Journal of the Association
of Mormon Counselors
and Psychotherapists

April 1981 Vol. 7/Issue 2

AMCAP supports the principles of The Church of Jesus Christ of Latter-day Saints; however, it is an independent, professional organization which is not sponsored by, nor does it speak for the Church or its leaders.

The purpose of this Association shall be:

a) To promote fellowship, foster communication, enhance personal and professional development, and promote a forum for counselors and psychotherapists whose common bond is membership in and adherence to the principles and standards of the Church of Jesus Christ of Latter-day Saints, both in their personal lives and professional practice.

b) To encourage members and assist them in their efforts to provide leadership in stemming the tide of materialism, amorality and immorality that threatens to engulf their various other professional organizations and the society at large.

Article 1, Section 2, AMCAP By-laws

Journal of the Association
of Mormon Counselors
and Psychotherapists

April 1981 Vol. 7/Issue 2

The ideas and opinions expressed by the authors are not necessarily those of the editors, Association, or of The Church of Jesus Christ of Latter-day Saints.

Subscriptions

Subscriptions to the *AMCAP Journal* are provided to AMCAP members. For information concerning membership, write to the address indicated below.

Change of Address

AMCAP members anticipating a change in address should forward the new address to AMCAP to ensure the accurate delivery of the *AMCAP Journal* and other AMCAP correspondence. For change of address and all similar correspondence write to:

AMCAP
Counseling Center
104 SWKT
Brigham Young University
Provo, UT 84602

Call For Manuscripts

The *AMCAP Journal* seeks manuscripts of interest to the broad interdisciplinary membership of the Association. Articles relating to the practice, research, or theory of counseling and psychotherapy are appropriate for the Journal. Manuscripts should generally not exceed twenty double-spaced typed pages. Style should follow the Publication Manual of the American Psychological Association (2nd edition). Authors should keep a copy of their manuscripts to guard against loss. Three copies of the manuscript should be sent to the editor:

Henry L. Isaksen, Editor
AMCAP Journal
Box 926
Salem, Utah 84653
(801) 798-2348

EDITORIAL

Most of us are very busy people. There are so many demands upon our time that it is hard to find a quiet hour or two in the day or even in the week for reading and contemplation. And even if we can, there is so much to read! We can't hope to read even a substantial portion of the best amount of literature that is available to us. We must, therefore, be highly selective and avoid wasting our time on reading material that does not make a substantial contribution to our lives.

But, oh how rewarding and enjoyable it is to read something that stretches our minds to new dimensions and understanding! Or, that stirs up issues that we have neglected to face and provides us with solid nourishing food for thought. What a thrill it is to discover a new idea or to arrive at a new synthesis of ideas already grasped but poorly organized.

It is our desire to provide through the pages of the journal the kinds of articles that will enable you to have experiences like those referred to above. We want the journal to be at or near the top of your list of reading priorities. We want to insure that each hour you spend reading the journal is an hour well spent.

We hope these goals are being achieved and we think they are. But we hear so little from you that we're not sure. We urge you to take a moment, after you have read this issue, to let us know how you feel about it. For example:

--If you deal with homosexual males in your practice, did you find Vic Brown's article helpful?

--Have you come to somewhat the same conclusions with respect to questions raised in the article by Charlie Madsen and Bob Millet as they did?

--Did you find the panel discussion led by Val MacMurray helpful? Do you still have unanswered questions about how church leaders and practitioners can work together more effectively?

--Etc., etc.?

Your editor has always operated on the assumption that, "no news is good news"--but this silence is getting oppressive! Say something please!

HLI

TABLE OF CONTENTS

MALE HOMOSEXUALITY: IDENTITY SEEKING A ROLE

Victor Brown, Jr., DSW*

Presented at the AMCAP convention
October 2, 1980

I have to chuckle a bit when Allen Bergin, in his introduction, said I have the courage to do this work. I was ordered to do it. It took more courage than I had to refuse, and so I'm here today.

The other day I was talking to someone who, up to that point, had been a rather close friend, and I told him that I was pulling eight years of work together. He said, "Well, take two minutes and tell me all about it." I told him what I thought of his invitation. So I'm going to read, and I'm going to read for about an hour. We'll give breaks in between to get the circulation going again, and then according to the invitation I received, we'll have time after that for questions or discussion.

The title of this is: "Male Homosexuality: Identity Seeking a Role."

In graduate school we were advised to determine early in our careers if there were treatment situations with which we would be professionally uncomfortable. I determined two: adolescent groups and homosexuality. Thus it followed that in keeping with some inexorable law my first major therapy opportunity was with adolescent groups. From this experience I found that my intuition was right. I did not relate with adolescent groups, probably they acted so much like I did at the same age.

Thus, when I was invited a few years later by Church authorities to become professionally involved with those people who practiced homosexuality, you can appreciate my distress. Frankly, I did all I could to avoid the assignment. Prior to that time I had referred such clients to other therapists. I had not read any of the literature and had no interest in the matter. Soon I found myself extensively involved in an aspect of human behavior that at first was baffling, disturbing, and at times very discouraging. However, recently I have found that, unlike adolescent group work, working with people who have homosexual problems is one of the most rewarding, though challenging, experiences of my life. I am grateful for the assignment that drew me into this work. My report today sums up about eight years of work, the most intensive part being the last two.

May I share with you some conclusions I have reached. First, homosexuality is learned, not inherent. Second, it is preventable. Third, it is changeable. Fourth, it is a destructive, or detrimental, orientation. Fifth, the label "homosexuality" is inappropriate and misleading and tells us little about the complex human being behind it.

In this report I intend to deal with two aspects. First, the origin of male homosexuality; second, change. May I note that in the interest of time I shall not say much about documentation and references, although every essential point is referenced in the literature.

The Origin of Male Homosexuality

The evidence I have been able to glean from the literature, clinical experience and the restored Gospel leads me to conclude that predominant male homosexuality is the search for and acceptance of a psycho-sexual role which enables the person to merge--that is, enables the *person* to merge--with a defined, clarifying role. Turner (1978) refers to this as merging. Turner suggests that a role-person merge is promoted, among other factors, by--and he has about 21, but I'll only list 4:

1. Intense identification by significant others of the person with the role.
2. A high degree of sacrifice.
3. A high degree of unresolved role strain, and
4. Intrinsic benefit.

Predominant male homosexuality fits these and Turner's other criteria. First, the boy or man has a history of being perceived as different, as not stereotypically masculine. He doesn't play ball well, he enjoys girls or dolls, he is obedient to his mother, and so forth. He is often called fag, sissy, or other terms derogatory of his masculinity. Second, he must face all manner of social derogation to be homosexually oriented. Third, homosexuality is perhaps the most stressful and unresolved role in our society. Fourth, while there may be few extrinsic benefits there are certain significant intrinsic rewards.

Thus, rather than being a rejection of a heterosexually based culture, homosexuality may actually be a reward within that "alien" culture. What others may label as negative, the homosexual male may regard as long-sought answers to extremely troublesome questions.

These apparent answers or rewards come through a developmental process which appears to consist of four phases. The first phase is *pre-homosexual role confusion* in childhood and includes parent-child disturbances, gender and role distortion, relationship skill deficits, and erotization.

***Brother Brown is Area Director, LDS Welfare Services, Northern California.**

The second phase, *pre-homosexual role compensation*, involves unilateral masturbatory fantasy--I'll explain all these; I had to have some jargon to appear professional--fragmentation, and self-focus.

The third phase is *crisis of fit*, a severe realization of being different.

The final phase is *homosexual role resolution*, or "merging" in Turner's terms, where the person and the role merge.

The inter and intrapersonal weight of these phases add up to a decision to adopt a predominantly homosexual role and then merge one's self with that role. Bisexuality, situational homosexuality, transexualism, transvestism, and female homosexuality are significantly different and are not discussed here.

I am going to go rapidly through these phases. Documentation for them can be gleaned from the bibliography which I will share with those interested.

Phase One: Pre-homosexual role confusion.

Within this phase there appear to be several factors of confusion: problematic parent-child relations, gender and role distortion, inadequate relationship skills and erotization.

Parent-child relations. Hooker (1969) concluded that troubled, even pathological parent-child and parent-to-parent relationships are more common among homosexual patients and non-patients than among comparable male heterosexuals. This includes the aloof, rejecting father, the close-binding mother, divorce, and so on. In general, these relationships are such that the boy, in childhood, never fits into a steady, rewarding role of son. Father seldom reinforces the role with approval, mother seeks to meet her own needs through the relationship, positive parental relationships are not modeled--all this during crucial formative years when the child's dependency and modeling needs are the highest.

Gender identity. The common assumption has been that there is over-identification with the mother with a resulting feminization. This is not supported by the literature, or my clinical experience. Pre-homosexual boys clearly know they are male. That is not the issue. The issue is what version of male are they? Their gender is clear; their role is not. Indeed, the problem is rather a hyper-male identification, not effeminacy, even though the boy's manners and interests have been criticized as sissy-ish.

This sense of difference is the seedbed of eventual homosexuality. That each of us has innate uniqueness, unexplained by genetics or environment, is perceived by researchers such as Kagan and Klein (1973) and many experts such as mothers, who see in their new-born infants clear personality traits. When these temporal observations are added to the knowledge we have of pre-mortal life, then we clearly understand the advanced development of individuality at the time of mortal birth.

In our culture, the feminist movement notwithstanding, women are granted a wider range of social-emotional role variations than are men, at least early in life. The male child who is inclined toward physical passivity, playing with dolls, avoidance of contact sports, reading and music, is excluded, often persecuted for these traits. What is remarkable is not that he is innately different but that society will not grant departures from stereotypic superficial expectations. He is given no viable role alternative. Thus, the prehomosexual boy is labeled "different," which eventually can become the label "queer" if he does not develop talents or interests which his peers accept as masculine. Thus, the "different" boy who torments teachers is a hero to his peers while the quiet, cooperative one is a sissy.

Merle Miller (1971, Pp. 18-19), in his book about his own homosexuality, recalls his childhood struggle with expected male stereotyped role performance.

"I clearly couldn't be a girl, so I tried the other." (I have to say parenthetically that I really think we make a mistake referring to the *opposite* sex. Perhaps we would be much more accurate to speak of the *other* sex.)

> I clearly couldn't be a girl, so I tried the other. I ate carloads of Wheaties, hoping I'd turn into another Jack Armstrong...I sold enough *Liberty* magazines to buy all the body-building equipment Charles Atlas had to offer, but it did no good. I remained an eighty-nine pound weakling year after year.
>
> I chased girls...and denounced queers. What a fink I was--anything to avoid being called a sissy again.
>
> It seems to me now that I heard that word at least once five days a week for...thirteen years, until I skipped town and went to the university.

Thus, the essence of the conflict is not between feminine and masculine gender identity, but between stereotypic masculinity or cultural demands and individualistic masculinity or eternal self-hood. Again, a person seeking a role.

Relationship skills. To be sure, the pre-homosexual boy develops certain social skills, but they tend to serve temporary relationships, a pattern which is carried over into his adult relationships.

Because of his role confusion and resulting isolation from stereotypic male peers and girls who expect stereotypic male behavior, the boy seldom acquires the social and emotional skills and confidence which lead to lasting relationships within the role. This includes key words, interaction subtleties or attitudes. He begins a process which Kandel (1978) calls selective response as opposed to peer influence. Kandel suggests that so-called peer influence, at least in the research she did, is over-estimated by 100 percent. (That doesn't leave a great deal of room for question.) She asserts that it is similarity which leads to formation of friendships; that general peer influence can be a deterring, even aversive, factor.

This describes the pre-homosexual boy's challenge. His peers, in general the objects of envy, are uncomfortable for him. So he begins a search for others who share his needs. Early in life, because they are all fighting the same battle, they are hard to find. Later, these others are rather accessible and plentiful.

Erotization. Concomitant with isolation is yearning for acceptance. With impressive frequency pre-homosexual boys engage in what I suggest are premature sexual episodes, erotic encounters which acquire far more significance than they would in another person who is less isolated and confused. Thus they are premature because the boy cannot integrate them into a larger context yet. These occur usually around 11 years of age and are considerably more common in homosexual than in heterosexual histories. Because these episodes offer relationships of a sort for a very isolated person, their impact is magnified until they become the model by which most other emotional efforts, successes and failures are measured. Erotic skills are, to risk a pun, seductive because they are easily acquired and practiced.

Almost always including fantasy and masturbation, these episodes offer the isolated and insecure boy reliable erotic and pseudo-emotional gratification because, as McGuire, Carlisle and Young (1965) observed, "even the poorest learner can acquire behavior which he practices several times per week."

Thus, erotization beguiles the pre-homosexual boy as both a retreat from depressing reality and a promise of future relationships as his person begins to acquire behaviors which, as yet, have no role with which they can merge.

These factors--*parental difficulties, gender and role stress, relationship skill problems and erotization*--add up to a profound and growing sense of difference, an awareness that this isolated person does not fit the role or roles which society has created for male people. Logically and demonstrably, he begins to compensate.

