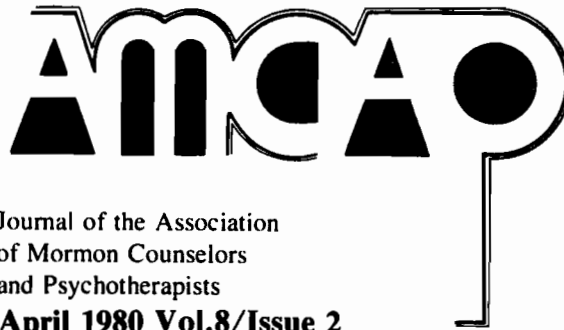


Journal of the Association
of Mormon Counselors
and Psychotherapists
April 1980 Vol 8/Issue 2

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of Mormon Counselors
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April 1980 Vol.8/Issue 2

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Richard W. Johnson
AMCAP Secretary-Treasurer
Counseling Center
C-273 ASB
Brigham Young University
Provo, UT. 84602

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Henry L. Isaksen
AMCAP Journal Editor
Ricks College
Rexburg, ID 83440

EDITORIAL

At last! we are able to publish some "letters to the editor". At last! we have more than enough good articles to fill an issue. At last! we are approaching (but not quite reaching) our objective of having the issue off the press on schedule. Many thanks to all who have contributed to the achievement of these goals.

But it's too soon to relax. We still need your help if the Journal is to be firmly established as a "medium that has some permanence," to quote Governor Carl Fred Broderick. It takes a steady flow of good materials — articles, poems, reports of research, letters to the editor, etc. — to establish the Journal as a professional quarterly of substance and stature. So please — keep them coming!

You will note that this issue contains two new features: a reprint of an article and an outline of structured group treatment. The reprint is a forerunner of the October issue, the guest editor of which will be Allen

Bergin, the author of this article which appeared recently in the Journal of Consulting Clinical Psychology. He is probably as well informed and knowledgeable about what is being published in various journals that is of significance to our readers as anyone. He has consented to select some of the most outstanding and pertinent articles that have appeared recently and edit them for us. We will look forward to hearing from you concerning how you feel about such an issue. Perhaps it can become a regular feature of our Journal.

The outline by Sisters Hoopes and Barlow should prove helpful to many of you. Please let us know.

As we continue to work with the printer and as we gain momentum and experience in doing the work associated with the editing and publishing of this Journal, we expect to improve in efficiency and skill. We appreciate your patience and understanding — and especially your letters. Please keep them coming!

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LETTERS TO THE EDITOR

Dear Dr. Isaksen:

Last month I received a letter from Richard W. Johnson concerning renewal of my AMCAP membership. At the bottom was a request to explain my reason for not rejoining AMCAP, if that was my decision. I have decided to renew my membership for one more year, but I am taking the occasion to explain why I almost didn't.

In your preface to the October, 1979 issue, you stated your editorial policy of not publishing any material which might be construed as questioning or contradicting Church doctrine. In the next paragraph you express the desire to avoid the problems that arise in the encounter with dissident viewpoints. There seems to be an implicit assumption in your policy that criticism or opposing viewpoints within the profession somehow imply criticism or opposing viewpoints within the Church. I do not want to suggest that the journal become "liberal" or "controversial." Instead I would pose a question. Are you addressing any of your readers' needs which are not already being met by Church magazines and the light weight professional journals?

In my experience there are some unique challenges and issues for an LDS therapist in treating both LDS and non-LDS clients, but the AMCAP journal, which has a unique potential for doing so, addresses none of those issues.

In closing, I would suggest to you that in our strange and peculiar society, the safe conforming voices are as likely to be self-seeking as the dissident ones, perhaps more so.

Sincerely,
Carol Atkinson
Boulder, Colorado

By presenting articles which combine LDS values and concepts with professional concerns and understandings, we feel that we are addressing our reader's needs in a way which is not being done elsewhere. However, we need to know what unique challenges and issues you are facing that are not being addressed. We would welcome specific questions or suggestions as to what issues you would like to have addressed. In fact, we would even welcome criticism and or opposing viewpoints. What we hope to avoid is any hint of opposition to or criticism of the Church, or its leaders. And yes, we want to avoid any appearance of "liberality" or "controversy" that might cause anyone to question our loyalty to the Church or the Brethren. We are of the opinion that we can address the unique challenges and issues we face as Mormon counselors and psychotherapists without running that risk. We need your help and the help of other thoughtful and articulate members to do so. And we do not feel that this stance is a safe and conforming one, nor do we feel that it is necessarily self-seeking. We hope to hear from you again.

—Ed

Dear Bro. Isaksen,

I am greatly impressed by the quality of this journal. Not being able to attend some of the conferences, I was grateful to find two articles I wanted very much to hear. These and other articles are of the quality I find in the more popular, scholarly journals.

This journal is a fine reflection of our organization. Thank you for your efforts which bring to me pride of membership.

Sincerely,
Gregory A. Newkirk
Provo, Utah

You're welcome Bro. Newkirk! And thank you for the letter!

—Ed

Dear Mr. Isaksen:

Just a note to let you know that I am delighted each time I receive your journal. I am aware of the progress that is being made in developing this journal and each issue that I receive seems to have more pertinent information in it for me. In fact, the last issue I received had an article in it which I very much enjoyed (on Anger), and later I saw it reprinted in the Ensign magazine. This helped me to incorporate the information in it as "gospel" because I know they are very selective about what goes into that magazine. I find the journal very beneficial and useful to me and appreciate all you are doing to advance the work.

With best wishes, I am sincerely,
Kathryn P. Dorff
Tyler, Texas

Thanks! We would like to feel that we, too, are very selective about what goes into our journal. We are pleased to know that you find it beneficial and useful. Please help us keep it that way.

—Ed

PSYCHOTHERAPY AND RELIGIOUS VALUES

By Allen E. Bergin *

Presented at Values and Human Behavior Institute, Brigham Young University

This article is reprinted from the Journal of Consulting and Clinical Psychology 1980 Vol. 48, No. 1, 95-105. It is an abridged synthesis of several lectures he delivered in symposia on the outcome of therapy Psychotherapy sponsored by the Institute for the Study of Human Knowledge, the University of Southern California, College of Continuing Education and Psychology Department, the Albert Einstein Medical College, and the European Conference of the Society for Psychotherapy Research (delivered in San Francisco, Los Angeles, New York and Oxford, England, in January, February, April and July 1979, respectively).

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

***Brother Bergin is Professor of Psychology at BYU and President-elect of AMCAP**

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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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STRUCTURED GROUP TREATMENT FOR DIVORCE/DEATH ADJUSTMENT

By Margaret H. Hoopes, Ph.D. and Sally Barlow, Ph.D.*

(This outline served as the basis for a presentation made at the Fifth Annual Convention of AMCAP in Salt Lake City, Oct. 5, 1979)

Structured group treatments have emerged in the last few years as a viable mode of helping people. They are defined as those groups taking place within a specified amount of time using specified exercises and/or treatment to accomplish a pre-determined set of educational and/or therapeutic goals. Such groups often focus on the stresses caused by such things as predictable developmental needs (leaving home) or unpredictable life crisis (divorce) by teaching skills otherwise left to chance. Underlying problems such as anxiety, depression, and low self-esteem may also be modified by structured treatments.

The following outline will help in the writing, developing, and eventual application of appropriate structured programs. (Drum and Knott, 1977) Following these instructions is a structured treatment for divorced/separated persons developed by Margaret Hoopes and tested by Vogel-Moline (1979). Moline found significant increases in self-esteem and significant decreases in depression among the persons who participated in this eight week structured treatment.

HOW TO WRITE STRUCTURED PROGRAMS

I. Pre-group Planning Variables

- A. Statement of Purpose & Focus of the Group. (Choosing the target population.)
- B. Assessment of Need for the Group in the Population being Served.
- C. Determination of Staff and Supportive Resources.
- D. Development of Marketing Strategy.

II. Procedures for Placing Participants in Groups

- A. Informing Participants that Treatment is Available.
- B. Selection of Participants (Orientation).
- C. Creation of Group(s): Place, Time, Size, Preparation.
- D. Involvement of Leaders.

III. Planning the Treatment: Some Considerations

- A. What are the Advantages for Treating this Population in Groups?
- B. What is the Theoretical Basis for Treatment?

***Sister Hoopes is Professor of Child Development and Family Relations at BYU and a member of the Board of Governors of AMCAP. Sally Barlow is a counselor at the BYU Counseling Center.**

1. Description of theory
2. Change factors--connected to objectives.
3. Brief description of the role of therapists, facilitators, leaders, etc.

