number, patients enter psychotherapy not for the cure of traditional "symptoms" but (at least ostensibly) for the purpose of finding meaning in their lives, for actualizing themselves, or for maximizing their potential. (Strupp et al., 1977, p. 93).

Consequently, "every aspect of psychotherapy presupposes some implicit moral doctrine" (London, 1964, p. 6). Lowe's (1976) treatise on value orientations in counseling and psychotherapy reveals with pains-taking clarity the philosophical choices on which the widely divergent approaches to intervention hinge. He argued cogently that everything from behavioral technology to community consultation is intricately inter-woven with secularized moral systems, and he supported London's (1964) thesis that psychotherapists constitute a secular priesthood that purports to establish standards of good living.

Techniques are thus a means for mediating the value influence intended by the therapist. It is inevitable that the therapist be such a moral agent. The danger is in ignoring the reality that we do this, for then patient,

therapist, and community neither agree on goals nor efficiently work toward them. A correlated danger is that therapists, as secular moralists, may promote changes not valued by the client or the community, and in this sense, if there is not some consensus and openness about what is being done, the therapists may be unethical or subversive.

The impossibility of a value-free therapy is demonstrated by certain data. I allude to just one of many illustrations that might be cited. Carl Rogers personally values the freedom of the individual and attempts to promote the free expression of each client. However, two independent studies done a decade apart (Murray, 1956; Truax, 1966) showed that Carl Rogers systematically rewarded and punished expressions that he liked and did not like in the verbal behavior of clients. His values significantly regulated the structure and content of therapeutic sessions as well as their outcomes (cf. Bergin, 1971). If a person who intends to be nondirective cannot be, then it is likely that the rest of us cannot either.

Similarly, when we do research with so-called objective criteria, we select them in terms of subjective value judgments, which is one reason we have so much difficulty in agreeing on the results of psychotherapy outcome studies. If neither practitioners nor researchers can be nondirective, then they must accept certain realities about the influence they have. A value-free approach is impossible.

Thesis 2: Not only do theories, techniques, and criteria reveal pervasive value judgments but outcome data comparing the effects of diverse techniques show that non-technical, value-laden factors pervade professional change processes. Comparative studies reveal few differences across techniques, thus suggesting that non-technical or personal variables account for much of the change. Smith et al. (in press) in analyzing 475 outcome studies, were able to attribute only a small percentage of outcome variance to technique factors. Among the 475 studies were many that included supposedly technical behavior therapy procedures. The lack of technique differences thrusts value questions upon us because change appears to be a function of common human interactions, including personal and belief factors—the so-called nonspecific or common ingredients that cut across therapies and that may be the core of therapeutic change (Bergin & Lambert, 1978; Frank, 1961, 1973).

Thesis 3: Two broad classes of values are dominant in the mental health professions. Both exclude religious values, and both establish goals for change that frequently clash with theistic systems of belief. The first of these can be called clinical pragmatism. Clinical pragmatism is espoused particularly by psychiatrists, nurses, behavior therapists, and public agencies. It consists of straightforward implementation of the values of the dominant social system. In other words, the clinical operation functions within the system. It does not ordinarily question the system, but tries to make the system work. It is centered, then, on diminishing pathologies or disturbances, as defined by the clinician as an agent of the culture. This means adherence to such objectives as reducing anxiety, relieving depression, resolving guilt, suppressing

deviation, controlling bizarreness, smoothing conflict, diluting obsessiveness, and so forth. The medical origins of this system are clear. It is pathology oriented. Health is defined as the absence of pathology. Pathology is that which disturbs the person or those in the environment. The clinician then forms an alliance with the person and society to eliminate the disturbing behavior.

The second major value system can be called humanistic idealism. It is espoused particularly by clinicians with interests in philosophy and social reform such as Erich Fromm, Carl Rogers, Rollo May, and various group and community interventionists. Vaughan's (1971) study of this approach identified quantifiable themes that define the goals of positive change within this frame of reference. They are flexibility and self-exploration; independence; active goal orientation with self-actualization as a core goal; human dignity and self-worth; interpersonal involvement; truth and honesty; happiness; and a frame of orientation or philosophy by which one guides one's life. This is different from clinical pragmatism in that it appeals to idealists, reformers, creative persons, and sophisticated clients who have significant ego strength. It is less practical, less conforming, and harder to measure than clinical pathology themes because it addresses more directly broad issues such as what is good and how life should be lived. It embraces a social value agenda and is often critical of traditional systems of religious values that influence child rearing, social standards, and ultimately, criteria of positive therapeutic change. Its influence is more prevalent in private therapy, universities, and independent clinical centers or research institutes, and among theologians and clinicians who espouse spiritual humanism (Fromm, 1950).