This is **Phase Two: Pre-homosexual Role Compensation.**

There appear to be four basic aspects of these compensatory efforts. They are unilateral self-expression, masturbatory fantasy and fragmentation, and self-focus.

Unilateral self-expression. Early on, the pre-homosexual boy fails at peer collaboration not because he cannot congenitally collaborate but because, given his eternal uniqueness (could this be called "intelligence"?), he does not adopt stereotypic attitudes and behaviors. Rapidly he develops ways to gain approval without collaboration. Because peers usually demand a rough type of democracy--such as, you are accepted through playground football games--this boy tends to do things that appeal more to those adults who value less rambunctious behavior. Thus he practices the piano, speaks carefully to adults, avoids upsetting his parents. Eventually he is seen as an unusually mannerly and dependable young man. In the Church he may be the bishop's delight because he seldom gets in trouble. He doesn't leave a girlfriend when it comes time to go on a mission, either. Activities which permit both uncollaborative success and clear expression of self offer him roles with which his person can merge. From this has come the misleading assumption that homosexuals are feminine and choose the arts. In fact, the arts offer solo roles of socially approved self-expression. But so do certain sports, the military, and lumberjacking, all of which attract homosexual men (Adair, 1978).

Masturbatory fantasy and fragmentation. Erotic gratification combined with fantasy offers compensating escape. The fantasy often serves the purpose of achieving a relationship which is beyond the person's skills in real life. One client made a breakthrough when he finally realized that the man in his fantasies--and he had a recurring fantasy for years--was actually himself, achieving career, church and sexual successes in his imagination.

Self-focus. The pre-homosexual person attempts to fill a social-emotional void without the realities of deep social-emotional relationships with others. By turning inward he protects himself. He acquires skills which often give the appearance of social role competence but he is almost always concerned first and foremost with himself. This ranges from relatively benign self-protection to serious manipulation and exploitation of others. Self-focus is a compensation which permits liaisons of convenience within a hostile society. It seems to go no deeper nor further than that.

Because of these limitations, the pre-homosexual boy or man eventually encounters an unavoidable reality, that is, he knows that he does not fit, his person does not merge with available roles; hence occurs what can be called Phase III, the *Crisis of Role Fit.*

This admission is painful in the extreme to the boy or man. Often there is a convulsive, frantic attempt to prove to himself that he is heterosexual, so he attempts to seduce a woman--or some other stereotyped activity--and thereby qualify for society's approval, which requires that a real male person perform within the macho role. He fails and cannot deny that he actually is what he has been afraid of--a homosexual. This then leads to the last phase, *Resolution or Merging of Person and Role.*

Resolution means that self and role appear to merge, recalling Kandel's concept of selection as opposed to peer influence. That is, we resist peer pressure and seek associates for similarity and acceptance. The pre-homosexual boy or man who is on the verge of homosexual resolution appears to merge and is attracted to people who appear to be like

him. For years peer pressure has done what Kandel found it did--it has excluded the boy from relationships. If it had worked he could have been as macho as his peers claimed they were. In fact, he has found--or believes he has--people of similar needs. And they all have found--or believe they have--what Turner spoke of: a role with which their persons or identities can merge. In the vernacular this has been called "coming out." In writing of his own resolution or merging, Cory (1960) recalled that he felt "like one of the elite of the world." This sense of self merging with role was so profound that even though Cory later changed from homosexuality, he said, "I cling [even now] to my entire personality." He had accepted important realities about himself--differences, if you will--and in changing away from homosexuality did not, could not, and I believe should not, have given up what he had discovered about himself.

Thus, after a painful life of confusion, vain compensation and severe role-self crisis, the pre-homosexual male becomes a homosexually-oriented male. Because the merging process must be as complete as possible--seamless, if you will--there remains an essential post-resolution phase. I call it historical revision. Hooker (1965) describes it without labeling it. This is where the person reinterprets life-long yearnings, his sense of difference and all the other pre-homosexual stuff and begins to declare with increasing conviction, "I have always been this way. I was born this way." With such a revision, his new role and his old self make sense--at least in theory.

You have noticed that throughout I have used qualifying phrases such as "alleged," "so it seems" or "as he believes." The reason is simple. I have found no evidence that the homosexual resolution is successful, if success is defined as lasting, growth provoking, peace giving, benevolent, or most crucial of all, leading to eternal life.

Change

Cory's own words contained the seed of the problem and also the seed of the true answer when he wrote, after his change away from homosexuality, "I cling [even now] to my entire personality."

You see, my conclusion is this: Perhaps all of us experience what the homosexual male experiences. We all have confusions about who we are and which roles we fit. We all compensate. We all have crises which demand terribly significant decisions. All of this is provoked by a corrupt world which is alien to the spirit of Christ which motivates every person. Those who *successfully*, that is righteously and eternally, negotiate their personal crises do so, I suggest, on one basic principle. They reject the world. Nearly crushed, at a personal Rubicon where worldly pressures bid them to surrender to secular values and behaviors, they say, often in pain, seldom in triumph, for the battle has left them bruised and weary, "I reject you. *You* are wrong, not I!"

I further suggest that this is the key to preventing or changing away from homosexuality. It occurs when the person finally understands the deception which has been played upon him. Seeing this, he casts off what Brother Bergin has called the "mortal overlay" and begins to discover all that is right and harmonious between himself and eternal truth. In short, there is another resolution, another role-person merger. It is not simply adopting heterosexuality which, in its socially distorted forms, has been the core of the deception. Rather, it is the merger of self with the role of a Christlike male. That is, the person begins to see that much of what society believes about normal masculinity is at best erroneous and at worst is in conflict with the Savior's example.

The pre-homosexual man, throughout his life, has been trying to cope with stereotypic male role expectations which often conflict with deep, inner beliefs which are decent, honorable and right. To avoid homosexuality he needs to see this and to accept the Lord's pattern of masculinity. To change away from homosexuality he need not accept worldly heterosexuality but he must accept Christianity, with its interpretation of ideal heterosexuality in social-emotional terms and, usually, he must repent of erotic misbehavior, a situation not unlike most other young men.

Change implies exercise of will, freedom to reconstruct one's life and development of clearly different thoughts and behaviors. I prefer "change" to "cure" for change implies exercise of agency rather than being acted upon in a curative process, both in the origin of the problem and changing from it.

Is homosexuality a pathology, then? My colleague Allen Bergin has made a pertinent comment about this. He observed that pathology is not merely an individual matter but that apparently rewarding private behavior--that is, the consenting adult doctrine--may actually yield societal pathology. This is the essential flaw in the consenting adult doctrine.

Consider President Kimball's deep concern: selfishness as the root of most, if not all, relationships problems. It may be quite logical when viewing human behavior through the lens of individual autonomy to see almost any behavior as acceptable. Thus, for example, masturbation is now taught to be normal, even necessary, for healthy psycho-sexual development. However, as Sagarin (1973) wrote in a witty article (if you don't read anything else about homosexuality, read his article; it's at least funny), psychology has been so focused upon the individual that it cannot see the sociologic implications of homosexual behavior. This is interestingly seen in Sarnoff and Sarnoff's book (1979) where they extol

the intrapersonal benefits of masturbation by saying that it relieves the individual of any concern for fulfilling a partner's needs.

So it is with homosexuality. Two consenting adults may well fit society's current criteria for self-focused functionality, yet by virtually any standard--historical, sociological, ethical, or in our case, gospel--homosexuality is personally detrimental and, I believe, is socially pathological. It follows logically that when one uses other people to meet one's own needs then societal problems must ensue. Eventually this self-focus involves misuse of godly powers such as unrighteous dominion or sexual manipulation and exploitation. Thus, for the the Latter-day Saint professional, evaluative, preventative and change criteria all stem from the eternal principle in John 15:12: "This is my commandment, that ye love one another as I have loved you."

What then do I consider the most serious danger to the homosexually-oriented person and society, and what is the justification for urging change? After eight years of intensive study I have come to understand what President Kimball has been saying all along: selfishness is the symptom, the problem, the attitude, and the behavior which needs changing, a selfishness born of an erroneous role-person merging or resolution, fostered by a decadent culture's counterfeit of true masculinity.

With this conceptual preface in mind may I share some clinical experience. In my clinical work, which has extended over several years, as I mentioned, I've had many experiences. But for the past little while we've focused on specific research. There were eight clients involved. They ranged in age from 18 to 48. (Parenthetically, may I note that over the years my two youngest clients have been 6 and 9 and my oldest 58). Overt erotic history ranged from three months to 27 years. Education ranged from still in high school to Ph.D. Number of partners ranged from two to several hundred. My shortest therapeutic involvement was two weeks, the longest two months (some of that has to do with changing jobs). I felt that a pattern was shaping up of about three to four weeks of intensive work with monthly follow-up for about six months. This is the most frustrating part of this effort because my move from Provo to Sacramento has disrupted important follow-up.

Four of the clients were married. Two were single and had no dating involvement. Two were single and had dating involvement but with no physical affection with their girlfriends yet shown.

The change approach employed with the eight research clients consisted of five phases, which are listed here:

Phase I: Rapport
Phase II: *Fred's Story*, which I will explain
Phase III: Redefinitions
- A. Erotic impulse versus emotional legitimacy
- B. True masculinity
- C. Extent of change

Phase IV: Identifying the Homosexual Excuse
Phase V: Nurturant Expansion

Rapport. The first visit is intentionally kept to one half hour or less. Its purpose is to establish rapport. We must remember that almost every homosexual client we encounter is, at the very least, uncomfortable. He is anxious not so much about our professional reaction, for he expects basic civility. He is anxious about our humaneness, our ability to see and respond to him as a real person and not a caricature, let alone a pervert. After perhaps 20 minutes, during which I intentionally avoid discussion of sexual or moral details, I give him *Fred's Story*, which is Phase Two.

Fred's Story was written after it became apparent that the client needed to have important data in his repertoire. Telling it to him was very inefficient and ineffective, so *Fred's Story* was written. It is a compendium in biographical form of actual experiences of many clients and several excerpts from the literature. It has been revised several times and needs another important revision due to later clinical experiences.

Fred's Story is about two clients and a therapist. It takes the reader through the origin of Fred's homosexuality and through the change in Clark's, who is a successfully changed client. The client is asked to read this copyrighted document, making written comments as he goes along. I'd like to share some of these excerpts with you. The thing is 70 pages long so I don't think I'll read them all today, but just enough to give you a feel for what *Fred's Story* says, realizing that I'm going to skip almost all of it. This is handed to the client with virtually no explanation except what I've given you here, and he goes home and reads it. It begins:

> Fred, age 19, was a slight, quiet young man. His hair was sandy, his speech precise, and his expression solemn. He announced uncomfortably that he had come to seek help with a problem. After a few minutes of avoiding the obvious, Fred announced "I am homosexual." He dropped his eyes and slumped in his chair as if expecting the counselor to denounce him for his confession. The counselor asked many questions which almost seemed to Fred to avoid the subject for which he had come. The counselor was trying to get acquainted as well as help Fred relax. Fred was filled with guilt and embarrassment for having strong interest in men and almost no interest in women. Indeed, his entire life lately had revolved around this guilt, because he knew what society expected of him as compared to how he really felt.

Going into the developmental history now:

> As Fred's world expanded beyond the house to the neighborhood and into the school yard, he had many painful experiences. Like most little boys, he enjoyed any playmate

and any toy. He especially enjoyed girls because they were gentler than boys. He liked to play with dolls and didn't like rough and tumble play. For some reason, he did not learn 'boy's games' easily. He really did throw awkwardly. At first this did not matter too much, but by the time he was ready for school, other boys began to tease and pick on him. They called him 'sissy' and hit him. It was as if he wore a sign saying 'hurt me.' His reaction was at first to try and please them, do everything they wanted. But that did not work. They still taunted him. Eventually, he began to withdraw and avoid them. Avoiding most other children became a skill. During this time Fred began to develop a seriousness that adults noticed. Their usual response was, 'My, what a polite boy. I wish others were like him.' He soon learned that adults, including his parents, liked him to be neat, clean, and quiet. Or, if he did make noise, they liked it to be refined, such as proper speech, singing, or playing a little piano piece. Since adults were the only people who seemed to respond to him, Fred began to seek their company and approval. In doing this, however, the gap between him and his age mates widened. He was neat, they were scruffy. He was quiet, they were loud. He was confused by groups, they enjoyed lots of people. He was clumsy, they were coordinated. He recalls this period as the time when 'I was always chosen last for the team games, even after the girls. And I always did something wrong.'