C. How Many Leaders, What Kind of Training Must They Have, What Kind of Training for These Groups Must They Have?

IV. Writing the Treatment

- A. General Description of the Treatment--How Many Sessions, What Will Generally Be the Tone?
- B. Objectives for Overall Treatment (Outcomes).
- C. Measurement for Treatment
 1. Cognitive, affective, behavioral
 2. Individual, interactional
 3. Formal, informal
- D. Control Measures for the Treatment (Seeing if you really accomplished what you set out to!).
- E. Writing for Each Session.
 1. Objectives for the session or groups of sessions
 2. Role of therapist and participants
 3. Exercises, procedures with specific time estimates
 4. Incorporation of data collection
 5. Treatment structured enough to reach goals but also allows for personality of leader(s).

V. Training Leaders, Therapist, Etc.

- A. Written Treatment, Clear Enough That the Essentials Can Be Understood From Reading--Leader Given A Copy of Pre-Training Sessions.
- B. Training Sessions (Number, Length, Timing).
- C. Responsibilities for Each Session in Addition to Treatment.

Instructions for Leaders:

This outline contains instructions for a structured group treatment for single people who are adjusting to separation through death or divorce. The instructions have been written for you to facilitate treatment objectives. Doing the following will help you effectively administer this treatment.

1. Read the instructions until you are very familiar with the procedures.
2. Participate in training sessions until you feel at ease with the concepts and appropriate phrases.
3. In the training sessions learn and practice supportive behaviors.
4. With your co-counselor map out a plan for each session
 - a. Who will do what?
 - b. How will you keep to the time limit?

- c. What will you do to help your partner?
- d. What help will you expect from your partner?
5. During the training sessions conceptualize information to help you understand the psychological dynamics of separation.

You will receive a room assignment from the project leader. Arrive early and prepare the room. Also procure audio tapes from the project leader and tape each session.

Treatment Procedures

Group Leaders:

Co-therapist; male and female

Group Size:

Six or seven participants and two group facilitators.

General Instructions:

1. Please follow the order given in the treatment.
2. Watch the clock. You must be finished within two hours and you should not dismiss in less than ten minutes of that time. In other words, it's important that all groups have approximately the same amount of time together.
3. Tape all sessions. Be sure your recorder is working and that the tape gets turned over.
4. Contact absent members by phone the day after the group meeting.

Overview of the treatment; three phases:

Phase I: Support:

This phase of the treatment includes the first session of the group process but is emphasized in every session. The underlying value of this phase is the idea that divorced/widowed persons lose their support system and the group is going to provide that support for them while at the same time teaching them how to develop their own support outside the group. The major theme or idea that members learn is that in order to feel support in one's environment one must learn how to give, receive and ask for support. These principles are taught in the group.

Phase II: Problem Solving:

This phase goes from session 2 to 5. During this phase of the treatment members learn a method for problem-solving. One of the effects of divorce is that persons find it hard to solve the accompanying problems evoked by divorce/separation. The overall process for problem-solving introduced in this group is as follows: 1) be specific as to what the problem is, 2) discuss what has one done in past to solve the problem, 3) how would the person like things to be, 4) members in the group, without evaluating, give as many possible solutions to the problem, 5) the person evaluates each solution (disadvantages and advantages), 6) the person decides which solution will best solve the problem, 7) the person commits verbally to the group that they will act upon the solution(s) they choose to solve the problem. The ideas about support brought out in

session one will be made use of during this phase; i.e. members will ask, give and receive support from one another.

Phase III; Strengths:

During sessions 6 to 8, the group members will learn how to develop an understanding of their personal strengths they have to help them during their post divorce/separation/death from their spouse. Members will be helped by group members to become aware of their strengths. Then if there are some personal weaknesses they wish to overcome they can discuss them with the group and some suggestions will be presented on how to overcome weakness. However, the main focus of this phase is to concentrate on the positive, to help members of the group realize they have potentials which can be made use of and will help them to solve problems and overcome weaknesses.

Each phase builds upon the previous phase, the goals being that group members will learn some ways of dealing with problems and how to gain support in their environment. Also, members will become aware of their own potentials as self sufficient beings who will be able to help themselves and others. These phases are particularly important for individuals going through a separation from a spouse either from death or divorce.

Session One:

- I. Introduction: (5 minutes) Have each one introduce him/herself using first names only. Use an exercise or whatever you want to do, but by the time you finish each participant should know everyone's name. You can preface the introduction by saying that everyone will get better acquainted before the session is over, but just to start out it's helpful for people to be able to call each other by name. This should not take more than five minutes. It probably will take less.
- II. Tape recorders: (1 minute) Explain to the group that the tape recorders are there for your help. They're to give you information so that you can do the best job possible. Also, assure them of confidentiality and that they will soon forget about them. Give participants an opportunity to discuss their feelings but do not give them a choice as to whether the session is taped.
- III. Expectations of participants: (10 minutes) By confirming or disconfirming the expectations of participants the group leaders should be able to discuss the group process and the major aspect of the treatment; i.e., the support system. Utilize the following instructions to accomplish this:
 - A. Ask some of the following questions to encourage participants expression of their expectations. Sample questions are: What do you expect to hear? What do you think will happen here? What do you expect of me or of us as group leaders? What do you expect of the other participants? Be sure that you get clarification from the

participants as they express their expectations. Be patient. Silences sometimes mean that people are thinking and will come up with what they want to say. Discuss your own expectations. Be sure that either through what you introduce or what the group members introduce you cover honesty, confidentiality, cooperation, responsibility, and attendance.

- B. Define and discuss as a group, support. Ask the following questions: Support — what is it? Why is it important? How will we build it in this group? Make statements like, "We wouldn't be together if you didn't recognize you need help." "What are your resources for help?" Focus on resources of the individual, the group participants, the group leaders and people outside the group. Talk about the importance of having the ability to recognize one's own strengths and not have them obscured by feelings of worthlessness. Ask them for the kinds of behaviors from others, from themselves, that are helpful. Examples of behaviors include: being listened to, having somebody ask them for help, using their own abilities, giving someone help, etc. Some participants may have difficulty seeing themselves as giving or receiving support and will have a hard time giving suggestions.

Caution: As people talk about expectations they may want to discuss their problems. Tactfully, but emphatically, do not let them do this at this time. That is, they may mention their problem. They may say something like, "I expect to be able to deal with my children more effectively" or "I want to be able to date and not be afraid." General statements are O.K.; but if you don't keep control of this, some of them will want to go right into an elaboration of their problem.

- IV. Introduction in depth: (30 minutes) Give each person an opportunity to talk about herself and himself. A sample introduction is given and a list of interaction guidelines which must be covered before introduction is given.

Sample introduction to this exercise:

We will take some time now to get better acquainted and to find out the nature of the problems so we will be working with in this group. Each of you take 2 or 3 minutes and tell us some thing about you that will help us to know you. Risk telling us about the parts of you reserved for old friends. Also, identify in a general way the problems you want to work on in the group. (This first identification may not be the problem they will eventually work on but it will begin the process). After each person tells us about himself let's take time to respond and ask questions. (Then talk about the frustration and necessity of keeping within the time limits).

Interaction guidelines:

- A. They can't talk about anyone who isn't in the

group in a derogatory manner even though they may have had problems with them. They can describe the problem, but they can't get into a dumping session about how bad the other person is. Divorced people may have a tendency to do this.

- B. Persons in the group should be discouraged from dating one another until the group has come to a conclusion. If a dating relationship occurs during the group, this relationship may hinder personal growth. They may form a coalition which prevents them from helping each other as is intended.

- C. Watch the time. Give each person a certain amount of time to talk and the group an opportunity to respond to what they have said, but still keeping it within bounds.

- D. Introduce good rules of communications as the need arises, such as not interrupting. There may be opportunities to teach ways to be supportive by re-enforcing effective behavior happening in the group.

- E. Schedule enough time so that the two group leaders can tell a little bit about themselves.

- V. Commitment: (50 minutes) The objective of this exercise is to commit each participant to the group and its goals. Before the commitment process, group leaders are to discuss activities which will develop support in the group. That is, there is to be a general discussion about activities which members will later commit themselves to be engaging in. Group leaders should help members to discuss what will help or hinder them from doing the following activities.

Activities which will develop support in the group:

1. attending each session
2. proposing solutions to problems
3. sharing experiences
4. giving support by being honest, empathetic, and responsible
5. expressing gratitude or acknowledging support when it has been given
6. identify a meaningful problem and ask for the kind of help needed

After the discussion get a personal commitment from each person in detail. That is, ask each person, one at a time, the following questions. Be sure that they give definite answers to the questions.