Though clinical pragmatism and humanistic idealism have appropriate places as guiding structures for clinical intervention and though I personally endorse much of their content, they are not sufficient to cover the spectrum of values pertinent to human beings and the frameworks within which they function. Noticeably absent are theistically based values.

Pragmatic and humanistic views manifest a relative indifference to God, the relationship of human beings to God, and the possibility that spiritual factors influence behavior. A survey of the leading reference sources in the clinical field reveals little literature on such subjects, except for naturalistic accounts. An examination of 30 introductory psychology texts turned up no references to the possible reality of spiritual factors. Most did not have the words *God* or *religion* in their indexes.

Psychological writers have a tendency to censor or taboo in a casual and sometimes arrogant way something that is sensitive and precious to most human beings (Campbell, 1975).

As Robert Hogan, new section editor of the *Journal of Personality and Social Psychology*, stated in a recent *APA Monitor* interview,

Religion is the most important social force in the history; of man.... But in psychology, anyone who gets involved in or tries to talk

in an analytic, careful way about religion is immediately branded a meathead; mystic; an intuitive, touchy-feely sort of moron. (Hogan, 1979, p.4).

Clinical pragmatism and humanistic idealism thus exclude what is one of the largest sub-ideologies, namely, religious or theistic approaches espoused by people who believe in God and try to guide their behavior in terms of their perception of his will.

Other alternatives are thus needed. Just as psychotherapy has been enhanced by the adoption of multiple techniques, so also in the values realm, our frameworks can be improved by the use of additional perspectives.

The alternative I wish to put forward is a spiritual one. It might be called theistic realism. I propose to show that this alternative is necessary for ethical and effective help among religious people, who constitute 30% to 90% of the U.S. population (more than 90% expressed belief, while about 30% expressed strong conviction about their belief. American Institute of Public Opinion, 1978). I also argue that the values on which this alternative is based are important ingredients in reforming and rejuvenating our society. Pragmatic and humanistic values alone, although they have substantial virtues, are often part of the problem of our deteriorating society.

What are the alternative values? The first and most important axiom is that God exists, that human beings are the creations of God, and that there are unseen spiritual processes by which the link between God and humanity is maintained. As stated in the Book of Job (32:8),

There is a spirit in man and the inspiration of the Almighty giveth them understanding.

Table 1
Theistic Versus Clinical and Humanistic Values

Theistic	Clinical-Humanistic
God is supreme. Humility, acceptance of (divine) authority, and obedience (to the will of God) are virtues.	Humans are supreme. The self is aggrandized. Autonomy and rejection of external authority are virtues.
Personal identity is eternal and derived from the divine. Relationship with God defines self-worth.	Identity is ephemeral and mortal. Relationships with others define self-worth.
Self-control in terms of absolute values. Strict morality. Universal ethics.	Self-expressions in terms of relative values. Flexible morality. Situation Ethics.
Love, affection, and self-transcendence are primary. Service and self-sacrifice are central to personal growth.	Personal needs and self-actualization are primary. Self-satisfaction is central to personal growth.
Committed to marriage, fidelity and loyalty. Emphasis on procreation and family life as integrative factors.	Open marriage or no marriage. Emphasis on self-gratification or recreational sex without long-term responsibilities.
Personal responsibility for own harmful actions and changes in them. Acceptance of guilt, suffering, and contrition keys to change. Restitution for harmful effects.	Others are responsible for our problems and changes. Minimizing guilt and relieving suffering before experiencing its meaning. Apology for harmful effects.
Forgiveness of others who cause distress (including parents) completes the therapeutic restoration of self.	Acceptance and expression of accusatory feelings are sufficient.
Knowledge by faith and self-effort. Meaning and purpose derived from spiritual insight. Intellectual knowledge inseparable from the emotional and spiritual insight. Intellectual knowledge inseparable from the emotional and spiritual. Ecology of knowledge.	Knowledge by self-effort alone. Meaning and purpose derived from reason and intellect. Intellectual knowledge for itself. Isolation of the mind from the rest of life.

This approach, beginning with faith in God, assumes that spiritual conviction gives values an added power to influence life.