Now I've selected these excerpts not because I thought they were interesting. These are the excerpts about which the clients wrote, almost to a man (we have a column here for them to write their comments in) "This describes me." In fact, one of them wrote, "How did you write my life story?" Continuing:

Approximately from this time on [and we're talking of the time after these painful experiences], Fred began to pursue solitary interests; that is, he became unilaterally involved in interests which required as little collaboration with others as possible. He practiced the piano regularly, he studied his school work every night, he collected pets of various kinds, but always those that were controllable--tropical fish, small puppies, and so forth. [One of my clients, way back, collected rocks. I had that in one of these versions and two of the other clients said they collected rocks too.] He also became very aware of his body and found unilateral ways to compensate for his clumsiness. He began to run and found great pleasure both in the exertion and the accomplishment. After a time he became good enough to compete in cross-country in the fall and track in the spring. His father was rather pleased with this, mistaking it as a development of manly interests at last. But as Fred said to the therapist, 'I found a way to beat the real boys through running. I never liked the team stuff. The thing for me was to win on my own without worrying about someone else's performance.' By 11th grade Fred's solitary devotion to music, his studies and athletics had taken him into a spotlight of sorts. He was considered to be a bright, talented and unusually well-mannered boy. Even his lack of interest in girls and social life in general was interpreted as a rather nice departure from the rowdy antics of his peers. But this acceptance, especially by adults, created another pressure for him. Fred was not actually any more gifted than his peers. His advantage was that he had worked so hard on his unilateral interests that, by the law of the harvest, he reaped more rewards than his less diligent peers.

This is the end of the first session, after, in essence, discussion of the origin of his behavior.

As he left [the first session], Fred turned and asked, 'If I decide I do not want to consider changing, what will you do?' The counselor responded as warmly and as honestly as he knew how. 'It would be dishonest of me to help you adjust to homosexuality. I do not know any homosexual people whom I consider happy and fulfilled by their activities. I cannot reinforce what I have observed to be a detrimental lifestyle. For this reason I would refer you to other counselors. I would also hope we could keep in touch, as I have with a few others who have decided not to change. In fact, a couple of these folks and I have been friends for several years now.'

And then the beginning of the next session.

Several days later Fred called to make an appointment. He came into the room looking weary [which is part of the program]. After a few casual remarks he said, 'I cannot decide whether I can change or not. What do I do now?' The counselor reminded Fred that he had never said that this decision has to be made just yet, that Fred was feeling pressure from himself. The therapist suggested that they finish what they had interrupted last time and then Fred might be ready to consider the change question. This surprised Fred. He seemed to expect some kind of pressure, but the counselor had learned the hard way that behavior change is voluntary and cannot be preached or forced, only encouraged and aided. Fred indicated that he wanted to continue.

And then on into the second session a ways.

Fred interrupted a third time. He asked the counselor about change. 'I have heard and read so much that says change is virtually impossible. The *New York Times* had an article which said that. It really discouraged me. I need to know what the truth is.' There was no anger in his voice, but there was obvious doubt. The therapist had hoped Fred would ask this question. It was better when it was asked. To volunteer the information before Fred was ready could have sounded like salesmanship, trying to cheerlead him into change. 'Fred, change is possible and, in your situation, very probable. It was harder for Clark because his decision came after he chose to accept homosexuality. You are still struggling, so the probability for people like Clark is less optimistic than for people like you. Yet Clark did change. With both types of people lumped together, the pre-impulsed homosexual, the rate of change is about 60 percent. We once reviewed over 100 studies. In them, two out of three men were either changing measurably during the study or had changed completely. This is about the same rate of change or cure as for alcoholism and other problems of self-esteem and self-control and loneliness.' [I'll be the first one to agree that the literature upon which that statement is based is weaker than one would wish. I'll be the first one to state, however, that it's a heck of a lot better than the unsubstantiated myth that change is impossible!]

Now at the end of the third interview.

The counselor sat back in his chair as if to indicate Clark's story was complete [Clark is the individual who changed]. Fred seemed lost in thought. Finally Fred said, 'If I decide to try to change, what do I do next?' 'You go home and think about what we've discussed and then call me for an appointment. Then we will begin the tasks we have talked about.

'Do you think I can do it,' Fred asked earnestly. 'I have no doubt you can,' the counselor responded, just as earnestly. 'What will you do if I do not come back?' I will continue to respect you and pray that you will find happiness. As I told

you before, some of my friendships are with homosexual clients who have not chosen to change. But through these very friends I can see the increasing loneliness that we talked about. Please do not misunderstand me, Fred. Whenever I get to know someone as well as I do through this experience, I almost always learn to admire them. I am not their judge. That is what a bishop is for. But I also see the narrow and eventually unrewarding life they lead. I cannot in good conscience wish them well in pursuing what my information tells me will turn out to be an unhappy and detrimental way of life. Because of this I hope you will return and begin the change experience, for your own sake and for those who admire and love you.' Fred stood, shook the therapist's hand and left. As always, the therapist wondered what Fred's decision would be.

So that's *Fred's Story*, rather condensed.

Fred's Story seeks to do three things. It provides the reader with data he probably does not have, such as the sequence of developmental experiences common to homosexual men and the probability of change. It raises the question of self responsibility and change. By the time the client returns, hopefully no more than one week later, he and the therapist have a common view of the matter, even though they may not agree as to the details.

The second session consists of going through *Fred's Story* page by page. May I repeat, the first session was just 20 minutes of rapport at which time *Fred's Story* was handed to the client, who took it home and read it. Therefore, the second session consists of going through *Fred's Story* page by page and discussing the client's written comments. This either resolves differences or underscores them.

Considerable action occurs during this phase. Without exception the clients have returned with increased optimism about changing and with important questions. May I emphasize that Fred's Story is not a Pollyanish pep talk. If anything, it emphasizes the pain of change. But it also offers factual hope to men who have been persuaded by the world that change is impossible.

The third session involves what I call redefining. In this phase it is important to help the client separate his social-emotional problems from his erotic impulses or habituations. It is also crucial to explore true or Christian masculinity, such as the traits spoken of in the Beatitudes or the Fourth Section of the Doctrine and Covenants. As President Kimball said two years ago at General Priesthood Meeting, the men of the Priesthood must be different from men of the world. This contrasts with the secular version with which the client has struggled so long. Finally, it is essential to define the extent of change that is needed. That is, is the client supposed to forsake all he ever has been or are there parts of his personality, circumstance and character upon which the future can and should be built?

To facilitate this discussion beyond *Fred's Story* when needed, I am in the process of gathering some pictures which either aid in introspection or facilitate therapeutic discussion. Essentially they are just pictures cut from magazines and they just facilitate discussion of the individual's circumstance. There are two things, though, that we are learning with impressive regularity. One is that clients select pictures which show nurturance. They reject pictures which show macho behavior. And they have not yet selected a picture showing homo-emotional or a homo-social nurturance because I can't find one, nor can my research associate Richard Anderson find anything. The fact that I cannot find such a photograph--homo-social or emotional nurturance--is a comment on our society and strikes to the heart of change. This is the critical point, for it focuses the therapy sharply on the question of "normal" masculinity. At this juncture the client is torn between rejection of past myths and acceptance of new myths. This is no small matter and I have found the discussion and explorations of this phase as challenging, yet rewarding, as any in my career.

Once this redefinition phase has been dealt with, the client faces another major challenge. Remember, please, that his homosexuality has served a purpose and provided some rewards. Redefining his need to control erotic impulses, clarifying true masculinity and accepting much of himself as not needing change do not automatically solve the problem. He has many years of learning in a certain direction. Now he must either change from or, in a rather calculated way, re-accept homosexuality. Thus we must deal with the excuses which he uses or might use to continue as before. These are not rationalizations so much as they are the symbiotic benefits of homosexuality. May I share an example. I shall call this client Brother R.. Rapport came to be warm and rather deep between us. I genuinely enjoyed his quick mind yet tender emotions. *Fred's Story* got us around his defenses because it helped him see that his feelings and experiences were not mysterious. Redefinitions were very freeing as he was able to accept himself as a rather positive person rather than as totally perverse or bizarre.

However, he strongly resisted giving up his homoerotic fantasies and activities. I despaired until it became clear that he was clinging to the past for fear of the future. This was the first time I realized that even after the origin of the problem was understood there remained reasons to continue in it. In an intensive session Brother R. was able to identify his "excuse." He was married to a very decent, well-educated woman. However, they had married more for mutual protection than from strong attraction. The problem, as it finally came out, was that he had felt his commitment weakening. His homoerotic episodes, though wreaking havoc upon their relationship, served another purpose--they permitted

him to avoid dealing with his lack of emotional interest in his wife as a person. Now, if shorn of his homosexuality, he would be confronted by the fragility of his marriage. Once we got this point out in the open, Brother R. relaxed markedly. At that point therapy shifted from homosexuality to interpersonal and affective deficiencies, and thus to marital problems.

This brings up a factor which I have found rather important. I call it the shin splint syndrome. With the homosexual client I have found it very helpful to specify, clarify and reinforce the point at which he feels he has come to understand and reject his homosexuality. This has usually happened early in the therapeutic experience. I use the example of shin splints--I assume everyone knows what shin splints are, if you jog. It means your legs hurt. I use the example of shin splints and how they can be healed by a simple program of no running for three days and then resumption of running only on yielding surfaces with good shoes. I pointed out that this is a complete cure, that if the runner violates these simple rules and gets shin splints again he cannot claim the treatment was faulty.

This applies directly to the client's efforts to control and eliminate erotic impulses. If he will reduce fragmentation--that is, focusing on a body part instead of a whole person--by avoiding lingering looks at arousing body parts and learning to relate to the whole person, read uplifting material, enjoy positive entertainment, identify his personal impulse chain and learn to interdict it, scrupulously avoid dark or secret places and so forth--just like anyone else who seeks to bring their impulses under control--then the client will experience rapid and lasting erotic discipline. If not, then he, not the method, is at fault. Parenthetically, one young man ceased masturbation and lost his erotic impulses in two weeks because he stopped shutting the door to his bedroom. I have frequently suggested that we decide upon circumstances which would make it dramatically impossible to repeat the erotic habituation.

This is for the short range. For the long range I believe there are just as certain methods but they take longer and require more self-discipline. This is phase five, *nurturant expansion.*

Due to the assaults upon their sense of self over the years, these men have become very self-focused, as described in the profile section. Thus, they need to taste the sweetness of nurturing others to enable them to break away and enter a new life. Another way of saying this is that these men missed in childhood tender, reassuring, benevolent experiences. Now it is too late to receive them in that manner, yet they must taste the nectar of nurturance. Therefore, in the logic of eternal law they receive by giving. They do unto others what was not done unto them. They may well have been victims but now cannot use that as an excuse. Like everyone else--all of us--who had less than perfect upbringings, they must decide to make up the deficits by their own efforts. They must expand themselves through nurturance.

In President Kimball's words:

> When we are engaged in the service of our fellowmen, not only do our deeds assist them, but we put our own problems in a fresher perspective. When we concern ourselves more with others, there is less time to be concerned with ourselves. In the midst of the miracle of serving, there is the promise of Jesus, that by losing ourselves, we find ourselves (See Matthew 10:39).
>
> Not only do we 'find' ourselves in terms of acknowledging guidance in our lives, but the more we serve our fellowmen in appropriate ways, the more substance there is to our souls. We become more significant individuals as we serve others. We become more substantive as we serve others--indeed, it is easier to 'find' ourselves because there is so much more of us to find!

In the empirical candor, my change of jobs cut short ongoing evaluation of the nurturant phase. I have experienced it with earlier clients but only in the beginning stages with my eight research clients. Nonetheless, the initial experiences indicate much promise as the clients shifted from self-focus to nurturance.

Thus, at this point, in a rather short period of time, my clients have gone through the five phases of change. Armed with the homey shin splint syndrome and the more profound overview of origin and change, these individuals experienced marked change. For reasons already given, I cannot speak to maintenance. Obviously the next research effort is to employ these methods, with refinements, under more rigorous empirical conditions, especially with neutral observers and pre and post measures. I have begun to develop a basic instrument for these measures.

Change was determined by cessation or diminution of overt behavior and cessation or diminution of fantasies. In seven cases overt behavior ceased. In four cases, erotic fantasy ceased; in two it reduced; in two it did not reduce or cease but it was no longer exclusively thematically male, that is homosexual. Seven clients verbalized clear changes in their thought and relationship patterns. One deteriorated clearly and markedly. I kept telling him that he couldn't do that, but he did. However, his situation was complicated by loss of employment and very detrimental living arrangements. Even then, his overt behavior ceased. Although these results are not based on a standardized research design, they are promising in that the clinically observed rates of change are higher than any yet published in the treatment literature. Since the field of behavior therapy received its initial impetus from similar reports by Wolpe with phobic cases, perhaps we have reason to be optimistic

continued on page 35

THE GOSPEL AND PSYCHOTHERAPY: A MORMON COUNSELOR'S DILEMMA

Charles H. Madsen, Jr. and Robert L. Millet*[1]

Presented at the AMCAP convention
October 2, 1980

In introducing this topic, it was especially important for us to be honest with ourselves and express the concerns that we have had, and ask others simply to do the same. We do not profess to have all the answers, but we are grateful that we have taken the time to at least explore some *questions*. Such vexations of the soul can be a bit threatening unless undertaken in sincerity. The following represent a selection of personal and professional concerns that have arisen over the past ten to fifteen years with regard to our role in this business of helping--counseling and psychotherapy.

QUESTION #1.

IS THERE IN REALITY A DICHOTOMY IN OUR LIVES BETWEEN OUR PRACTICE OF RELIGION AND OUR PRACTICE OF THERAPY?