Example of group leader asking a group participant questions which must be committed to:

"David, do you plan to attend our group meetings? Good, I think you will benefit from the group and I can see already that you have

much to offer. Will you come every time? What might stop you from attending? (If the response represents any kind of resistance set up a procedure for someone in the group to help overcome the resistance). Do you plan to be honest in the group? What difficulties do you see? etc. Do you plan to be responsible to yourself and to members in the group? Do you think you can share your experiences and solutions to problems? Will you ask for help as you need it? Thank you David. I think I understand your commitment. I plan to help you in every way I can."

VI. Some people will not be able to be committed whole heartedly to each of these. Their feelings of inadequacy may hinder this, or someone may decide the group isn't for him/her. Respond appropriately, but make sure that everybody in the group has had an opportunity to respond to that commitment. Then each group leader should take his commitment to the group. Tell what he/she is willing to do in relationship to attendance, being on time, and honesty and responsibility to your own set of skills in giving and helping people build a support system and solve personal problems.

Participants will not fully comprehend the commitment. You should be able to detect resistance. Re-enforce any commitment they make and redefine lack of commitment in a positive manner, i.e. Your ability to be honest with us is an indication of strength you have which will be important to all of us. Do not confront persons who are resistant.

VI. Challenge: (10 minutes) Invite participants to practice with other people during the week the rules you are using in the group, i.e., refraining from talking about other people in a blaming way, and concerning their own problems being honest, responsible, etc. Indicate that a couple of people will talk about their problems the following week. Tell them that this time the group will learn a process of solving problems as well as determining explicit solutions for them. Encourage each person to be supportive in some way to at least one person during the week.

Sessions 2-5

Behavior for the therapist:

1. Model supportive behaviors toward group members and each other.
2. Reinforce supportive behavior in the group and any that group members have done outside the group.

Nonverbal

Touching Touching in a positive, empathetic, understanding way.

Head nodding Recognizing, agreeing with, relating to, listening to the other person(s).

Umhum Relating to and/or understanding what is being said.

Smile Indicating warmth and acceptance of the person(s) receiving the smile.

Tears w/other Weeping with and in response to another person because of feelings of empathy, understanding, etc.

Voice tone This refers to change in the general quality of the voice in response to support toward a group member.

Body position open .. This refers to the open position of arms and legs not being crossed or legs loosely crossed in relation to acceptance of an individual - acceptance of feedback.

Proximity close The physical distance between group members, 10 inches or less is close.

Hugging Placing arms around another person and applying pressure with the arms on the person.

Leaning forward Reclining of the body torso toward the group or an individual.

Finger snapping Snapping fingers indicating agreement or support.

Verbal

Concern This refers to statement that expresses care, such as I like you, I accept you, I am glad to be in this group with you, etc.

Confrontation The verbalizing by one person of two sets of incongruent behaviors of another. Must manifest helpfulness and nonattaching in intent.

Positive re-enforcement Statements intending to create a positive emotional experience for the recipient.

Agreement When two people reach the same conclusion and at least one of them verbalizes it.

Similarity When two or more people discover common points or interest, background, knowledge, belief, activity.

Understanding A statement following a statement that indicates the first statement was heard and cor-

rectly deciphered by the person making the second statement.

- I. Greetings: Both therapists should say hello to everyone individually by name and in some way verbally and nonverbally let them know that you're glad to see them back. Enforce upon their minds how important it is that everybody be there.

- II. Review: Review the importance of a supportive system by asking the group what impressions they have from last week. Bring out what a supportive system is. Emphasize how it includes a lot of people rather than one and that they will be able to build a supportive system by giving support and asking for support. Remind them of how the small group, the one that they are now in, is an opportunity for them to ask and give support. Check to see if any of them are aware of adding to their outside support system by asking for support in some way or giving support after what happened to them in the group last week. (Steps I and II should not take much more than 10 minutes).

- III. Discuss the following points with the group: The roles of the therapists and group members are very similar. You should make this clear to group members that they will get better at the things that you do as a therapist as the group progresses. Some of the functions are listed below, but this is not an exhaustive list.

A. Listen carefully.

- B. Be responsible for your own understanding of the problem. This means that if you don't understand, then you should ask for information or make clarifying statements which could be checked out by the person who is telling something or recounting a problem. (This is an opportunity for the therapist to teach responsible behavior to the group.)

If you are a group member and you sense that the person who has been talking has risked something, be sure and point this out to them and compliment them on it. Also, if you have had experience similar to the person who is talking, let him/her know that. In every way possible present an optimistic positive approach to the solving of the problems.

- D. The therapist(s) should briefly outline a process for solving problems. That outline will be found in the list of general proceedings. Before briefly describing the process tell them that they will learn the procedures as they go along but you want to let them have a general idea of what will be taking place.

- IV. Volunteer: The therapist now indicates that this is the first opportunity for them to ask for help from the group by indicating what problem they want to

work on. This may startle the group a little bit, but they really should be prepared to do this from last week's introduction to the group and the fact that you are focusing on problems. If you do not get a volunteer, you may want to talk about the resistance of the fear that they have — the risk that it is taking to be first in the group. Have them practice formulating statements which ask directly for help.

- V. General Outline of Proceedings: Use this outline to solve problems group members bring up.

A. The person selected will talk about his problem while others listen and get information from that person.

- B. The description of the problem should be complete. That is, therapists and group members should encourage the person who is talking about his problem to be specific — to give really useful information.

- C. This step has two parts. The first is to have the individual describe how he would like to be. In other words, he has been talking about what the problem is and now he will describe how he would like to be. The second part of this is to ask the individual what solutions he has already tried in solving his problem. (To get information or to get a description of how the individual would like to be, the therapist should feel free to use imagery, role-playing, small bits of sculpturing, etc., anything that really makes it very clear what the problem is.)

- D. What are some ways to change the behavior or attitude or feeling? In other words, try to find as many possible solutions as the group can create, both from their experience and from brainstorming. Both group members and therapists should be highly involved in this process. It would be a good idea for one of the therapists to write the ideas on a note pad and give a summary before moving on the next step.

- E. Weigh the advantages and disadvantages of the solutions that are suggested and then have the individual choose a plan. A decision should be made based on what's really reasonable and possible for the person to do.

- F. Train the person to do what he/she has planned to do to solve his problem. You can use people in the group to act as people outside the group in role playing or in skill learning situations. The individual with a problem should practice. This is a teaching-training part that therapists will be highly involved in, but don't discount ideas that come from the group. Some of them won't work and some of them may divert you from the path that you are on, but be sure to comment on the fact that they are thinking and that they are putting forth ideas.

Now that the person has a plan and has

been trained to do it, get a commitment from him/her that she will actually try this out in an environment away from the group. Find out what will get in his/her way and what kind of help is needed from the group and have people volunteer to do whatever is necessary.

VI. If you have time, move to another person and follow through on the same procedures. If you don't have time, summarize what the group has done. Talk about some things that you've seen happening in the group that were supportive and helpful. Indicate that you recognize some problems that other people were wrestling with and that they will have an opportunity to solve the problem in the group. Indicate that you are very interested in everybody and that there will be time to take care of those things. (Keep in mind your responsibility to limit the group to within ten minutes of the two hour time that we have specified. Also be sure to collect any written response, such as the depression check list.)

VII. Challenge each person to continue to practice communication skills and supportive behaviors in his/her own support system during the week, and to supply the problem solving steps where appropriate.

Sessions 6-8:

Behaviors for the Therapists:

1. Model supportive behaviors
2. Reinforce supportive behaviors
3. Clarify
4. Participate by giving strengths and weaknesses but do not dominate
5. If the group does not follow the procedures, make process comments to pull them back to the structure.

I. Greetings: Same as you have been doing.

II. Review: Comment on the problem solving process they have been learning and the problem each is trying to solve. Be supportive as you summarize. Emphasize that persistence and time coupled with support from the group and from outside the group as well as drawing on their own strengths will help solve their interpersonal problems. (Limit this to ten minutes or less.)

III. Final Phase of Treatment: Introduce the final phase. Include in the explanation the following: We have three more weeks together. Some of you may wish to negotiate for more sessions, but for right now we need to move into another phase. Tonight we want to talk about our strengths and our weaknesses. Sometimes because our problems seem so big we tend to minimize or ignore our strengths and focus on our weaknesses. The procedures for this session will help us all to focus on our strengths to the point that we can maximize them in most situations.