With respect to such belief, Max Born, the physicist, said, "There are two objectionable kinds of believers. Those who believe the incredible and those who believe that belief must be discarded in favor of the scientific method" (cited in Menninger, 1963, p. 374). I stand in opposition to placing the scientific method in the place of God, an attitude akin to Bakan's (1972) notion of "methodolatry" that has become common in our culture.

Abraham Maslow, though viewed as a humanist, expressed concepts in harmony with the views presented here. He said, "It looks as if there is a single, ultimate value for mankind — a far goal toward which men strive" (cited in Goble, 1971, p. 92). He believed that to study human behavior means never to ignore concepts of right and wrong:

If behavioral scientists are to solve human problems, the question of right and wrong behavior is essential. It is the very essence of behavioral science. Psychologists who advocate moral and cultural relativism are not coming to grips with the real problem. Too many behavioral scientists have rejected not only the methods of religion but the values as well. (Maslow, cited in Goble, 1971, p. 92).

To quote further, "Instead of cultural relativity, I am implying that there are basic underlying human standards that are cross cultural" (Maslow, cited in Goble, 1971, p. 92). Maslow advocated the notion of a synergistic culture in which the values of the group make demands on the individual that are self-fulfilling. The values of such a culture are considered transcendent and not relative.

Maslow's views are consistent with the notion that there are laws of human behavior. If such laws exist, they do not sustain notions of ethical relativism. Kitchener (1980) has shown, for example, that behavioristic, evolutionary, and naturalistic ethical concepts are not relativistic (cf. Bergin, 1980). He makes the important point that ethical relativism is not a logical derivative of cultural relativism. Such views are consistent with the axiom of theistic systems that human growth is regulated by moral principles comparable in exactness with physical laws. The possible lawfulness of these moral traditions has been argued persuasively by Campbell (1975). Some comparative religionists (Palmer, Note 1) and anthropologists (Gusdorf, 1976) also recognize common religious value themes across dominant world cultures. Palmer in particular has stated that 80% of the world population adhere to common value themes consistent with the theses argued here (cf. Bergin, in press). Conceivably, these moral themes reflect something lawful in human behavior.

In light of the foregoing, it is possible to draw contrasts between theistic and clinical humanistic values as they pertain to personality and change. These are my own constructions based on clinical and religious experience and are not intended to support organized religion in general. History demonstrates that religions and religious values can be destructive, just as psychotherapy can be if not properly practiced. I therefore am not endorsing all religion. I am simply extracting from religious traditions prominent themes I hypothesize may be positive additions to clinical thinking. These are depicted in Table 1 alongside the contrasting views.

It should be noted that the theistic values do not come ex nihilo, but are consistent with a substantial psychological literature concerning responsibility (Glasser, 1965; Menninger, 1973), moral agency (Rychlak, 1979), guilt (Mowrer, 1961, 1967), and self-transcendence (Frankl, Note 2).

The comparisons outlined in the table highlight differences for the sake of making the point. It is taken for granted, however, that there are also domains of significant agreement, such as many of the humanistic values outlined by Vaughan (1971) that are fundamental to personal growth. Fromm's brilliant essays on love (1956) and independence (1947), for example, illustrate value themes that must be given prominence in any comprehensive system. The point of difference is their relative position or emphasis in the values hierarchy. Mutual commitment to fundamental human rights is also assumed, for example, to those rights pertaining to life, liberty, and the pursuit of happiness specified in the Declaration of Independence. Both theistic and atheistic totalitarianism deprive people of the basic freedoms necessary to fully implement any of the value systems outlined here; therefore, clinical humanists, pragmatists, and theists all reject coercion and value freedom of choice. This basic common premise is a uniting thesis. Without it, theories of mental health would have little meaning.

Substantial harmony can thus be achieved among the views outlined, but there is a tendency for clinical pragmatism and humanistic idealism to exclude the theistic position. On the other hand, religionists have

tended to be unempirical and need to adopt the value of rigorous empiricism advocated by humanists and pragmatists. My view then would be to posit what each tradition can learn from the other rather than to create an artificial battle in which one side purports to win and the other to lose. Thus, the religion-based hypotheses stated later in Thesis 6 are an open invitation to think about and test these ideas.