We have experienced conversations with colleagues, Mormon therapists who reply, in essence: "You know, everything I do from Monday through Friday is based upon my training as a therapist--secular learning and dealing with the theories of man. However, I find no problem in changing hats on Sunday and becoming a good Latter-day Saint." We have thought to ourselves: What are you saying? What is it that you're really telling us? Here are men who serve on the high councils, in bishoprics, in stake presidencies--good, active, committed members of the Church. They attend the temple as often as possible. Yet they attempt to create a dichotomy in their lives that may be unnecessary.

Is there a dichotomy at all? Should there be a dichotomy? One member of a psychology faculty was asked, "Don't you have difficulty with this 'dichotomy' problem?" He replied that he did not, that (and these words are worth pondering) "I have had to make that kind of compromise in my life." Again, is that necessary? Is it even *safe*? One wonders where academic necessity ends and moral responsibility begins.

A young psychologist was attending an Abnormal Psychology class at BYU. The class was being taught by a High Priests' group leader, a fine man. While turning the pages and following along in the textbook, looking carefully at what was being discussed (it was Coleman's book on Abnormal Psychology) he remembers hearing these words: "Now we know, of course, that there are no such things as evil spirits. We recognize that these are simply mental disorders." That remark had the effect of a *cold* slap in the face. The student's reaction: "Now wait a minute. Wait a minute. How can you say that? What's the message of the New Testament?" The professor insisted that demonic possession was a symbolic or unsophisticated way of saying that people were troubled mentally and emotionally. This caused great concern. It seemed as if an awful price was being paid needlessly.

Anyone who has had experience with demonic possession will testify of the reality of evil powers. We are foolish to ignore or deny their existence. The issue of demonic possession is one example of many in which Mormon professionals have been forced, as they suppose, into an unnecessary compromise, which compromise may follow such a dichotomy.

QUESTION #2.

DOES A COMPARMENTALIZATION OF OUR LIVES AS MEMBERS OF THE CHURCH AND AS MEMBERS OF A PROFESSION DILUTE OUR EFFECTIVENESS AS TRUE DISCIPLES OF THE LORD JESUS CHRIST?

Let us suppose that we *can* compartmentalize our lives. Though we have no data from which to base our feelings at this point, the real issue seems to be: if one can produce that compartmentalization Monday through Saturday, and on Sunday put on a different hat, is it affecting us in some way of which we may be unaware? We have come to sense in our own personal lives that such a compartmentalization may be detrimental to our discipleship.

Consider Alma's beautiful definition of faith. He taught that faith is not to have a perfect knowledge of things, but it is to have a hope for things *which are true*. (Alma 32:21.) President N. Eldon Tanner has given an example of the Indians planting gunpowder with all the sincerity in the world, with all the diligence possible, trying to nourish and harvest more

***Brother Madsen is first counselor and Brother Millet is second counselor to President Richard L. Chapple in the Tallahassee Florida Stake. Professionally, Brother Madsen is Professor of Psychology and Brother Millet is Director of the LDS Institute of Religion at Florida State University.**

[1]The impetus for much of the work contained herein can be attributed to the work of Allen E. Bergin.

gunpowder--only to find that such is not possible because the seed was not proper, was not true, simply wasn't what they thought it was. Is it improper to ask, "Are we planting gunpowder?" with regard to our work? Does much of what we teach or use have any basis in truth? Are we certain there is no personal effect?

We find that many people say, "Well, I can borrow from this theory and I can take from that one. I can take *techniques;* I don't have to believe in the theory. I can use these kinds of applications in my therapeutic practice with my clients." But what if the theory is based on a godless system created by godless men who have no affinity for the spiritual dimensions of Man? Could there be a toll, however subtle, that might occur--one that works inexorably but slowly to dilute faith and perhaps even to weaken our effectiveness as members of the Church? None of us would suggest that we embrace and use false doctrines within our theology. We know this is the path to apostasy. However, are we willing and open enough to examine and understand every aspect of the therapeutic theories we employ and profess--to examine every theory carefully--to "prove all things; [to] hold fast that which is good"?

President Jeffrey Holland suggests the importance of placing the Gospel as the "hub of the wheel" and arranging any other secular disciplines as spokes. This is the thrust we suggest. So often we hear in classes: "Here is the principle that's taught by this particular theorist; isn't that interesting? That's very similar to what Jesus taught." Here is what another therapist says: "Why, isn't that something? Paul had something to say in just that same fashion." This may be in error. We need to approach the problem from the opposite viewpoint. We need to proceed from hub to spokes in order to enhance our professional lives and the practice of our religion.

QUESTION #3.

HAVE WE AS LATTER—DAY SAINTS SUCCUMBED TO THE UBIQUITOUS PRACTICE OF IMBUING THERAPY WITH MAGICAL QUALITIES?

We have all heard individuals speak of the uniqueness of the therapeutic relationship. Should not that make one wonder about the type of relationship being considered? The only unique relationship that is critical within the Gospel is one's personal relationship with the Savior. When we speak, therefore, about a special relationship with a therapist, we may be establishing a dependency that is totally unnecessary. We often hear therapists acclaim: "Oh, you ought to see the kind of feelings that my clients (or my patients) have about me. I have to work with these feelings in such depth, with such gravity because it's so important to everyone that I see." Ought it to be? One wonders sometimes whether counselee or counselor is in greatest need of emotional acceptance and support!

We sincerely sense the need to recognize the therapist or counselor as a *teacher.* If we could see things from that perspective, it might alter what we do in our own sessions. Who is so bold as to suggest that what really matters is not the theory, but the *therapist?* It is even more threatening to imply that we have made something of this counseling matter that should not exist. Maybe we have "created" something. Perhaps Brother Packer's talk on self-reliance, given first at Brigham Young University (See Self-Reliance. Ensign, Aug., 1975, Pp. 85-89.) needs to be studied carefully in trying to determine if it is possible to cause the very thing we're trying to prevent. Could we be contributing to the epidemic spread of "counselitis?" ("If there are problems we'll abate them. If there aren't, we'll create them!" ...B.K. Packer) If we do not place the therapist in the role of the master teacher, as educator, we may be contributing to the erroneous notion of the therapist as "magic worker."

If we conceptualize therapy as a subcase of teaching, then perhaps we will not succumb to this thinking (therapy is magical). We have had the experience of suggesting that clients may be treated anywhere (e.g., a restaurant to work on social skills). Colleagues often respond with a perplexed look and state, "You are polluting the relationship of a therapist with his client." They continue, "You mean you are going to take him out of," (one almost hears "these sacred walls")--"these walls and put him in a *restaurant?* Nobody can do therapy in a restaurant." We need to recognize properly and assess accurately this relationship variable, accepting it for what it really is (student--teacher).

Kids love their teachers too. Everyday after school, one of our third grade children runs up to her teacher, puts her arms around her and gives her "a love goodbye" until the next day. Of course we should have positive relationships with our people. But such are not magical. We are teachers of men and women, trying to help them find the right way and make responsible decisions about and adjustments to life. We are not practicing magic.

QUESTION #4.

WHEN TRUE PRINCIPLES OF DEALING WITH MAN ARE READILY AVAILABLE THROUGH THE RESTORED GOSPEL, ARE THEORIES REALLY NECESSARY?

Suppose one of us was approached by a non-Mormon with: "I'd like you to consider carefully our religion. I'd like you to adopt the doctrine of grace as it's taught by most of Protestantism." Could you imagine turning to him and saying, "Well, I think we could probably adopt much of what the Protestants

teach, because it's close. We could handle predestination without much difficulty, because foreordination is very similar. Another practice we could adopt is baptism. You use water, we use water. Dipping is terribly close to immersion. Let's accept the baptism. Yes, it seems like a 'good fit'." Would we even consider doing that with *theology?* Ecumenism in theology results in what Elder Neal Maxwell has called "shared impotence." We fear that too often we find ourselves doing similar things with our *therapy.* We indicate that this theory or that principle is a "good fit" to the Gospel. Perhaps the undergirding question is: "Is a good fit good enough?"

The Gospel is not a theory. The Gospel *has* the answers. We work from the *known.* As President Ezra Taft Benson has said, "The Lord has already done his research." In a very real way we should consider therapy or research differently from a gospel point of view. *We* do research to *verify* truth, not to *discover* it. In this sense, there is no apparent need to *construct* theories of human relationships. The Gospel is the grand application of eternal verities to the human being: relationships with God and man. It seems that what is needed most is to uncover or discover the truths and principles and practices that are contained within the writings and sermons of ancient and modern prophets. More than ever before we need to undertake a systematic study to formulate and organize the *Lord's* methods and techniques in *His* way. We have the Gospel of Jesus Christ and we have the principles that are taught in the scriptures and the writings of the living prophets. However, we have not yet formalized them into a body of knowledge which would allow us all to be working toward the same goal. Certainly we are all different, and essential research indicates personality variables are important ingredients. But we ought to be working and building upon the same foundation. We teach with different techniques, but our message is the same.

Would we say, "I'll follow Joseph Smith even though he was immoral, because he had a great program."? Or, "It's okay if Joseph Smith did the following blasphemous things. That's alright; he had a great system." We would never even consider those propositions because we expect the man that represents the system to be the embodiment of what his system claims to produce. Joseph Smith stood boldly and preached to the Saints in 1844 that the goal of man is to become even as God is. And so, if we are really honest and true to ourselves, we ask the question, "Is it not important what the person who espouses the theory believe that man may become as God is?" There is not a single major theory of therapy or counseling that is not propounded by a godless man, or at least a man who is not a believer in anything close to the kind of God that we believe in. Most theorists are either pure humanists or exclusively deterministic. Some of them give passing reference to the fact that a God may exist, but the major theories were developed and propounded by men who are godless. Can we in good conscience ignore what it is that Freud or Skinner or Maslow would have man to become?

QUESTION #5.

IS THERE A TENDENCY TO REIFY OR EVEN DEIFY CERTAIN THEORETICAL CONCEPTS CONCERNING HUMAN BEHAVIOR?

In our culture it is difficult to avoid the imputation of excessive meaning. You often hear people say, "Oh, that's a Freudian slip," or "He's what I would call a self-actualized person!" What is unfortunate is that some of these theoretical concepts are antithetical to Gospel principles. We are dealing with such matters in a book now in preparation. In the meantime we are concerned with the fact that "ego strength" and "unconditional positive regard" and "I'm O.K." and "contingencies of reinforcement" have not only inundated our speech and general world view, but have slipped subtly into the literature of the Church. The conflict models of personality at the base of all Freudian and Neo-Freudian systems, when taken to their ends, deny the notion that man is "an agent unto himself." The humanistic models place man at the center of existence and deny the need for divine assistance or Grace. Behavioristic models, when taken to logical extremes, view man as an organism shaped by the consequences of his actions, by reinforcing stimuli which are independent of any divine source. There is a tendency among us all to classify or label in order to alleviate a bit of the anxiety we feel over a lack of understanding. That is, our tendency to propose that a person's problem is really a "fixation" or a "deficient behavioral repertoire" or an "aberrant action" in response to "conditions of worth" seems to us to be a sincere, albeit misguided, attempt at understanding. If a label truly defines a problem and leads to correct remediation, then there is no problem with labeling. Far too often, however, labels are mere tautologies. Some labels even alleviate responsibility--that is, give away the problem. And even more distressing, labels occasionally may distract our attention from true principles.

Too often intellectuals seem to be fascinated by something that appears to be complicated or at least esoteric. Many are unduly attracted to systems based predominately upon hypothetical constructs ("Parent-Child"; "id"; "reinforcement"; etc.) Some explanations simply complicate the matter further through the use of language which is difficult to follow. Such expressions seem to have an aura of authority about them, but if we are not careful we can get so caught up with the language system itself that we confuse the issue. We must take special care that we do not become like the Jews in the Meridian

Dispensation who were guilty of "looking beyond the mark" (Jacob 4:14), and thus miss the message of the Master. President Ezra Taft Benson has taught:

> Sometimes Gospel principles are written with such erudition that the Gospel is hardly recognizable in them. Worldly phraseology and authority replace the scriptures and the prophets. You institute teachers [this was given to C.E.S. personnel in 1976] need to be aware of this in teaching courses such as "Courtship and Marriage" and in giving counsel on child-rearing. Be careful of lending your worldly training to the Gospel courses you teach lest you be guilty of diluting the pure Gosepel of Jesus Christ and end up teaching the philosophy of men mingled with a few scriptures.

QUESTION #6.

DOES IT PLEASE THE LORD WHEN THE PRINCIPLES OF HIS GOSPEL ARE PLACED IN JUXTAPOSITION WITH THE THEORIES OF MAN?

Too often we use and rely upon concepts, ideas, and techniques that are not fully the Lord's. For a number of years we have heard of the need for *integrating* the theories of human behavior with the Gospel. We are not so certain that an *integration* is what is needed, since far too often we are attempting to integrate disparate entities which do not successfully mix. President Benson has reminded us that "nominal Christianity outside the restored Church stands as an evidence that the blend between worldly philosophy and revealed truth leads to impotence." (Benson, *op. cit.)*

This particular problem is not unique to counselors. How many of us have perused manuals published by the Church wherein are found secular suggestions and interpretations that are readily recognizable because of our academic background in therapeutic systems? One good example will suffice. We recall a particular mother education lesson wherein mothers were encouraged in spiritual terminology to engage in practices which run counter to the revealed Word (i.e., allowing children to "fight it out," rather than teaching the self-control advocated by King Benjamin in the Book of Mormon - Mosiah 4:14).