IV. Instructions to the Group: Here is a set of instructions for us to follow. Let's take time to read through them individually. Then let's discuss anything that isn't clear. (Pass out the instruction sheets. You may get resistance in the form of wanting to discuss the instructions longer than necessary. Say something like the following, "We seem to be having a little trouble getting started. Does anyone wish to volunteer?" Should you not get a volunteer you may ask the group if they want to draw a number to begin or some similar plan.)

V. The Scribe: So that you will have a record of what we do here, I will ask one of you to write down the strengths as they are given by the individual and the group.

VI. Discussion: Use the last five to ten minutes of the session to have the group discuss what they have learned from the session.

VII. In the 8th session, at the beginning of the session, get commitments from everyone to complete research measurement instruments.

INSTRUCTIONS FOR GROUP PARTICIPANTS

Step One:

We have been stressing the need for support. One way of getting support is to volunteer information and also to ask for help. This exercise is designed to help all you do this. One person volunteers to tell the group about his/her strengths. Include talents, abilities, hobbies, interpersonal skills and so forth. Say something like "I have some strengths I want to tell you about." Here are some guidelines to help you.

A. We need not do something all of the time in order to call it a strength. Not one of us is consistent. Therefore, do not qualify your strengths. And example of a qualifying statement would be "Sometimes I speak clearly and distinctly or once in a while I can say what I want to say."

B. You are not to say anything negative about yourself. Everything is to be put into a positive context.

(Have someone in the group write the strengths for the person as they talk.) Group: You may ask questions but you are not to negate nor qualify. If you have seen the strength mentioned say so.

Step Two:

When the individual has exhausted her/his lists of strengths, group members then add to it. Be as specific as you can by using incidences which occurred in the group, or specific incidences that you have seen outside the group.

Step Three:

The person who has been telling about his/her strengths now tells the group some things he or she wants to improve. These may be things already mentioned on the strength list which needs strengthening or they may be things that he/she regarded as weaknesses. Problems already dealt with in the group may go on this list, if the individual needs to continue to work on them. When the list is completed, the individual may say to the group, "Are there other things I should be working on? What are your suggestions?" (Asking for help.)

Step Four:

The group then adds to the list the things the individual needs to work on. Be sure to use specific incidences related to the behavior. However, if you don't have it clearly defined, discuss it. Either the individual or the group members will help you define it more clearly.

Step Five:

The individual now indicates some specific things she/he will do to improve the behaviors indicated as weaknesses. The group will help by asking clarifying questions and by giving suggestions. Then, as a group, examine a list of strengths to see which ones will help the individual strengthen the behaviors that he or she is dissatisfied with. Be sure to fill in what resources are available outside the group.

The scribe then gives the list with the specified behaviors to the individual and a new person in the group then begins the same procedures.

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CLINICAL HUMOR: A POSITIVE APPROACH TOWARD HEALTH

By Dale F. Pearson, M.S.W.*

(This paper is based on a presentation made at the Fifth Annual Convention of AMCAP in Salt Lake City, Ut. Oct. 5, 1979)

Today I would like to discuss clinical humor and laughter as therapeutic approaches toward one's emotional and physical well-being and health. President David O. McKay has said, "Everytime a man laughs, he takes a kink out of the chain of life." We usually associate laughter with some kind of humorous experience. "Laughter is most often described as the overt expression of humor — an indicator that the person is in an 'amused frame of mind,' or 'experiencing something as funny.'" (Keith-Spiegel, 1972, p. 16). Webster has defined humor as "that quality which appeals to a sense of the ludicrous or absurdly incongruous, meriment disposition, mood; to yield to the whims!"

The scriptures are full of examples of laughter as communicating many varied messages such as joy, doubt, or even scorn. For example: Sarah laughed with joy because of having born a child at 90 (Gen. 21:6). But earlier, she laughed in disbelief and doubt that she could bear a child in her old age (Gen. 18:13-15). In Ecclesiastes, we read that there is, "A time to weep, and a time to laugh ..." (Ecclesiastes 3:4). In Proverbs (Proverbs 17:22) we read, "A merry heart doeth good like a medicine: but a broken spirit drieth the bones." In the Doctrine and Covenants, (Section 59:15), we read, "And inasmuch as ye do these things with thanksgiving, with cheerful hearts and countenances, not with much laughter, for this is sin, but with a glad heart and a cheerful countenance." I would suggest that "not with much laughter" means critically laughing at someone or something. Laughter itself is not sin, but its misuse may be sinful, according to the scriptures. It's the timeliness and appropriateness of the laughter which is important.

In every relationship, including one where humor is used in the actual therapeutic process, the use of humor has marked potential for negative as well as positive results. The strong professional relationship is most important if humor is to be useful in strengthening and enhancing therapeutic outcome. This author is aware that the way in which humor is employed and by whom used, are two of many important variables for professionals to carefully consider in any decision to use humor in clinical practice. Most of the literature on humor is based on clinical and other observational and professional experience, rather than findings based on experimental data. Rarely, however, is humor as a

counselor characteristic mentioned or discussed in most psychology or counseling textbooks.

This paper will focus on the positive and therapeutic uses of humor in clinical practice. Space does not permit an evaluation of the potential hazards of humor, as major emphasis here will be placed on humor and laughter as positive therapeutic tools in the hands of a sensitive therapist.

Humor, as a means of communication, has been called a "social lubricant" and can represent an opportunity for therapist and client alike to share in a meaningful experience which can have therapeutic possibilities. The ability to laugh at oneself is one of the prime characteristics of man, as man is probably the only creature with the ability to laugh or express a sense of humor. Humor has also been described as a paradox. To really be completely effective, humor requires a spontaneity, and even an element of surprise. If we stop to analyze or dissect a funny happening or joke, it may lose its funniness. Play also requires this same element of enjoyment, openness and fantasy, as though to say, "this is just for fun." Humor is very individual. What seems humorous or funny to one person may not come across in that same way to another person. Humor is often "situation specific." Humor can represent a way to "break the ice" or begin a counseling relationship, while yet formative. "When one smiles or laughs with the other, as sharply distinguished from laughing at him, one shares a mutual experience" (Rosenhein, 1976, p. 59). Humor can also help one to maintain his sanity, to the extent to which it "moves beyond jokes, beyond wit, beyond laughter itself. It must constitute a frame of mind, a point of view, a deep-going, far-reaching attitude to life" (Mindess, 1971, p. 10). Most clinicians tend to agree that the capacity of a person to deal with life and humor may directly relate to an individual's psychological adjustment (Hickson, 1977).

But, the ironic part is this — just as humor and laughter can represent a healthy expression of the ego, it has over the years suggested emotional distress or even "madness" within the individual personality (Baudelaire, 1956, p. 115). As Moody (1978, pp. 60-61) points out:

There is an astounding degree of overlap in ordinary language between the words which are used to describe behavior as mentally disturbed and those which are used to describe behavior as humorous. This ambiguity extends even to the word 'funny'

*Bro. Pearson is Professor of Sociology and Social Work at BYU and a Licensed Marriage and Family Counselor and Clinical Social Worker in private practice.

itself. 'Funny behavior' could just as easily mean disturbed behavior as it could amusing behavior. Comic individuals, actions or indicents are typically characterized as 'dizzy,' 'zany,' 'mad,' 'goofy,' 'daffy,' 'crazy,' 'wild,' 'hysterical,' 'insane,' 'madcap,' and so on. These same labels are used at times in informal conversation to characterize actions or thoughts as mentally disturbed.... Even in the most recent textbooks or psychiatry, various recognized mental disorders are described or defined by the use of some of the very same terms that are used to characterize people, events, or remarks as funny, humorous, or laughter-provoking. In a number of texts, passages describing the behavior of persons with some mental disorders abound with words like 'ludicrous,' 'silly,' 'whimsical,' 'absurd,' 'ridiculous,' and 'jocular.'

The psychoanalytic theory of humor originated by Sigmund Freud has been perhaps one of the major frameworks for the study of humor in recent years. Freud became interested in jokes when he became aware of the similarity between the technique of jokes and dreams, resulting in his book, *Jokes and their Relation to the Unconscious* (1905). There are two types of jokes: the harmless joke, and the joke with a purpose or 'tendentious' wit. Civilization has produced repression of many basic impulses, he says, and joking as a socially acceptable way of satisfying these needs. He describes four types of purposeful jokes: the sexual joke; the aggressive, hostile joke; the blasphemous joke; and the skeptical joke. The process is an unconscious one and there is a saving of psychic energy.... Freud also developed a theory of laughing at tragedy and death, called 'gallows humor' (Robinson, 1977, p. 14).