Thesis 4: There is a significant contrast between the values of mental health professionals and those of a large proportion of clients. Whether or not one agrees with the values I have described above, one must admit that they are commonplace. Therapists therefore need to take into account possible discrepancies between their values and those of the average client. Four studies document this point. Lilienfeld (1966) found at the Metropolitan Hospital in New York City large discrepancies between the values of the mental health staff members and their clients, who were largely of Puerto Rican, Catholic background. With respect to topics like sex, aggression, and authority, the differences were dramatic. For example, in reply to one statement, "Some sex before marriage is good," all 19 mental health professionals agreed but only half the patients agreed. Vaughan (1971), in his study of various samples of patients, students, and professionals in the Philadelphia area, found discrepancies similar to those Lilienfeld obtained. Henry, Sims, and Spray (1971), in their study of several thousand psychotherapists in New York, Chicago and Los Angeles, found the values of therapists to be religiously liberal relative to those of the population at large. Ragan, Malony, and Beit-Hallahmi (Note 3) reported that of a random sample of psychologists from the American Psychological Association, 50% believed in God. This is about 40% lower than the population at large, though higher than one would expect on the basis of the impression created in the literature and at convention presentations. This study also indicated that 10% of the psychologists held positions in their various congregations, which also indicates more involvement than is predictable from the public statements of psychologists. Nevertheless, the main findings show that the beliefs of mental health professionals are not very harmonious with those of the subcultures with which they deal, especially as they pertain to definitions of moral behavior and the relevance of moral behavior to societal integration, familial functioning, prevention of pathology, and development of the self.

Thesis 5: In light of the foregoing, it would be honest and ethical to acknowledge that we are implementing our own value systems via our professional work and to be more explicit about what we believe while also respecting the value systems of others. If values are pervasive, if our values tend to be on the whole discrepant from those of the community or the client population, it would be ethical to publicize where we stand. Then people would have a better choice of what they want to get into, and we would avoid deception.

Hans Strupp and I (Bergin & Strupp, 1972) had an interesting conversation with Carl Rogers on this subject in LaJolla a few years ago, in which Carl said,

Yes, it is true, psychotherapy is subversive.

I don't really mean it to be, but some people get involved with me who don't know what they are getting into. Therapy theories and techniques promote a new model of man contrary to that which has been traditionally acceptable. (Paraphrase cited in Bergin & Strupp, 1972, pp. 318-319).

Sometimes, as professionals, we follow the leaders of our profession or our graduate professors in assuming that what we are doing is professional without recognizing that we are purveying under the guise of professionalism and science our own personal value systems (Smith, 1961), whether the system be psychodynamic, behavioral, humanistic, cognitive, or whatever.

During my graduate and postdoctoral training, I had the fortunate experience of working with several leaders in psychology, such as Albert Bandura, Carl Rogers, and Robert Sears. (Later, I had opportunities for substantial discussions with Joseph Wolpe, B. F. Skinner, and many others). These were good experiences with great men for whom I continue to have deep respect and warmth; but I gradually found our views on values issues to be quite different. I had expected their work to be "objective" science, but it became clear that these leaders' research, theories, and techniques were implicit expressions of humanistic and naturalistic belief systems that dominated both psychology and American universities generally. Since their professional work was an expression of such views, I felt constrained from full expression of my values by their assumptions or faiths and the prevailing, sometimes coercive, ideologies of secular universities.

Like others, I too have not always overtly harmonized my values and professional work. By now exercising the right to integrate religious themes into mainstream clinical theory, research, and practice, I hope to achieve this. By being explicit about what I value and how it articulates with a professional role, I hope to avoid unknowingly drawing clients or students into my system. I hope that, together, many of us will succeed in demonstrating how this can be healthy and fruitful.

If we are unable to face our own values openly, it means we are unable to face ourselves, which violates a primary principle of professional conduct in our field. Since we expect our clients to examine their perceptions and value constructs, we ought to do likewise. The result will be improved capacity to understand and help people, because self-deceptions and role playing will decrease and personal congruence will increase.

Thesis 6: It is our obligation as professionals to translate what we perceive and value intuitively into something that can be openly tested and evaluated. I do not expect anyone to accept my values simply because I have asserted them. I only ask that we accept the notion that our values arise out of a personal milieu of experience and private intuition or inspiration. Since they are personal and subjective and are shaped by the culture with which we are most familiar, they should influence professional work only to the extent that we

can openly justify them. As a general standard, I would advocate that we (a) examine our values within our idiosyncratic personal milieus; (b) acknowledge that our value commitments are subjective; (c) be clear; (d) be open; (e) state the values in a professional context without fear, as hypotheses for testing and common consideration by the pluralistic groups with which we work; and (f) subject them to test, criticism, and verification.