Merely because the Lord uses rewards and punishments is no reason to conclude that behavior theory is sanctioned by the Lord. Because the scriptures speak of a natural vs. a spiritual man does not give us the license to equate "natural" with a conflict-oriented unconscious. Because the Lord expects us to strive toward an ultimate exaltation, we should not conclude that "self-actualization" represents that spiritual process. Many well-educated Latter-day Saint therapists take the liberty of attempting to integrate gospel principles and secular theories. Apparent similarities (on a surface level) appear to lend credence to attempts at such an integration. Could it be, however, that aligning ourselves too closely with either artificial or at best superficial concepts is like moving (on a stormy night) toward a lighthouse placed tragically amid the reefs?

QUESTION #7.

SHOULD OUR APPROACH AS L.D.S. COUNSELORS BE DIFFERENT FROM THAT OF OUR NON—MEMBER COLLEAGUES?

Do we deal with Mr. and Mrs. Jones in the same way we do with Brother and Sister Brown? An initial response might be: "Well, no. The Joneses aren't Latter-day Saints, and don't have the same value system." But we wonder. Perhaps we need to be more aware of our own doctrine on this matter in recognizing that "the Spirit of Christ is given to every man, that he may know good from evil," (Moroni 7:16) and also that "the Spirit giveth light to every man that cometh into the world." (D&C 84:46.) The Light of Christ is a moral monitoring device given to every Child of God. We are taught that every son or daughter of the Father who adheres and responds to the Light of Christ will eventually be led to the Covenant Gospel. (D&~~D~~C 84:47-48.) We are committed to the principle that as therapists/teachers it is our responsibility to help clients, *members or non-members,* to be in harmony with their divine monitors or consciences. Much success should therefore be associated with our ability to assist people to be true to what they really are. It may very well be that some persons have come close to quenching the Light of Christ within themselves, and others perhaps have extinguished it. This does not change our basic task: to reinforce *absolute truths,* eternal verities which hold irrevocably for Mormons, Methodists, or Muslims.

Can we in good conscience pretend that adultery, homosexuality, theft or emotional abuse (sin) are not paths which lead toward misery and unhappiness? We should not feel any more at ease about helping a homosexual feel emotionally comfortable about his male "sexual preference" than we should about assisting a colleague to feel at ease about his embezzlement. We should no more ignore a couple's marital infidelity in marriage counseling than a bishop should ignore an abortion in the life of an unmarried Latter-day Saint young woman. We should not bury our heads in the academic sands and try to overlook the fact that *we know better!* Because we recognize that laws have been established, that blessings and punishments are the consequences of one's actions, we are in a peculiar position in the professional world--we need not teach Mormonism in our sessions, but we must suggest that individuals "get in touch" with their hearts, with their souls. If these people can honestly affirm that they do not know what is right or wrong in given cases, then we need to become serious about our assignment as *teachers.* We feel that the Latter-day Saint therapist is one who ought to stand firm in defense of the moral

continued on page 35

MARITAL DISSOLUTION AND FAMILY SOLIDARITY

Larry Langlois, "A.B.D."*

Presented at the AMCAP convention
October 3, 1980

The divorce rate in Utah has consistently been higher than that in the United States as a whole, whether figured per 1000 population or per 1000 married women. (See Goodman and Bahr, 1979.)

With the strong Mormon emphasis on family solidarity based on the notion of eternal marriage, this higher divorce rate taken alone appears incongruous. It has been hypothesized in explanation that the emphasis on family and the high expectations of marriage among Mormons places added strain on Mormon marriages and therefore inflates the Mormon divorce rate. (See Christiansen, 1970.)

The purpose of this paper is to show that Utah divorce rates are not by themselves a meaningful measure of family solidarity among the Mormons, and that if other significant factors are considered, the rate of marital dissolution among Mormons is actually considerably lower than that in the United States as a whole.

Belief systems play an important role in regulating marriage and divorce in all societies. The Mormon belief system differs from that of other groups on some important particulars. Divorce, for example, is seen by Mormons as a great human trajedy, but *not* as a moral sin. The bitter, centuries long struggle between the notion of marriage as a church sacrament as opposed to a civil contract, never emerged in the Mormon sub-culture. Unrealistic barriers against divorce therefore did not emerge in the Mormon community. Divorce laws have always been liberal in Utah, and divorces have been relatively easy to obtain. (see Goodman and Bahr, 1979.) But long separations with informal sexual alliances are viewed as noxious social evils, and are severely discouraged, as are all pre-marital and extra-marital sexual alliances. Marriage and family life is considered not only the preferred mode of living on earth, but the basic order of heaven.

Assuming that the Mormon belief system has a significant effect on the behavior of Mormons, several postulates follow logically from this basic Mormon theological stance.

Postulate 1: When Mormon marriages fail, they will likely be reflected as divorces and not separations. This tendency should be significantly divergent from that in the general United States populace.

Postulate 2: There should be a lower instance of pre-marital and extra-marital sex in the Mormon sub-culture than in the rest of American society, measurable as follows:

A. Age at marriage will be lower because the pressures to become sexually active will be more likely to lead to marriage among Mormon youth than among others.

B. Illegitimacy rates will be lower, since illegitimate conceptions will be both less likely to occur and more likely to result in marriage before the birth of the child.

C. Abortion rates will be lower.

Postulate 3: Because unstable sexual alliances among youthful Mormons will more likely be reflected as marriages and divorces than elsewhere in American society, divorce rates will be higher for Mormons in the younger age groups.

Postulate 4: Finally, because of the heavy emphasis on family ties, divorce rates should be attenuated rather than increased by Mormon Church influence.

In order to subject these postulates to meaningful empirical testing, a more homogeneous population than the entire state of Utah is needed. To isolate such a population, a measure was developed to identify the county in Utah reflecting the greatest Mormon influence.

This measure consists of a ratio of Melchizedek Priesthood holders to total male members, and another of Melchizedek Priesthood to total female members. Since these two ratios will both always fall between 0 and +1, they are combined by simply multiplying them together.

Next, several counties in Utah were subjected to this measure of relative church strength to isolate the county where the church exerts the greatest influence. To control for urban-rural differences, only urban counties were included. Only Salt Lake, Weber and Utah counties have urban populations large enough for meaningful comparison. The relative strength in these three counties is shown in Table 1.

Figures from the U.S. Bureau of the Census

TABLE 1

County	M.P./Adult Males	M.P./Females	Combined Ratio
Salt Lake	.665	.587	.391
Weber	.661	.590	.391
Utah	.796	.706	.569

Source: *Deseret News Church Almanac.* Deseret News Press, Salt Lake City, Utah, 1979: 225-26.

***Brother Langlois is a Faculty Member of the Department of Sociology, University of Southern California.**

Population Estimates and the Deseret News Church Almanac show that in 1976 Utah County's population was 89.5% Mormon, while that of Salt Lake County was 66.7% and Weber County was 63.4% Mormon. Utah County, then, by two different measures, one showing relative church strength, the other percentage of population, is the best for measuring the Mormon sub-culture, while Salt Lake and Weber Counties will reflect more of the non-Mormon influence. With this tool for more accurately measuring Mormon behavior, we are ready to begin testing the postulates developed above.

Postulate 1: When Mormon marriages fail, they will likely be reflected as divorces and not as separations. This tendency should be significantly divergent from that in the general United States populace.

Table 2 gives data regarding separated persons.

TABLE 2

TOTAL SEPARATED PERSONS PER 1000 URBAN WHITE POPULATION AGE 14 AND ABOVE

	Male	Female
United States	11.58	16.59
Northeast Area	14.10	21.80
North Central Area	8.30	11.10
South Area	11.40	15.70
West Area	12.70	17.90
Utah	6.30	9.50
Salt Lake County	7.43	10.77
Weber County	6.79	10.33
Utah Conty	2.80	4.32

Source: Population Characteristics, Bureau of the Census, 1970, and Utah Population Characteristics.

These data clearly offer striking evidence in support of postulate 1. They take on more meaning when juxtaposed with comparative data regarding divorced persons, as in Table 3.

While the divorced persons per 1000 population is not greatly divergent from the national average when the state is considered as a whole, Utah County's rate is about half that of the state. Thus, both the divorced persons and the separated persons rates are significantly lower in that strong Mormon county.

The situation is further clarified by combining the two rates as in Table 4, below:

Use of this combined measure gives several interesting bits of information. First, it indicates that the Utah marital dissolution rate as measured in this way is well below the national average, which is consistent with what one would expect. It is more comparable in every cell to the lower Northeast and North Central figures than to its own region.

Secondly, the Utah County rate and ratio, which more accurately reflect the Mormon influence, are strikingly lower than the Utah rate, the national rate or any of the regional rates. The higher rates of the

TABLE 3

MARRIED, DIVORCED, AND SEPARATED PERSONS AGE 14+ PER 1000 WHITE URBAN POPULATION AND MARRIED/DIVORCED, MARRIED/SEPARATED RATIOS.

	Married	Divorced	Separated	M/D	M/S
Males					
U.S. Total	649.5	28.6	11.6	22.7	56.0
Northeast	637.6	18.6	14.1	34.3	45.2
North Central	653.4	28.2	8.3	23.2	78.7
South	667.6	29.3	11.4	22.8	58.6
West	637.7	41.8	12.7	15.3	50.2
Utah	652.3	27.9	6.3	23.4	103.5
S.L. County	672.0	33.6	8.0	20.0	84.0
Weber County	674.6	31.8	6.8	21.2	99.2
Utah County	593.0	15.3	2.8	38.8	211.8
Females					
U.S. Total	586.4	43.5	16.6	13.5	35.5
Northeast	560.2	29.3	21.8	19.1	25.7
North Central	587.2	41.6	11.1	14.1	52.9
South	608.6	46.4	15.7	13.1	38.8
West	594.2	63.0	17.9	9.4	33.2
Utah	608.9	46.4	9.5	14.3	64.1
S.L. County	622.7	49.9	11.3	12.5	55.1
Weber County	640.0	44.6	10.3	14.3	62.1
Utah County	561.6	24.8	4.3	22.6	130.6

Source: Population Characteristics, Bureau of the Census, 1970, and Utah Population Characteristics.

other two counties tend to obscure the strength and direction of the Mormon influence.

A third interesting fact is that the combined ratio is far more homogeneous than the figures taken alone. It appears that the regional differences in divorce rates do not necessarily reflect real differences in the instance of marital dissolution.

Postulate 2: There should be a lower instance of pre-marital and extra-marital sex in the Mormon sub-culture than the rest of American society, measurable

TABLE 4

COMBINED DIVORCED AND SEPARATED PERSONS RATE AND RATIO

	Male		Female	
	Combined Rate	Married Div Sep	Combined Rate	Married Div Sep
U.S. Total	40.2	16.2	60.1	9.8
Northeast	32.7	19.5	51.1	11.0
North Central	36.5	17.9	52.7	11.1
South	40.8	16.4	62.1	9.8
West	54.4	11.7	80.9	7.3
Utah	34.2	19.1	52.0	11.7
S.L. County	41.5	16.2	61.2	10.2
Weber County	38.6	17.5	55.0	11.6
Utah County	18.1	32.8	29.1	19.2

Source: Population Characteristics, Bureau of the Census, 1970, and Utah Population Characteristics.

as follows:

A. Age at marriage will be lower because the pressures to become sexually active will more likely lead to marriage among Mormon youth than among others.

Table 5 gives the age specific marriage rates as a percentage of total first marriages.

TABLE 5

AGE AT FIRST MARRIAGE AS A PERCENT OF TOTAL FIRST MARRIAGES

	Under 20	20-24	25-29	30-34	35+	Median
			BRIDES			
United States	42.0	42.6	10.2	2.7	2.8	20.6
Utah	47.4	45.1	6.1	.9	.4	19.8
			GROOMS			
United States	19.3	52.9	18.7	4.9	4.3	22.6
Utah	21.9	59.9	14.8	2.4	1.2	21.9

Source: Vital Statistics, 1974, Marriage and Divorce, Table 7.

Postulate 2 is clearly supported by the age at marriage figures. The figures given are from 1974 vital statistics, but are comparable over time.

B. (Under postulate 2.) Illegitimacy rates will be lower, since illegitimate conceptions will be both less likely to occur and more likely to result in marriage before birth of the child.

Some percentage of these younger marriages will be consummated under pressure because of pregnancy. Christiansen (1960) has shown that such pressures are relatively high in Utah. Also, if the norms are at all effective among the Mormons, they should cut down on the premarital pregnancy rate. Both of these factors should attenuate illegitimacy.

Table 6 gives the illegitimacy ratios.

TABLE 6

ILLEGITIMACY RATIO PER 1000 URBAN WHITE WOMEN. DATA FROM 1970

United States	15.27
Utah	9.55
Salt Lake County	12.8
Weber County	17.30
Utah County	2.79

Source: Vital Statistics, 1974, Natality, Table 62.