The use of humor presents a real challenge to the clinician, in light of the conflicting, foregoing materials. When a client begins to see his own situation in a humorous way, he is closer to understanding and overcoming it as genuine humor can be an important coping mechanism. Much of clinical and hospital humor arises spontaneously from a specific situation and is therefore difficult to describe to others out of context. Spontaneous humor generally comes from ordinary situations and is witty only because of the immediate circumstances of the moment. The specific cases presented are taken from personal experiences and from a variety of writers. Among the variety of theories of humor is the concept of humor as a release from anxiety, tension, and the frustrations of the severe realities of life. Often physicians, psychiatrists, and even attorneys are the butts of many strong and conflicting emotions. The following poem by Richard Armour (1963, p. 33), suggests that today we are more knowledgeable about health and illness than formerly

and better able to laugh at it:

A LITTLE LEARNING

Patients once let surgeons cut
Without an if or and or but.
They rarely raised demanding questions
And never offered up suggestions.

Patients once, not long ago,
Believed the doctor ought to know,
Submitted with the best of will,
And trusted in his practiced skill.

But patients now, and patient's wives
Are sharper than a surgeons knives,
And argue over each incision —
They've seen it all on television.

Humor in health and illness serves three major functions: a communication function, a social or behavioral function, and a psychological function. In a health setting, a variety of messages need to be communicated and are usually very serious and filled with emotion. These are: fear, anxiety, anger, embarrassment, concern, frustration, hope, and tragedy. In times of crises, patients and staff are thrown together into intimate and dramatic contacts — without time to develop a personal relationship. Humor provides an easy access to interaction and a shortening of formality and distance between people.

Clinical examples which illustrate attempts to reduce patient and client anxiety and distress through the use of kidding or joking are the following:

When a male patient who was admitted for a biopsy was sent to a gynecological ward because of a shortage of beds, the nurses teased him with, 'You're in for a hysterectomy, of course!' and 'You're the only male on the ward and I thought we were liberated!' (Robinson, 1977, p. 43)

About a year ago ... a young woman suffering from severe anxiety consulted me. It was the first time she had ever visited a psychotherapist and she told me she had been reluctant to come. She had heard that therapists not only failed to help many patients but that they frequently harmed them. The word she used was 'destroy.' 'I have heard about people,' she said, 'who have gone into therapy and been destroyed!' Now I, it is obvious, could have responded in several ways. I could have remained silent and waited to hear what she would say next. I could have told her that I understood how she felt. I could have said that other people felt the same way too. I could have wondered what was behind this manifest anxiety and led her to explore its ramifications. I decided instead, to react in a mildly facetious manner. (Decided, however,

is not the right word. I did react facetiously, but the remark I made was so instantaneous that I cannot claim to have planned it.) What I said was, 'Well, you're in luck. I've already destroyed my quota for this week.' Her response was rich laughter, and I flatter myself into believing it expressed both relief and expanded awareness: relief that she had found a therapist who understood her anxiety not in professional terms but as a fellow human being, and awareness that her fear that I would destroy her was absurd. (Mindess, 1976, p. 336).

Mindess (p. 337) comments further about the use of kidding in counseling:

I recall, for example, responding to a tearful woman's tale about her husband getting drunk, hitting her and threatening to shoot her, then breaking down and begging her forgiveness, with the observation, 'Well, at least your life's not dull.' There is no more evidence, of course, that any particular style of dream interpretation or confrontation or support is superior to its counterparts. It seems important, however, to note that humor as a mode of response is broad enough to be amenable to many different purposes. Both the gentle, supportive therapist and the tough, confronting one can utilize wit as part of their repertoire. It is employed with the patient's improvement as its goal, it can be helpful in more ways than one.

The many jokes and cartoons about psychiatrists tend to make him more human, with human failings. For example:

A cartoon pictures a psychiatrist's office. The patient and psychiatrist are moving the couch across the room. The psychiatrist is saying, 'Frankly, Mrs. Watson, I liked the furniture the way it was.'

Another example of the need to reduce distance between professionals and patients is the example of a Mental Health Center (Robinson, 1977, p. 44).

In the early days of social psychiatry, during the development of one community mental health center, in the attempt to move from an illness orientation to one of "health," and to foster the "blurring of roles," the staff wore ordinary street clothes rather than uniforms. The clinical director, however, insisted that the staff still wear name tags, which spelled out: Jane Doe, R.N., and David Brown, M.D. The staff objected that this violated the intent of the change. The director countered that the

patients would feel more secure if they knew who the staff were. The controversy ended very suddenly when one of the day care patients appeared one morning with a name tag which read Mary Smith, N.U.T. The name tags went the way of the uniforms!

A cartoon shows a hospital room with two patients in bed. One is saying to the other, 'Look, you phone down to the desk and ask about my condition, and I'll phone down and ask about yours.'

A get-well card says, 'Remember, it's okay to let your doctor joke with you a little -but, don't let him needle you!.'

A few warnings about the use of humor, however, are in order. The therapist must be sure that his wit does not arise from rancor toward his patients and that it represents a genuine laughing together about shared human problems and experiences. I prefer to frame my more confronting and unpalatable comments or interpretations in such terms as, 'We all share ...' or 'Most of us human beings ...' For the therapist to be able to gauge how far he can go with which couple is also critically important — a few inches beyond where they are, but not far enough to shock or offend them, is desirable.

Letting matters rest at a humorous level can also be hazardous: It could lead to a later increase in guilt and, thus backfire. I almost always follow up humor with a serious comment about the couple's plight. In the case of the mock serious prescription I might add, depending on circumstances: 'I have been joking a bit with you, but I also mean all this very seriously; the two of you have been depriving yourselves of possibilities of pleasure and relaxation that you both richly deserve,' (Fitzgerald, 1973, pp. 80-81).

In the operating room and emergency room, where tension is the highest, humor becomes almost a standard pattern of interaction, from single, jocular talk to macabre, risqué joking.

Two students were observing surgery for the first time. The shorter one was complaining she couldn't see. The tall one quipped, 'Be glad you're not tall. You have a longer way to fall when you faint!'

The humor between colleagues is very often a self-deprecating one, which is acceptable within status lines but might not be understood in the same vein by the patient. This story making the rounds some years ago may serve as an example.

Two psychiatrists are coming down in the elevator after a day in the office. The younger psychiatrist looks weary and somber. The older psychiatrist is whistling cheerfully. The younger man looks over and says, 'How can you be so spry and cheerful after a long day of listening to patients with all their problems and troubles?' The older man shrugs his shoulders and responds, 'Who listens?' (Robinson, p. 72)

Greenwald (1975, p. 116) discusses a humorous treatment approach in dealing with a woman who had trouble talking during therapy:

... I had a patient who had been to five previous therapists who terminated her therapy because she couldn't talk. Two things happened in the first session. First when she came in and couldn't talk to me, I said, 'What's the problem?' She said, 'As long as you're in the room, I can't talk.' I had a closet in my office. I went into the closet and I sat there and she talked pretty well.... I had to sit in the dark closet during her session. Then she decided that I was doing something else in that dark closet, and she told me she didn't want me to sit there any more. So I came out and again she couldn't talk.... I said, 'Were you ever able to talk at home, under any circumstances?' 'No', she said ... 'Only when the family was at dinner.' I said, 'So, I'll tell you what. We'll have lunch together. I'll bring in lunch ...' 'No, no,' she said. 'Not like that. When the family would be having dinner, I would get under the dining room table, and then I could talk to them 'fine.' Well, I had a big desk, and I said, 'Why don't you get under here?' She replied, 'I can't do that.' So I got under the table and she spoke very well. We had a great session. She came back the next session and she wasn't talking, so I started to get under the desk. She stopped me. 'I'll talk. I'll talk, just don't get under that — table again!' Which was fine until her husband called me two weeks later and said, 'My wife is beginning to hallucinate. Do you know what she told me happened at your office?'

Patients may deny the seriousness of their illness through the use of wit or humor. On one occasion, a group of young people were involved in a near fatal accident. The driver of the car called home to report to her parents. The mother in hearing laughter in the background asked them how they could laugh about it! She replied, "Mother, if we couldn't laugh about it, we'd go crazy!" Death is one event in a hospital that occurs constantly, and both patients and staff attempt to insulate themselves from it through jest and humor. Even a dying patient can utilize humor. She wrote this letter two weeks before her death from cancer:

I think it is time we let down our hair and told the truth. We have the urge to rush into print all right, but we who are dying of cancer are not martyrs or saints or holy folk. Frankly, if the truth were told we embarrass our friends and we often bore them! ...