On this basis, I would like to offer a few testable hypotheses.¹ These are some of the possibilities that derive from my personal experience.

1. Religious communities that provide the combination of a viable belief structure and a network of loving, emotional support should manifest lower rates of emotional and social pathology and physical disease. To some extent this can already be documented (cf. Lynch, 1977).

2. Those who endorse high standards of impulse control (or strict moral standards) have lower than average rates of alcoholism, addiction, divorce, emotional instability, and associated interpersonal difficulties. For example, Masters and Johnson (1975, p. 185) found that "swingers" at a 1-year follow-up had reduced their sexual activity and had stopped swinging. They apparently found that low impulse control increased the subjects' problems, and all but one couple said they were looking for an improved sense of social and personal security.

3. Disturbances in clinical cases will diminish as these individuals are encouraged to adopt forgiving attitudes toward parents and others who may have had a part in the development of their symptoms.

4. Infidelity or disloyalty to any interpersonal commitment, especially marriage, leads to harmful consequences — both interpersonally and intrapsychically.

5. Teaching clients love, commitment, service, and sacrifice for others will help heal interpersonal difficulties and reduce intrapsychic distress.

6. Improving male commitment, caring, and responsibility in families will reduce marital and familial conflict and associated psychological disorders. A correlated hypothesis is that father and husband absence, aloofness, disinterest, rejection, and abuse are major factors and possibly the major factors in familial and interpersonal disorganization. This is based on the assumption that the divine laws of love, nurturance, and self-sacrifice apply as much to men as to women but that men have traditionally ignored them more than women.

7. A good marriage and family life constitute a psychologically and socially benevolent state. As the percentage of persons in a community who live in such circumstances increases, social pathologies will decrease and vice versa.

8. Properly understood, personal suffering can increase one's compassion and potential for helping others.

¹Hypotheses like these have been tested, with ambiguous results (Argyle & Beit-Hallahmi, 1975). The reasons for the ambiguous results are analyzed in a forthcoming paper by our research group.

9. The kinds of values described herein have social consequences. There is a social ecology, and the viability of this social ecology varies as a function of personal conviction, morality, and the quality of the social support network in which we exist. If one considers the 50 billion dollars a year we spend on social disorders like venereal disease, alcoholism, drug abuse, and so on, these are major symptoms or social problems. Their roots, I assume, lie in values, personal conduct, morality, and social philosophy. There are some eloquent spokesmen in favor of this point (Campbell, 1975; Lasch 1978; and others). I quote only one, Alexander Solzhenitsyn, who said,

A fact which cannot be disputed is the weakening of human personality in the West while in the East it has become firmer and stronger. How did the West decline? ... I am referring to the calamity of an autonomous, irreligious, humanistic consciousness. It has made man the measure of all things on earth....Is it true that man is above everything? Is there no superior spirit above him? Is it right that man's life...should be ruled by material expansion above all?...The world...has reached a major watershed in history....It will demand from us a spiritual blaze, we shall have to rise to a new height of vision...where...our spiritual being will not be trampled upon as in the Modern Era. (Solzhenitsyn, 1978, pp. 681-684).

Conclusion

Although numerous points of practical contact can be made between religious and other value approaches, it is my view that the religious ones offer a distinctive challenge to our theories, inquiries, and clinical methods. This challenge has not fully been understood or dealt with.

Religion is at the fringe of clinical psychology when it should be at the center. Value questions pervade the field, but discussion of them is dominated by view-points that are alien to the religious subcultures of most of the people whose behavior we try to explain and influence. Basic conflicts between value systems of clinical professionals, clients, and the public are dealt with unsystematically or not at all. Too often, we opt for the comforting role of experts applying technologies and obscure our role as moral agents, yet our code of ethics declares that we should show a "sensible regard for the social codes and moral expectations of the community" (American Psychological Association, 1972, p. 2).

I realize there are difficulties in applying the notion of a particular spiritual value perspective in a pluralistic and secular society. I think it should be done on the basis of some evidence that supports doing it as opposed to the basis of the current format, which is to implement one's values without the benefit of either a public declaration or an effort to gather data on the consequences of doing so.

It is my hope that the theses I have proposed will be contemplated with deliberation and not emotional

dismissal. They have been presented in sincerity, with passion tempered by reason, and with a hope that our profession will become more comprehensive and effective in its capacity to help all of the human family.

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PSYCHOTHERAPY AND RELIGIOUS VALUES

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