Again the data supports postulate 2. Utah is among the lowest states in the union on illegitimacy rate, and Utah County has only about 1/4 the rate of the state as a whole. Again the differences are wide enough to make this evidence compelling.

C. (Under postulate 2.) Abortion rates will be lower.

Such abortion figures as are available are shown in Table 7.

TABLE 7

LEGAL ABORTIONS PER 1000 WOMEN OF REPRODUCTIVE AGE. DATA FROM 1974

United States	16.5
New England	9.7
Middle Atlantic	31.5
East North Central	11.0
West North Central	9.0
South Atlantic	16.2
East South Central	3.9
West South Central	4.6
Mountain	9.2
Pacific	28.4
Utah	0.4

Source: Weinstock (1975).

Again the data supports the postulate.

Data in all three sub-areas lend support to postulate 2. The Mormon norms effectively impose the responsibilities of marriage as a condition for sexual union. Along with the desired results of these norms, however, comes an undesired one as reflected in postulate 3.

Postulate 3: Because unstable sexual alliances among youthful Mormons will more likely be reflected as marriages and divorces than elsewhere in American society, divorce rates will be higher for Mormons in the younger age groups.

Divorce rates are generally higher in the younger age groups, but the difference should be greater among Mormons. Table 8 gives age specific divorce rates.

TABLE 8

UTAH AGE-SPECIFIC DIVORCE RATES PER 1000 BY AGE OF SPOUSE AT TIME OF DECREE AS A PERCENTAGE OF TOTAL U.S. RATES. DATA FROM 1970.

	Husband	Wife		Husband	Wife
Under 20	139	103	45-49	87	86
20-24	115	104	50-54	116	118
25-29	99	103	55-59	94	97
30-34	84	110	60-64	109	87
35-39	84	110	65+	100	108
40-44	95	87	Total	109	110

Source: Goodman and Bahr (1978).

Utah County data was not available, but the data included lend general support to postulate 3.

Postulate 4: Because of the heavy emphasis on family ties, divorce rates should be attenuated by Mormon Church influence.

To test this postulate we look at divorce rates over time in the United States, the Intermountain region, Utah, and the selected counties within Utah. Table 9 gives these figures.

Utah is consistently below the regional average, but slightly higher than the national average. Utah County, however, is consistently below any of the

TABLE 9

DIVORCES PER 1000 POPULATION

	1970	1971	1972	1973	1974
United States	3.5	3.7	4.1	4.4	4.6
Intermountain	5.9	6.2	6.6	6.9	7.1
Utah	3.7	4.0	4.4	4.6	4.8
S.L. County	4.3	4.9	5.3	5.9	6.0
Weber County	5.6	5.4	5.8	6.2	6.4
Utah County	2.8	2.8	2.8	3.1	2.4

Source: Vital Statistics, 1971-1974, Marriage and Divorce.

other divisions. Thus postulate 4 is supported. This fact has two important implications. First, that the Mormon Church influence on its members in regards to family solidarity is significant, and second, that divorce among non-Mormons in Utah must be alarmingly high in order to inflate the overall rate so seriously.

There is ample theoretical development to suggest that this is likely the case. Chancelor and Monahan (1955) have shown that in general, interfaith marriages are more likely to end in divorce than same faith marriages. Locke, Sabagh and Thomas (1967) have shown that in areas where there is a high concentration of Catholics, fewer Catholics by far marry interfaith than where Catholics constitute only a small minority. Done (1937), Kunz (1964), and Balrow (1977) have found similar results in Mormon populations.

This being the case, one would expect most Mormon marriages in Utah to be same faith marriages, while a high proportion of non-Mormon marriages should be interfaith. One would thus expect Mormon marriages in Utah to be more stable than non-Mormon marriages, all else being equal. Outside of Utah, however, where Mormons constitute a minority, one would expect the opposite, all else being equal. Data developed by Kunz, (1964) and by Goodman and Bahr (1979) tend to confirm these expectations. The Goodman and Bahr data are partially reproduced in Table 10, below.

TABLE 10

MORMON DIVORCE RATES IN UTAH
PER 1000 POPULATION, 1975.

	Men	Women
Mormon	3.4	3.6
Non-Mormon	8.9	8.3

Source: Goodman and Bahr (1978).

There is clearly a substantial difference in Utah between Mormons and non-Mormons. But the data developed by Goodman and Bahr show no significant difference between divorce rates of Mormons and those of others in the rest of the intermountain states. This lends further evidence that the Mormon divorce rate, with majority-minority status held constant, is lower for Mormons than for non-Mormons.

The Mormon Church has not made a practice of making divorce figures public, but an exception was made in 1930, when the data in Table 11 were published by the church.

TABLE 11

DIVORCES PER 1000 POPULATION

	United States	Utah	Mormons
1922	1.36	1.29	.55
1927	1.62	1.88	.68

Source: L.D.S. Church Historian's Office, *Marriage and Divorce Statistics*, Salt Lake City, Dec. 8, 1930.

These data are consistent with those of Goodman and Bahr and serve both to further substantiate expectations, and to suggest strong continuity over time. With three entirely independent data sets confirming the fact, it is evident that Mormon divorce is substantially lower than non-Mormon divorce in Utah.

Conclusions

It would appear on evidence of the available data, that among Mormons a higher proportion of sexual alliances get reflected as marriages than is the case in in American society in general. This results in a greater proportion of unstable alliances among Mormon youth being subsequently reflected as divorces. Marital separation and premarital illegitimacy, abortion and informal sexual alliance as alternatives to divorce are effectively discouraged.

In spite of these pressures which tend to inflate the divorce rate among Mormons, the Mormon divorce rate appears to be substantially lower than either the intermountain or the total United States rates, all else being equal. This suggests that there are powerful forces at work among Mormons which tend toward family stability and marital durability. The influence of these forces is obscured, however, when only divorce rates are considered.

REFERENCES

Barlow, Brent A. Notes on Mormon interfaith marriages. Family Coordinator, April 1977; 143-150.

Carter, Hugh and Glick, *Marriage and Divorce* Published, 1970.

Cavanaugh, John B. Divorce and the church. In Fishbein and Fishbein, *Successful Marriage*, Published, 1971.

Chancellor, Loren F. and Monahan, Thomas P. Preferences and mixtures in marriages and divorces. *The American Journal of Sociology*, Nov. 1955: 232-240.

Christensen, H. T. Cultural relativism and premarital sex norms. *American Sociological Review*, Vol. 25, Feb. 1960: 31-39.

continued on page 36

THE EFFECTS OF PSYCHOTHERAPY: A PROFESSIONAL UPDATE

Michael J. Lambert, Ph.D.*

Presented at the AMCAP convention
October 3, 1980

The following review attempts to summarize research on the effects of psychotherapy and its implications for the practice of psychotherapy. This review deals mainly with research on adult non-psychotic outpatients. It is based on the assumption that controlled investigations will lead to replicable, trustworthy, and significant findings. It is also assumed that it will result in findings that are specific--in the sense of identifying the actual causal components in psychotherapy. The end result will be to place the practice of psychotherapy on a scientifically substantiated body of knowledge.

In such a review, I recognize that few therapist's practice is based upon research, and further that the interpretation of research evidence is influenced by defensive processes on those rare occasions when therapists do read research reports. For example, a recent well-controlled study indicated that therapists are much more critical of methodology in studies that contradict the therapy system with which they are identified.

I also recall Carl Rogers' comments about the apprehensiveness with which he undertook extensive evaluations of client centered therapy. What if his cherished beliefs and deep committments were not supported by the results of careful investigation? It is unusual to be open and to conclude as Rogers did: "The facts are always friendly."

Recognizing that therapists may feel somewhat threatened by information that comes from a base other than their own experience, I realize that presenting a list of conclusions is not the most effective way to proceed. Given the time available and the scope of this presentation, however, little more than a list of conclusions can be offered. The interested participant may wish to consult two resources that provide clearer documentation of these conclusions (Bergin and Lambert, 1978; Lambert, 1979; Lambert, in press). The following conclusions were based upon these extensive reviews of psychotherapy outcome literature.

Let me proceed now with a list of conclusions that have implications for the practice of psychotherapy.

General Conclusions

1. Psychotherapy works, is effective, causes positive personality change.
2. It is not the result of "placebo effects" -- although some "placebo" and genuine treatments generate "hope" and other emotions that increase successful coping and symptomatic improvement.
3. It is not due to "spontaneous remission." The effects of therapy clearly surpass no treatment or spontaneous remission baselines. The "unsystematic" curative factors within society and the individual do not result in as rapid improvements as psychotherapy.
4. Deterioration. Despite controversy, it is clear that a portion of patients are made worse by the therapists who intend to help them.
   a) Most recent evidence comes from video self-confrontation techniques.
   b) Several reports now suggest these negative effects occur in *sex therapies* with *conservative* couples.
5. The demonstrated effectiveness of those therapies which have proved successful has led to attempts to specify the causal components of treatment. The search for causality can be catagorized into three main headings:
   a) Those variables related to the client (e.g., symptom severity).
   b) Those related to the therapist (e.g., empathic attitude).
   c) Those that are related to the treatment method or technique.

   In general, outcome can best be predicted from patient variables, next by therapist attitudes of the client centered variety, and finally by technique variables. This conclusion is illustrated in Figures 1 and 2.

An important speculation related to these figures is the idea that therapist attitude/relationship variables are *least* strongly related to outcome in the most and least disturbed patients.

Prescriptive Psychotherapy

Although technique variables are not nearly as powerful as we would hope, the rest of this presentation focuses on techniques and upon the idea of prescriptive therapy interventions. There are several empirical strategies for investigating prescription. For example, patients can be assigned to treatments on the basis of compatible and incompatible personality traits, sex, racial background, and the like. Research on these

***Brother Lambert is an Associate Professor of Psychology at Brigham Young University.**

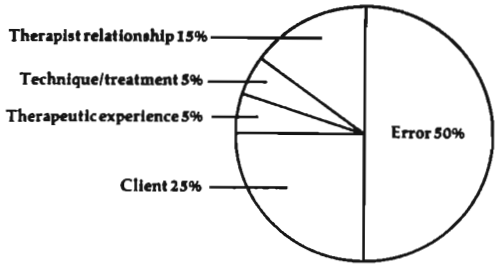

Figure 1. The relative contribution of client, therapist and technique variables to psychotherapy outcome.

Client: Included here would be such variables as age, sex, socio-economic level, IQ, marital status, diagnosis, motivation, ego strength, interaction with enviromental factors, therapy readiness, degree of disturbance, duration of symptoms prior to seeking treatment. Some of these are overlapping variables, but each considered separately interacts with treatment variables to produce outcome.

Therapist relationship variables: Include therapist offered conditions such as empathy, genuineness, warmth and respect.

Therapist experience: May include unspecified variables including perhaps poise, confidence, good judgment, accurate expectations, personal maturity and even relationship skills.

Technique and treatment variables: Include specified procedures which are clearly delineated and distinguishable from other procedures. Included would be diverse methods such as assertive training, EMG feedback, gestalt therapy, cognitive behavior therapy. In general it represents the conclusions drawn from comparative studies.

Error term: Represents unaccounted components of outcome such as measurement error (e.g. Since most outcome measures have reliabilities which do not exceed .80, 35% error could be due to this level of reliability).

strategies does not support this practice at this time.

It is more common to assign patients with certain problems to therapists offering a specific treatment technique. Overall, this practice is not supported by research. There are, however, some notable exceptions. Since the possibility of prescriptive assignment seems to be one of the goals of controlled research let us focus on research conclusions in those exceptional cases where prescription seems possible.

Conclusion 1. *Current research continues to support the exposure hypothesis: Systematic exposure to fear producing stimuli reduces or eliminates fears in genuine phobic patients.* Substantial evidence indicates that phobias are significantly reduced by exposure techniques such as systematic desensitization, behavioral rehearsal modeling, and flooding. When contrasted with relationship therapy, insight oriented psychotherapy, etc., systematic exposure procedures are clearly more effective.

Even greater prescription is possible when we consider that exposure *in vivo* is more effective than exposure in fantasy. The success of these prescriptive treatments is dependent on patients who are willing to carry out the exposure procedures and a therapist who can properly influence motivation and cooperation.