I'm still angry about it all, for I think no one has ever loved living more or had more fun doing it than I, and I want it to go on and on. But if I can't, then I must be truthful and say there are a few advantages in living only half a lifetime. Besides the end of good, death also means the end of the tribulations — no more holding in the stomach, no more P.T.A., no more putting up the hair in pincurls, no more cub scouts, no more growing old. (Beland, 1965, pp. 89-91).

Greenwald (1975) describes one of his patients who had the capacity for turning every single triumph of her life into a dark disaster:

She was a temporary teacher who was taking an education course which she needed to get her permanent license. She kept complaining during the entire semester about how poorly she was doing in this course, how awful it was, and how stupid it was, and how she would be drummed out of the educational field at the end of this course. Then, one day, she called me and said, 'Do you know what that (guy) did? He gave me an A plus in the course!'

I was all prepared. I knew that the next session I was in for a big depression. And she had a special costume for that. She'd come dressed all in black.... When she entered the room, I knew what to expect. I was sitting in the corner as she came in and started to complain. I didn't say anything for awhile. I just sat there and sighed. She talked her little lines, 'Oh,' I said, 'it must be terrible.' She looked at me for a moment, then continued, and I said, 'Well, maybe I could help you, but what's the use? You're only going to die! That was something she always says. And it went on this way a little bit longer.... Suddenly, she turned on me and she said, 'You know ... you're acting just like me. How do you put up with me?' She got the point and for the rest of the session, maybe because she was angry, she wasn't depressed.

I must emphasize the importance of really understanding the person if you use humor in your sessions. Because if you don't, it can be destructive, it can be mocking, it can be cynical, it can be painful. (p. 115)

Humor has the potential to be a valuable communication tool available to the therapist in furthering insight, monitoring dynamic states, and in catalyzing higher levels of adaptive processes. In sum, humor

can very well function as an important variable in the counselor's repertoire of helping response modes and techniques. (Hickson, p. 66)

HUMOR IS A FUNNY THING

Humor is a funny thing.
It causes smiles and snickering;
It lets life's losers feel they're winning,
Leaves them chortling, smirking, grinning.

Yet it also makes us see
That we are silly, you and me;
Absurd and awkward, foolish too,
Ridiculous — especially you.

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FULL RANGE EMOTIONAL DEVELOPMENT AND THE JOYFUL LIFE

By Gary L. Carson, Ed.D.*

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I know no better way of sharing my feelings and discharging my responsibility today in this presidential address than to tell you forth-rightly what I'd like to talk with you about, perhaps persuade you to consider more thoroughly, and then give you the substance of my thoughts which support my position. What I'd like to talk with you about is emotional constraint and its impact in terms of diminishing our ability to live a Christ-like or joyful life. What I propose to show is that, intentionally or inadvertently, we as people and as therapists may sometimes, by virtue of our own conditioning and the attitudes we reinforce in others, contribute to some of God's children being restricted in their emotional development and consequently in their ability to relate to Him completely. Specifically, when we emphasize that persons should school their feelings and more particularly, control anger and negative feelings, without paying as much attention to the facilitation and growth of positive feelings, then we haven't contributed maximally to the emotional development of the person. To be sure, individuals generate a lot of misery for themselves and others because they haven't developed control over destructive emotions. Just as certainly, however, there are those who generate a lot of misery for themselves and others because they haven't maximized the development of constructive emotions - I refer specifically to love - which leads to joy and so many of the other expansive emotions in life. That, then, is my position.

The same hymn that says:

School thy feelings, O my brother:
Train thy warm impulsive soul:
goes on to say,
Do not its emotions smother
But let wisdom's voice control.

Let me say at this point that a hymn, though inspired, is not scripture but represents one man's position; granted it may be a wise one. However, the wisdom must be reflected in the total message, not just parts of it. The second verse reads.

School thy feeling;
There is power in the cool collected mind;
Passion shatters reason's tower,
Makes the clearest vision blind.

The lesson of the hymn seems to be that we should overcome passion with intellect. For me the larger message is that we are to develop the wisdom to direct our feelings without smothering them or unnecessarily restricting them. To school one's feelings is to enhance them. We go to school to become informed, enlarged, to pursue increase understanding. In this connection it is not that emotions are beasts that must be tamed by a school master. Rather emotions are a God given endowment, as is free agency. Our ultimate test is to use our free agency to magnify our talents, to bring to fruition the natural endowment we have received. Whether in the physical, intellectual or emotional domain, we have a responsibility to become an active and directing force in the process of our own personal enlargement or fulfillment, disciplining our body, our mind, or our heart as is necessary to allow us to maximize our growth. Schooling then may include disciplining where it is understood that the Latin root of the word discipline means to self-direct. Therefore we have a responsibility to self-direct our growth.

The theme of our convention is:

"...that your souls may be joyful."

with the subtitle, self-enhancement approaches to therapy. The theme is taken from the 136th section of the Doctrine and Covenants and is supplemented by II Nephi 4:16-30.

Considering the context of these scriptures we find the following. In the 136th Section, the Lord is revealing among his last words in the formal scripture of the Doctrine and Covenants, His directions for the manner in which the saints are to conduct themselves as they leave Winter Quarters and head west. Among His instructions are some relative to the expression of emotions and how the saints were to cope with emotional stress. In verse 28 He says, "If thou art merry, praise the Lord with singing, with music, with dancing, and with a prayer of praise and thanksgiving." In verse 29 He says, "If thou art sorrowful, call on the Lord thy God with supplication, that your souls may be joyful." In verse 28 He says if you're happy or joyful - express it. In verse 29 He says if you're not happy - get that way. Clearly the Lord seems to want His people to be happy, to be joyful. It would seem that this is good not only for the people themselves but it helps the Lord to get His work done. What therapist, or anyone else for that matter, ever heard of sorrowful, depressed people accomplishing much? God needs happy, productive people to do his work - to serve him in the process of getting others to progress.

*Brother Carson is a counseling psychologist at Weber State College, Ogden, Utah and immediate past president of AMCAP.

What allows us to be joyful? For me one of the greatest evidences of joy and the qualities that contribute to it comes from Alma 27:17. Ammon, one of the sons of Mosiah, has been among the Lamanites as a missionary. He has taught King Lamoni and his people and has brought them into alignment with the attitudes and life of Christ. They have become so converted that they refuse to take up arms, to shed any more blood. They have set themselves apart from the other Lamanites, calling themselves the Anti-Nephi-Lehites. They have been scapegoats as the Lamanites (and Amalekites), unable to prevail against the Nephites, turn upon their former brethren and slaughter them. Leading these people, whom he has converted and learned to love so much, Ammon takes a course toward Zarahemla to see if he can find a refuge for his adopted people there. As he enters the land he meets Alma (one assumes for the first time in years since before their mission), and it is a glorious reunion. Verse 17 says, "Now the joy of Ammon was so great even that he was full; yea, he was swallowed up in the joy of his God, even to exhausting of his strength; and he fell again to the earth." Was this an excess? Did the Lord condemn Ammon for not being more moderate? Apparently not, for verse 18 says, "Now was not this exceeding [not excessive] joy? Behold, this is joy which none receiveth save it be the truly penitent and humble seeker of happiness." The scripture suggests to me that this fullness of joy is desirable and can be attained on the conditions of being truly penitent and a humble seeker of happiness.

Being penitent and a humble seeker clearly indicates that Ammon knew Christ. He recognized him as his redeemer, knew of his own need to be redeemed and thus was penitent; and, rather than approaching life in an arrogant or hostile manner, was a humble seeker of happiness.

A look at the life of another man in whom flowed the blood of Israel suggests that all men are not so expansive, so joyful as was Ammon as a result of his knowledge of Christ. John Powell relates this story:

"In the 1920s, the philosopher of American Communism was a Jew named Mike Gold. After communism fell into general disrepute in this country, Mike Gold became a man of oblivion. In this oblivion he wrote a book, *A Jew Without Knowing It*. In describing his childhood in New York City, he tells of his mother's instructions never to wander beyond four certain streets. She could not tell him that it was a Jewish ghetto. She could not tell him that he had the wrong kind of blood in his veins. Children do not understand prejudice. Prejudice is a poison that must gradually seep into a person's blood stream.

In his narration, Mike Gold tells of the day that curiosity lured him beyond the four streets, outside of his ghetto, and of how he was accosted by a group of older boys who asked him a puzzling question: "Hey, kid, are you a kike?" "I don't know." He had never heard the word before. The older boys came back with a paraphrase of their question. "Are you a Christ-killer?" Again, the small boy responded, "I don't know." He had never heard that word either. So the older boys asked him where he lived, and trained like most small boys to recite their address in the case

of being lost, Mike Gold told them where he lived. "So you are a kike; you are a Christ-killer. Well you're in Christian territory and we are Christians. We're going to teach you to stay where you belong!" And so they beat the little boy, bloodied his face and tore his clothes and sent him home to the jeering litany: "We are Christians and you killed Christ! Stay where you belong! We are Christians, and you killed Christ..."