Recent Examples. Emmelkamp, Kuipers, and Eggeraat

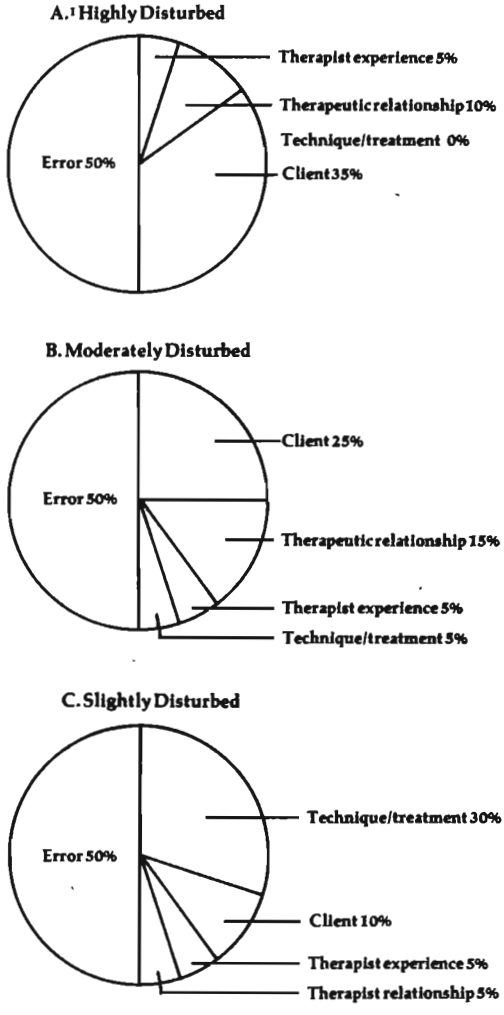

Figure 2. The hypothetical contribution of client, therapist, and technique variables to psychotherapy outcome in patient populations that differ in degree of psychological disturbance.

[1] *A* ignores the effects of drugs on psychotic disorders.

(1978) compared cognitive restructuring and prolonged exposure *in vivo* in a cross-over design with twenty-one agoraphobics. Assessments were made at the beginning of treatment, at cross-over, at the end of treatment, and at the follow-up one month later. Cognitive restructuring consisted of relabeling, elimination of irrational beliefs, and self-instructional training. Prolonged exposure *in vivo* resulted in significant improvements on most variables. There was not one variable on which cognitive restructuring resulted in more improvement than *in vivo* exposure. Some improvement, however, did result from the cognitive approach. The success obtained through cognitive restructuring seemed to depend upon the imaging ability of the patient. The better the patient's ability to imagine the situation, the more easily he could overcome it. The authors suggest that the relatively poor results for cognitive therapy compared to past research was caused by its application to a patient population that is more disturbed than the college student groups upon which past research was based.

Limitations. a) Exposure treatments are less effective with more complex phobias; b) Some patients who improve on target fears, generalize these improvements to other fears; c) Some patients improve without systematic exposure; and d) Some patients who are continuously exposed to phobic objects fail to improve.

Conclusion 2. *Current research continues to support the use of some exposure techniques with performance anxiety problems such as test anxiety, speech anxiety, and sexual dysfunctions.* Substantial evidence suggests that behavioral rehearsal, systematic desensitization, and cognitive restructuring methods are much more effective at reducing performance anxiety than insight and relationship oriented methods.

Recent Examples. (a) Goldfried, Linehan, and Smith, (1978) compared two procedures for reducing test anxiety with a waiting list control. The first was systematic rational restructuring where the subjects were asked to imagine test-taking situations and then realistically re-evaluate them. The second was a prolonged exposure condition where the same items were given without the instruction to cope cognitively. Questionnaire measures of anxiety indicated that greater anxiety reduction was found in the systematic rational restructuring condition, followed by the prolonged exposure group. The waiting list control showed no changes. The subjects in the rational restructuring condition reported a decrease in subjective anxiety when placed in an analogue test-taking situation as well as in social evaluative situations. This result adds to the increasing belief that the cognitive reappraisal of anxiety-provoking situations can offer a markedly effective treatment procedure for the reduction of anxiety.

(b) Riley and Riley (1978) presented the results of a controlled study that compared the effects of "directed masturbation" in combination with sensate focus and supportive psychotherapy versus sensate focus and supportive therapy in the management of female primary orgasmic failure. Fifteen married patients participated in the sensate focus/supportive psychotherapy treatment, while 20 married patients participated in this combined treatment plus the directed masturbation. After treatment, both partners were questioned about success or failure of the treatment because it was considered that this would give a more reliable assessment of outcome. Eighty-five percent of the patients who experienced the directed masturbation program, and 47 percent of the combined treatment group, became coitally orgasmic on at least 75 percent of coital occasions. The results suggest directed masturbation is an effective and necessary component in the management of *primary* female orgasmic failure. This result could be contrasted with *secondary* female dysfunction where communication between partners is more important to attend to in treatment.

Limitations. The above conclusions, while based upon a large, diverse body of research, have several important limitations.

a) The studies so far conducted have been directed toward test anxiety, speech anxiety, heterosexual/social anxiety and sexual dysfunctions. The subjects studied have not in general been "patients." Thus, the generalization of results to persons who are socially/vocationally incapacitated is not well substantiated.

b) The results with sexual dysfunctions seem to hold up for persons with *liberal sexual attitudes* who have a relatively conflict-free marriage, and who are free from more complex psychological conflicts. The early success rates reported by Masters and Johnson seem to be highly inflated by the sample studied, and the rather unclear criteria for "success."

c) The criteria for success in other performance anxiety problems provide results that are impressive on a self-report basis but unimpressive when actual performance on tests (GPA, actual speeches and similar, more rigorous criteria) is considered.

Conclusion 3. *The treatment of physical disorders that interact with psychological problems (Raynauds Disease, migraine and tension headaches, asthma, etc.) are more effectively treated with therapies that "engage the body" rather than insight, verbal methods.* Evidence indicates that systematic desensitization, systematic relaxation training to a lesser degree, hypnosis, and autogenic training, are useful methods of dealing with many psychosomatic disorders.

Recent example. Hock, Rodgers, Reddi, and Kennard (1978) evaluated the effectiveness of relaxation

training, assertive training, and combined relaxation plus assertive training in increasing respiratory function and decreasing the number of recurrent asthmatic attacks. The study was carried out in an allergy outpatient clinic and the subjects were ten 17-year-old male asthmatic patients. The psychotherapeutic treatment was combined with medical treatment. A 5x4 analysis of variance was used to analyze the forced expiratory volume (FEV) data, and a significant difference was found between the groups. A Newman-Keuls statistical comparison led to the conclusion that both relaxation training by itself and combined relaxation plus assertive training increased respiratory functioning and reduced the number of attacks. Assertive training alone failed to improve respiratory function and had a tendency to increase the frequency of asthmatic attacks.

Limitations. Several variables make the seemingly specific nature of treatment for these disorders difficult to rely upon.

a) The seemingly clear-cut relationship between biofeedback, hand temperature increases and improvement in Raynauds Disease and migraine headache appear less certain. Although it seemed that relaxation for tension headache and hand warming for migraine was a prescriptive difference, this is confounded by the fact that many patients improve without control over hand temperature.

b) A portion of patients who show clear control fail to improve.

c) Lasting improvements seem to be related to continued use of relaxation over long periods of time, thus the idea that biofeedback causes a permanent change is not true for a large number of those who are treated.

d) Placebo and expectancy effects cannot be ruled out as important contributions to positive outcome. Their effects are in need of further exploration.

Conclusion 4. *Cognitive psychotherapies which are rapidly replacing dynamic strategies may be uniquely effective with unipolar depression.* Recent investigations tend to support the use of cognitive and cognitive/behavioral strategies with some depressed patients. In some instances, their unique effects not only surpass traditional dynamic therapies, but antidepressant medications. These therapy strategies tend to be time limited and highly structured and are best represented in the work of Beck and his associates.

Rush, Beck, Kovacs, and Hollon (1977) recently reported a study investigating the effects of cognitive therapy on the symptomatic relief of depressive symptoms on a group of 41 outpatients.

The clients were carefully selected to include a homogeneous symptom pattern typical of neurotic depression. They were screened with the Beck Depression Inventory, Hamilton Rating Scale for Depression, and a clinical judgment consistent with unipolar depressive syndrome. Patients who had a history of schizophrenia, drug dependence, character disorder, and the like were excluded as well as patients who had a medical history that suggested prior prescription of antidepressant medication or a prior history of a poor response to tricyclic antidepressants.

Patients were assigned to cognitive therapy (N = 19) or anti-depressant treatment (N = 22) on a random basis prior to inclusion in the study. Therapists were, for the most part, inexperienced in psychotherapy but experienced in the use of drugs with depression. The majority were psychiatric residents. Treatment via cognitive therapy followed the training manual developed by Beck and lasted for a maximum of twenty 50-minute sessions over 18 weeks, but averaged 15 sessions for 11 weeks. Drug treatment averaged 11 weeks in duration with one 20-minute session per week.

Results suggest that both procedures reduce the symptoms of depression; but that the patient's self-report, as measured by the Beck Depression Inventory and clinician's judgment of improvement, as rated by the Hamilton and Raskin scales, showed the cognitive therapy patients to be improved significantly more than drug patients at termination and at three-month follow-up. This trend held up at the six-month follow-up, but was not statistically significant. In addition, there was a tendency for drug patients to drop out of therapy early. When these dropouts are included in the analysis, cognitive therapy was superior to drug treatment at six months. In addition, 13 of 19 pharmacotherapy patients re-entered treatment for depression, while only 3 of 19 psychotherapy patients sought additional treatment.

Limitations.

1) Cognitive and behavioral approaches are relatively recent and have not been fully studied as prescriptive treatments in depression. As with most "new" treatments, original successes may be followed by a gradual loss in enthusiasm and eventual disappointment.

2) The effects attained may be limited to "least disturbed" unipolar depression patients.

3) Their prescriptive, almost "programmed" approach with depression needs to be replicated by others. In fact, this is currently taking place in a world-wide study.

REFERENCES

Bergin A. E., and Lambert, M. J., The evaluation of therapeutic outcomes. In S. L. Garfield and A. E. Bergin eds. *The Handbook of Psychotherapy and Behavior Change*, New York: Wiley, 2nd Ed., 1978.

EmmelKamp, P. M. G., Kuipers, C. M., & Eggeraat, J. B., Cognitive modification versus prolonged exposure in vivo: A comparison with agoraphobics as subjects. *Behavior Research and Therapy*, 1978, *16*, 33-41.

continued on page 36

HOW CAN ECCLESIASTICAL LEADERS, LDS SOCIAL SERVICES PRACTITIONERS, AND COMMUNITY PROFESSIONALS COORDINATE EFFORTS TO ASSIST CHURCH MEMBERS?

A panel discussion*
Presented at the AMCAP convention
October 3, 1980

Introduction - Val MacMurray

Recently my wife and I returned to the Salt Lake area after a ten year period, having spent approximately five years in Boston and five years in Canada. Last year was the first time I had attended an AMCAP meeting for the past ten years, and I must say that I was impressed with the growth of the organization and its influence in the profession.

Fifteen years ago I sat in a BYU leadership conference as Aspen Grove and I recall Elder Marion D. Hanks telling a couple of short stories that I think have some relevance for us today. Elder Hanks said he once heard of an encounter between a little boy and Billy Sunday, the Billy Graham of another generation. Billy Sunday had arrived in the town to evangelize and, being widely known in his time, assumed that all would recognize him. He was a little bit disappointed when he went outside and said to the little boy selling papers there, "What's the way to the post office?"

"Well, sir, you go two blocks that way, and then you go two blocks that way."

"Oh," said Billy Sunday, "thank you. Do you know who I am?"

"No, sir."

"I'm Billy Sunday."

"Oh."

"Well, don't you know who Billy Sunday is?"

"No, sir."

"I'm an evangelist."

"Oh."

"Don't you know what an evangelist is?"

"No, sir."

"Well," he said, "I tell people how to get to heaven. Tonight I'm holding a tent meeting right down town here and I'd sure like you to come. I want you to be my special guest. Will you come?"

"No, sir. You don't even know the way to the post office."

And then he told another story very similar about an encounter which ended a little more quickly--this time between a traveler and a boy who, when asked how to get into town, said, "I don't know."

"Well," he said, "there's a highway here. Would you help me find it on the map?"

"No, sir, I don't know where you are."

Two or three questions were asked until the man finally said in disgust, "You don't know very much, do you?"

"No, sir, but I ain't lost."

It's my hope today that our panel presentation, in a preliminary way, may be useful in suggesting a direction we might pursue to orchestrate available resources for the benefit of those who seek assistance.

The topic that we're going to address today is:

How ecclesiastical leaders, LDS Social Services practitioners, and community professionals can coordinate efforts to assist Church members.

The purpose of the panel today is two-fold. *First*, to discuss current challenges involved in providing mental health services to Church members, and *second*, to propose methods that would enable more effective coordination of services provided by ecclesiastical leaders, those in LDS Social Services and professionals working in the community.

We have selected individuals to address the issues who represent a variety of areas. We're going to hear first from Marjorie Gibbons. Marge is currently a stake Relief Society President in the S.L. area. We will then hear from Corydon Hammond. Cory is Co-Director of the Sex and Marital Therapy Clinic in the College of Medicine at the University of Utah. We will then hear from Ken Matheson. Ken has been Director of the LDS Social Services agency in Southern California and has recently been appointed as Director of the Provo agency, located in the Comprehensive Clinic at Brigham Young University.

Following Ken, we will hear from Brian Swinton, who is currently stake president in the Salt Lake University Second Stake. We will then hear from Rich Cannon, who is Bishop of the Salt Lake University Sixth Ward and finally from Sharon Staples, who is Chairperson in the Department of Human Services at Utah Technical College in Orem.