When he arrived home, Mike Gold was asked by his frightened mother: "What happened to you, Mike? He could answer only: "I don't know." "Who did this to you, Mike?" Again he answered: "I don't know." And so the mother washed the blood from the face of her little boy and put him into fresh clothes and took him into her lap as she sat in a rocker, and tried to soothe him. Mike Gold recalled so much later in life that he raised his small battered lips to the ear of his mother and asked: "Mama, who is Christ?"

Mike Gold died in 1967. His last meals were taken at a Catholic Charity house in New York City, run by Dorothy Day. She once said of him: "Mike Gold eats every day at the table of Christ, but he will probably never accept him because of the day he first heard his name." "And so he died."

Mike Gold never knew Christ, nor was he apparently interested in becoming acquainted with the person whose name had first introduced him to the battered child syndrome at the hands of young "Christians". Why did Mike Gold never come to know or accept Christ as did Ammon? What was the net result of his early conditioning? In the answer to the second question we have an answer to the first. (Another answer will come in the lack of relationship with a mortal that precludes really knowing God.)

The June 1979 issue of the AMCAP Journal 1 described the processes of conditioning that brings about maladaptive, or adaptive but unnatural, behaviors. In the case of the Pike described there, conditioning generated avoidance behaviors that we're maladaptive. In the case of the whale at seaworld, a creature, through selective reinforcement, acquired responses that were adaptive; they allowed the whale to sustain life, but were not necessarily natural or inclined to foster maximum effectiveness in the whale in its natural habitat. (Similarly with hatchery raised fish.)

Conditioning that takes place in the life of man can have essentially the same outcomes. Mike Gold acquired an avoidance response as a result of the aversive conditioning that took place the first time he heard the name of Christ. He was therefore reluctant, or unable, to develop a relationship with Christ - to love Christ, to experience a fullness of joy. Others of us have been restricted in our capacity to love Christ because of (1) being reduced in our desire to love anyone or anything, (2) because differential reinforcement has led us to value other things more than love; for instance, intellectual accomplishment rather than emotional maturity. As an example of being reduced in our ability to love anyone or anything, allow me to share an

example from my personal work as a teacher and a counselor. A number of years ago, the path of my life crossed that of a robust man from Wyoming. We'll call him John. John was attending school with the assistance of the State Department of Vocational Rehabilitation. While he had some physical disability he also had been (or was) an alcoholic. He emulated in his dress and character the last of a vanishing breed. John was a rugged individualist in the truest sense of the word. A nice enough guy, pleasant, easy to know but wasn't about to let anyone get close to him. He had a marriage (his) annulled within 2 weeks during the quarter we were together, and though his 35 year old heart ached to return to the ranch where he grew up, he would not allow it because he had been on the outs with his dad for years and pride wouldn't let him go back. During the course of an encounter group, I thought of him often. One evening as I listened to my son's Carpenter records I found a song that sounded a whole lot like him and so brought the lyrics on a transparency and the recording to class for John to consider.

DESPERADO

Desperado
Why don't you come to your senses
You been out ridin' fences
For so long now
Oh, you're a hard one
But I know that you've got your reasons
These things that are pleasin' you
Can hurt you somehow

Don't you draw the queen of diamonds, boy
She'll beat you
If she's able
The queen of hearts
Is always your best bet

Now it seems to me some fine things
Have you laid upon your table
But you only want the ones
That you can't get

Desperado
Oh you ain't gettin' no younger
Your pain and your hunger
They're drivin' you home

Freedom, Ah freedom
That's just some people, talkin'
You're prisoners walkin'
Through this world all alone

Don't your feet get cold in the wintertime
The sky won't snow
And the sun won't shine
It's hard to tell the night time
From the day

You're losin' all your highs and lows
Ain't it funny how the feelin' goes away

Desperado
Why don't you come to your senses
Come down from your fences
Open the gate

It may be rainin'
But there's a rainbow above you
You better let somebody love you
You better let somebody love you
Before it's too late

(Words and Music; Don Henley and Glen Frey)

At the conclusion of the song and after my sharing some impressions as to how I saw him being depicted in the song, John related the following story - reflecting his awareness of what had conditioned him to become as he was.

From his earliest memories he aspired to be like his dad - tough, rugged, hard, a real cowboy. Before ever going to school he was in the saddle. By the time he reached adolescence he had already become a man. He had been out on the range with his dad before sun-up, riding, fixing fences, driving cows and drawing the cowhands wage - so to speak. Fourteen to sixteen hour days were not alien to John. His wages during his earlier years had really been hard work, sweat, and the company of his dad. As he started to come of age and enter his teens his dad gave him his first paycheck. At this point he had the chance for the first time in his life to buy without begging, and to buy something he really prized and really wanted - a horse. Not being allowed to show much tenderness or affection within the constraints of being a tough, rugged, hard cowboy, John channeled his natural inclinations for warmth, approval and the sharing of affection toward his horse. His world was more complete than it had ever been. He had the identity of his dad and the love of his horse; but, the two were shortly to come into conflict. At about the age of 15 or 16 they went to the state fair. They were enjoying the spirit of the fair until someone interrupted that spirit with the news that one of their horses was down in the stall and seemed to be unable to get up. John ran to the stalls to find that it was his horse that was in trouble. He was desperate. His horse was expiring and there was nothing he could do. Try as he may, he couldn't get the horse up. Futilely the horse struggled, looked at him through a glassy eye, nickered and rolled on its side. Momentarily it was dead. This was more than John's young, and not so hard heart could take. Even hard, rugged, young cowboys break when they lose the object of their affection in life. As John was lying there sobbing with his arms around the neck of his still warm but departed friend, his dad arrived on the scene; grabbed him by the nap of the neck, jerked him out of the stall and informed him that "that's the last time I want to ever see you cry over a damn horse!" Well, John was shattered. He left the stalls, he left the fair, he went home, fixed up a packhorse and saddle horse, and went into the mountains. No one saw him for 3 months. When he came out of the mountains, his dad would be proud of him. He was tougher and harder than ever. Nothing was to hurt him or make him vulnerable again. But he was through with his dad. He took a job as a hand on a

neighboring ranch - one that had been in an adversary role with his father. From there he had gone into the Navy, become a pugilist and later a roughneck in the oilfields - drinking, fighting and not giving a damn for man nor beast. It had been 15-20 years since he'd had any civil or relationship-generating words with his father. While his dad was a millionaire and John was struggling with physical, personal, and financial problems in an attempt to get through college, his pride and his acquired hard-heartedness would not allow him to ask dad for help or to return to the hills and plains that had given birth to his appreciation of God's creation.

How many John's are there in the world, people whose emotions have been abused to the point that they are more interested in self-protection than they are in self-development - who can't love because they can't trust, and how does this affect their relationship to God and subsequently their capacity to be joyful? We are told in Matthew, that we are to love God with all our heart, soul, might, mind and strength. What does it mean to love God in this way? What keeps us from doing so?

John Powell answered the question concerning what it means to love God in this way:

I think that St. John would answer this question by telling us that before anyone can really give his heart, soul and mind to God, he must first know how much God has loved him, how God has thought about him from all eternity, and desired to share his life, joy, and love with him. Christian love is response to God's infinite love, and there can be no response until one has somehow perceived that God has first loved him, so much so that he sent his only begotten son to be our salvation.

We know something of this love in our own instincts to share that which is good and is our possession: good insights, good news, good rumors. Perhaps the best analogy in our human existence is that of the young married couple, very much in love and very much alive because of love, wishing to share their love and life with new life which it is in their power to beget. But it is even more than this with God who tells man; if the mother should forget the child of her womb I will never forget you!

It is precisely this that is the point of most failures to love God truly. Most of us are not deeply aware of his fatherly, even tender, love. It is especially the person who has never experienced a human love with all of its life-giving effects, who has never been introduced to the God who is love through the sacrament of human love, that stands at a serious disadvantage. The God of love who wishes to share his life and joy will probably seem like the product of an overheated imagination - unreal."²

What keeps us from loving God?; not having had the experience of being loved in the physical reality of the human condition; and, whether a John or a Mike Gold, having our natural tendency to express curiosity or love blunted by those who should lead us to Christ. On another plane many cannot love deeply, not because love has been blunted, but because other values have been more highly rewarded, as may be the case when reinforcement schedules reward intellectual accomplishment and ignore emotional development and expression.

Of major concern for me then is how our lives have been shaped, with or without our knowledge, to the point that we have acquired, like some of our clients, maladaptive, or adaptive but unnatural behaviors. We avoid love because of aversive stimulation or we are shallow in our capacity to love because other things were more highly valued and therefore reinforced by those who reared us. Either way we are limited in a significant domain of our emotional development.

Another concern is generated when we look at how our becoming hard hearted, or emotionally shallow in our capacity to love, affects our ability to relate to God by virtue of being receptive or unreceptive to His spirit and the promptings of the Holy Ghost. We are told that we are to seek the Lord for guidance. We are to ask Him, after studying it out in our mind, if something is right for us, and if it is He will cause our bosom to burn within us (D&C 9:8). If we have no relationship with the Lord, no trust in Him, will we ask Him for guidance? If we do ask Him and we have suppressed our capacity to feel, to hurt, will we have the capability of registering the burning in the bosom? Nephi at the time he is called to build a ship chastises his brothers for their unbelief and says, in 1 Nephi 17:45, "... ye have seen an angel, and he spoke unto you; yea, ye have heard his voice from time to time; and he hath spoken unto you in a still small voice, *but ye were past feeling*, that ye could not *feel* his words; wherefore, he has spoken unto you like unto the voice of thunder ...". It would seem from this that the Lord had to communicate by shouting because Laman and Lemuel were not subject to the still small voice - being *past feeling*. At numerous places in the Book of Mormon reference is made to the people hardening their hearts and turning away from the Lord. Notice they did not harden their minds; they hardened their *hearts* - not their capacity to think but their capacity to *feel* was diminished. Similarly, when the Lord desired to really communicate, He did so through the heart, not the mind. As Nephi was closing out his account on his stewardship he wrote some things of significance, at the same time noting that he was not mighty in writing as in speaking for he said "... when a man speaketh by the power of the Holy Ghost the power of the Holy Ghost carrieth it into the hearts of the children of men. But behold, there are many that harden their hearts against the Holy Spirit, that it hath no place in them ..." (2 Nephi 33:2-3)

Within father Lehi's family there was constant concern over the hardening of the hearts of Laman and Lemuel and their eventual separation from the family and the Lord. How it must have grieved Lehi as a father to have a vision of the tree of life and see that two of his children were not partakers. In 1 Nephi 8:37 he exhorts

and entreats them "... with all the feelings of a tender parent ..." Nephi, after gaining an awareness of the meaning of the analogy of the tame and wild olive trees, clarifies some things for his brothers but not until he observes that "being hard in their hearts, therefore they did not look unto the Lord as they ought" (1 Nephi 15:3) and asks them in verse 10 "How is it that ye will perish, because of the hardness of your hearts." In 2 Nephi 5:21 we find that the Lamanites hardened their hearts like unto flint and were given a dark skin so as to not be enticing to the Lord's people.

Finally, in the closing chapters of Moroni's record, he notes that the Nephites were due their destruction because of their iniquity. They did exceed the Lamanites in the gravity of their abominations. They devoured the flesh of their victims "...because of the hardness of their hearts;" (Moroni 9:9-10). The scripture is replete with references to the hardening of hearts and the removal of the person or people from being subject to God's spirit. When we insulate ourselves against feeling or fail to develop feelings we restrict ourselves by that amount in terms of our ability to relate to God, to know Christ as our Lord and redeemer and to be joyful.

As is noted in Helaman 16:22 "... Satan did stir them up to do iniquity continually; yea, he did go about spreading rumors and contentions upon all the face of the land, *that he might harden the hearts of the people* against that which was good and against that which should come." Thus we see that Satan is the author of the hard-hearted syndrome. If people are to develop a capability of really being joyful they must learn to love God, which means overcoming Satan and his efforts to make them hard hearted. *How is this love developed?*

The case of John and Mike Gold tell us how not to engender love. The work of Harlow, Montague and others underscores physical closeness or contact comfort as a prime vehicle for generating love. Brother Robert Harbertson, a Mission President of the California Fresno Mission and presently a Regional Representative, said that following his initial interview with missionaries as they came into the mission he would clasp their right hand, place his left hand behind their neck, look them in the eye and tell them that while not their father, he hoped to serve that role while they were on their mission and that he loved them very much. He would then pull them to him to give them a hug. The response in many cases was astounding - tension induced rigidity. One elder, after months of wearing a sneer on his face, was asked what the matter was. With some degree of sarcasm he answered, "Do you really want to know what the matter is? I'll tell you what the matter is. I can't stand you and I can't stand you to touch me." Elder Harbertson apologized and promised to not touch him again. Thereafter all their interviews ended with a formal handshake. At the end of his mission the young elder came in for his final interview. As it concluded he shook hands and walked to the door; before existing he hesitated and turned. "President," he said, "Can I have a hug?" His mission had been a success for he had been introduced to the love of God by experiencing the reality of human love. Could it be said that he was at one time hard hearted, to some degree, at least-protecting himself? What had teaching for Christ and working

with a companion for Christ ultimately taught him? - to love.

My experiences in teaching and counseling are not too unlike those of Brother Harbertson. As an inservice teacher I went into a Sunday School class of four year olds. Their teacher, my wife, was taking them through a make-believe world of their creation to teach them how to relate to and appreciate all of God's creation. The children cast me in the role of the little boy who went on the walk. I took my dog (the college president's boy) and we walked through this world appreciating and loving all that we had put into it, each aspect being represented by the child who had placed that particular sun, mountain, tree or animal into our creation. Our interaction was significant and our involvement more than just cursory. I felt prompted after the prayer to invite them for a hug as they left the room. I got down on my honches and got a spontaneous hug from one little boy. Seven or eight other four year olds filed out.

In another instance I had a student in an encounter class who years earlier had taken several classes from me, confided in me regarding his involvement with LSD in the early days of the drug culture, helped me collect data for comparing background and responses to stress of drug users and nonusers and then had disappeared. I often wondered what had happened to him. I was definitely closer to him than to the average student and his presence was missed. Then one December I got a Christmas card. The postmark read Indian Creek, Alaska. The card bore his name - nothing more.

I was both gratified to hear from him and provoked to hear nothing from him. Now he had returned, we had had some good interaction in my office but in the classroom he had disclosed or given very little. Wanting to help others know and appreciate him as I did - to see that he had substance - I reviewed some of our past experiences together in a general way, and without violating his privacy I told him how I had felt about him and how I had genuinely missed him. I asked him to ponder these things, to realize that class and the quarter would be over the next day and that we might part again without knowing when we might see one another again. I told him if there were feelings we needed to express we maybe ought to take the chance because we didn't know when we would get another one. If he had nothing to say to me then he could just say goodbye. Nonchalantly, and without feeling he said, goodbye. I was hurt and I guess I showed it. He asked if he hurt me and as I tried to express myself tears rolled down my cheeks. At this point this young man expressed, through tears, how he had always tried to please his dad, how he had virtually "busted his back" on the farm to get dad's praise only to get criticism and experience hurt. He concluded that all he could do was hurt. He tried to help but ended up hurting. Eventually he had tried to seal himself off from hurt. He taught me a great lesson that day and I hope I gave him something to take away. He had concluded that in trying to help you end up hurting. I concluded that unless you could hurt you couldn't help. Only when I could be hurt and could show it could he be helped to realize that he had insulated himself from deep loving

relationships for fear of being hurt and only when he could risk the hurt and pursue love in those relationships that were most significant could he ever be complete; and, I might add now, could he ever have knowledge of Christ and be joyful.

School thy feelings. O my brother;
Train thy warm impulsive soul;
Do not its emotion smother,
But let wisdom's voice control.

Wisdom's voice says love completely. Control but do not smother the emotion of your warm impulsive soul. Develop a full range of human feelings. Regulate those that would restrict your growth and cause you or others to suffer. Enhance those that bring about your growth, your joy and the joy of those most meaningful to your life. Love your fellow man and allow him to love you. We are our brother's keeper and must stand in for God in the expression of love that we may come to know of His capacity to love us. Then and only then will we be magnified to our utmost. Then perhaps we can register and express the joy of Ammon. In the name of Jesus Christ, Amen.

References

1. Powell, John, *Why Am I Afraid to Love?* Niles. Illinois: Argus Communications Co., 1967, pp. 114-116
2. Ibid., pp 9-12.

Biography

Powell, John, Why Am I Afraid to Love? Niles. Illinois: Argus Communications Co., 1967.