What we will do is give each panelist ten minutes to make a brief presentation. I have asked each of them

***Moderator, Brother Val D. MacMurray, Ph.D., is the Assistant Manager, Special Services, LDS Social Services.**

to address a particular issue related to their own work.

Marjorie Gibbons

My first experience with LDS Social Services was when I was living in Oklahoma. I was a ward Relief Society President there, and not having lived in Utah for about ten or twelve years because of my husband's work and school and military, I wasn't really very familiar with the agency. We had adopted children, but we were out of the state at the time. I knew that there was this great group called LDS Social Services, but my first experience was really a learning one that I appreciated. We had a girl in our ward who was going to have a baby out of wedlock. She came from a poor home, poor circumstances. It was decided that she would give the baby up for adoption. I counseled with the bishop at that time to see how he wanted us to handle it, and we did get in touch with Social Services here in Salt Lake. One of the social workers flew out to Oklahoma at the time the baby was born, brought a suitcase full of clothes for the child, and was to take the baby back.

The girl signed over the papers and everything went fine until the airline lost the suitcase full of baby clothes. That was the first crisis I ever encountered with Social Services. We were able to have some donations made and the social worker did return to Salt Lake with the baby and a new layette, other than the one she brought.

But I gained an appreciation there for these people, you people, who are able to come in at a time of crisis like that and not only help the person who is having the crisis, but help those of us who hadn't had that experience before and give support and love at a traumatic time like that.

The second opportunity that I had as a ward Relief Society President was with a young girl who was just 14, who came from a family of six children. The mother was not well emotionally and as a result she took out her frustration on the 14-year-old girl, who was not well at that time. As we entered in to see how we could help, we tried to give support to the girl in the ward, because she didn't really know she had friends at home. She was just too mixed up at this point to even realize that we wanted to be her friends and she sought other companions, started sluffing, using pot and this type of thing. So we felt like we needed more help than we could give her in the ward and we did call in LDS Social Services. The bishop made the referral. This girl is doing much better now because of the counseling and help she's receiving. The mother was the sick one to begin with, but the mother does not yet recognize it, and no matter what we do to give support, the mother refuses to believe that she has any problems, so things are not as effective even with the girl receiving the counseling as they could be if the mother would recognize that she needs help too. She refuses to go to appointments with the counselor, but the girl is still going and is making some progress.

Another experience that I had was a very great learning experience also. There was a sister within our ward who had been a missionary and had been married in the temple. She came from a family of ten children. Apparently, because there was such a large family, she was afraid as a child that she wasn't going to get enough to eat and this manifested itself in that when she was a young mother, she would always feed herself first before she fed the children. It was very obvious that the children were suffering from poor nutrition. There were quite a few neighbors in the neighborhood who complained about this sister because, as a routine, she would get up in the morning, put her babies in the stroller and go visiting. As I talked to her and as I talked to the bishop and sought his counsel on what we could do, it became very obvious that she needed a lot of help. But where to start?

I made an appointment with her, went to her home and "just visited." Eventually we opened up to each other about how we were doing as homemakers. She realized that she wasn't doing very well. Her personal appearance was unkempt and the home was not being cared for. Then I asked her if we couldn't just talk some of these things over together. So we evaluated together that day in her living room what she felt she needed to do to improve, and she wrote down some goals. Before I left we had prayer togehter, and I felt like maybe we were on our way. But because of her insecurities, she didn't make very much progress. So after she and her husband had been interviewed by the bishop, he called in a case worker from LDS Social Services.

I took her to her first appointment. I talked to the social worker after. They didn't gain much ground, but he felt that she was beginning to open up.

As I talked with the counselor several more times following her appointments, they reached a stand-still, and she wouldn't go any more. I was brought into it again because of the grandmother in the case, also in our ward. She became really frightened by the children not being cared for. They weren't receiving the attention or the help in any way that she felt they needed. They were not even being kept clean.

At this point we had to call in some community resources: The Women, Infants, Children Program sponsored through the Salt Lake City/County Health Department. We were able to get an appointment for her and she went. I tried to give her some counsel in nutritional snacks and how to prepare more nutritious meals. We tried to use the facilities we had within the ward, but she didn't want to learn that much. She just wasn't conditioned. It was threatening to her and she didn't want to learn. Through the WIC

Program, they were able to share some of these things as they gave her the commodities; they did try to teach her. She did do all right for a while.

I have a suggestion to interject: We have our commodities that we are able to get through our bishop's storehouse and the Welfare Program. On the Deseret Brand label food that we get for these people that get the welfare food orders, there is nothing but the Deseret Brand label. Could we have recipes and nutritional information on the labels? So many of our senior citizens who are receiving the Deseret Brand don't know what to do with it when they get it. We have a lot of people who don't really know how to prepare these things. This is something that I think we could do to help.

Back to our young sister--she was seen at the WIC program and was helped some, but now another report. She has decided that she doesn't need anybody to help. I guess she got to the point where she felt too threatened by everybody. She's moving out of state, and it's with sadness in my heart that I see this happen because it's a special little family that needs this help.

Some of the other community resources that were used at this time were Crippled Children's Service. I felt inadequate as a ward Relief Society President, in that I felt like I needed to gain from the experience and education of others that were concerned with this family. Anything that we can do to correlate, whether it be a phone call or meeting in person, I think would really be desirable.

As the Church seems to be narrowing in more and more on the individual needs of the members of the Church, there is a specific area that has become of great concern to me, because I'm a mother of a boy who uses pot. There are other problems involved and I felt so inadequate when I found this out that I didn't know where to go for help besides to my Heavenly Father. I think this is something that we need to get help from you people on. The Rape Alert program that came through Church security went to thousands of women and really had an effect and made an impression in their lives, of what they could do. I think if we could do something like this and be helped by you as Social Services workers. As parents we thought that with the gospel nothing like this could come into our homes, but it has. And it's growing larger and larger and as a parent and a Stake Relief Society President, I feel that we need to educate our stake and ward leaders concerning deviant behavior, what to look for, what we can do in a supportive role.

Cory Hammond

I'm speaking from the perspective of a clinician working in several capacities. One is seeing people occasionally referred by bishops to me in private practice for counseling--private practice as a psychologist and a marriage counselor. Also seeing people over a nine-year period, who were referred to the alcohol and drug abuse clinic at the University Medical Center, where I still spend a portion of my time. And then in the last three and a half years, seeing people coming to the Sex and Marital Therapy Clinic at the Medical School.

Perhaps I could talk a little about Social Services and something that I think many clinicians may have felt over a period of time. Particularly in the past, I have felt very strongly a vagueness about what LDS Church Social Services does. To me, there has often seemed to be a lack of communication with clinicians in the community about what the programs are and what services are available in social services. Therefore, I found myself and many colleagues often wondering about this and how we could coordinate things between us, and what we were doing that duplicated efforts. There was an impression among some of us several years ago that it seemed as though Church Social Services was moving in the direction of becoming a massive mental health clinic. More recently it has seemed to me, from the outside, as though they're moving more in a direction of becoming a referral resource. This is something that I feel can be a very valuable role of Church Social Services with regard to specialty areas.

As I've tried to think about what my ideal concept would be of the Church Social Services system, another aspect is that of prevention. One of the specialty areas that I've had contact with is alcoholism. Recently my stake president had the foresight to call together an advisory committee in our stake, because he believed that there was a serious alcohol and drug problem among many of the youth. He got input from this committee and eventually formed several sub-committees. The one that I was asked to chair has been preparing lessons to be presented to the bishoprics, the young men's priesthood leaders, and the young women's counterparts, over an eight-week period, training them in human relation skills and educating them about alcohol and drug issues. Other committees in the stake are evolving special family home evening lessons and lessons for parents of teenagers. I was a little overwhelmed by the magnitude of the undertaking as we've become involved in this and I know that at one point, as I started preparing for this panel, I thought how valuable it could be to have the Church Social Services involved in a lot more preventative work like this. They could be valuable consultants for training Church leaders in human relations and counseling skills, parenting skills, etc.

Going back to the concept of referrals, another specialty area where this seems appropriate is in the area of couples having sexual difficulties in their marriages. This is a specialization area in which most marriage and family counselors and psychologists

have not received training and supervision, and yet studies suggest that probably one of every two couples struggles with sexual problems. And I think that there are other specialty areas where we need community resources and where referral can be a very appropriate function of LDS Social Services.

One of the things that has been very encouraging to me as a clinician in the community in the last couple of years is the fact that Social Services personnel have seemed to be more and more open to learning. We've had them come to the Alcohol and Drug Abuse Clinic at the University and to the Summer School on Alcoholism and Other Drug Dependencies to become more knowledgeable. I understand they've developed program materials of their own around alcoholism. The only unfortunate thing, I think, is that there hasn't been more communication with some of us who've been out in the community so that we can coordinate efforts with them.

Another thing that's been very encouraging to me about the openness of the agency has been that in the past year, several workers in Church Social Services have taken a Division of Continuing Education class at the University on Human Sexuality. They felt that they needed to become more sensitized to these issues, recognizing that many of the couples they saw had problems in this area and they were uneasy about talking openly with them, and about where they could refer them. Recently they have even come to the Sex and Marital Therapy Clinic and suggested the possibility of having us conduct a workshop for LDS Social Services counselors to help them feel more at ease in dealing with problems when they are brought up in therapy. So I think these are some encouraging sorts of things that I've seen.

Now speaking to the ecclesiastical people on our panel, there have been a few times that I am aware of as as a practitioner when a bishop, an ecclesiastical leader, has referred someone to me without talking with me about what their expectations were regarding feedback. Because of that, I have been trying to remember to ask them at the time of the referral if they want further contact with me, if I should have the couple or the individual sign a release of information form so I can provide some information to them, or what their needs are in that regard. I wonder if something more might be said about how to make referrals. I know that one of the lessons that we've been preparing in our stake on alcohol and drug issues contains a list of referral sources here in the Salt Lake City area for alcohol and drug problems and some suggestions about how to make referalls. And that's appropriate to a professional agency.

These are some of the rambling thoughts and concerns and things that I've experienced out in the community from sort of another perspective.

Ken Matheson

At the outset I would like to clarify two points: First, my comments are based mainly on my experiences in Southern California. I know that in other locations experiences would be different because of circumstances. Second, I do not speak for LDS Social Services. Just because I say something here today doesn't mean that that's the way it's going to be within the system.

I would also like to state some assumptions that I believe are false in regard to social services. Elaboration of these assumptions will not be made in this presentation; however, implications of each are interwoven in my comments. 1) LDS Social Services is the only agency where counselors utilize gospel principles. I think this organization knows that, but there are other persons who don't. 2) Within LDS Social Services are the best LDS practitioners. Even though they are well-qualified, there are also well-qualified LDS practitioners outside Church employment. 3) LDS Social Services agencies are equipped to handle every case referred to them.

Now to the main part of the presentation. The three areas that Val wanted me to cover are: 1) the working relationship with ecclesiastical leaders--the positive and the negative aspects associated with that; 2) the utilization of the professionals in the community, both members and non-members; and 3) my ideal model as to how LDS Social Services can be used and should be used.

The first critical issue that we as LDS Social Services workers need to assess is that of the confidence, trust and respect of the priesthood leaders with whom we work. We say many times within the system that our client is not the member in need, but rather the priesthood. Respect is something that is earned. It's not just given because we "represent" the Church as an organization. That respect will be developed on an individual basis. We develop that respect by responding to requests, being professional in our dealings with them, showing them we have something to contribute (either in interviews or over the telephone), and attending meetings where we can become more visible. If the priesthood or other individuals have a complaint, we as social service practitioners ought to use all the clinical and problem-solving skills we have available to listen to that complaint and not project blame, thinking that if there is a difference, the other person is wrong. When a crisis arises, we usually deal with the crisis, we don't problem solve.

Sometimes the problem is that there is a gap betwen what the expectations are of those who don't know us and the service we deliver. We need to do a better job of orienting the priesthood leaders.

The second area is the utilization of professionals in the community. We need them, especially in

Southern California. There are not many qualified LDS psychiatrists, psychologists, social workers, or marriage counselors. As a result, we have had to refer to some non-LDS professionals. I don't think that that's ideal, but it is better than having no referral service, especially when the catchment area of an office is large. And so the identifying of both LDS and non-LDS professionals is very important.

There are some tremendous programs outside the system that the Church will probably not get involved with; such as group homes, inpatient homes for alcoholism, retirement homes and those types of programs. We therefore need to identify competent community programs and utilize them. I don't think we ought to use them blindly either. Social Service workers need to block off time to go out and make on-site visits. I never refer a person to someone with whom I haven't first talked or to a facility I haven't seen. I want to see the facility and talk to them. In the case of a private clinician, I usually try to have them come to the office and meet the other staff members who will also be making referrals.

Now, as far as the model goes that I've been contemplating to assist Church members. I hope that sometime in the near future Social Services will be given the sanction to become more preventive oriented than we are now. Right now we've the ambulance at the bottom of the cliff, and I hope that we can be given the license to become more preventive oriented and be the rail at the top. In the older edition of the welfare manual, there is a sentence that states the main aim of welfare is prevention. Right now when we get members referred to us it's usually too late, and that's sad. Somehow we need to help priesthood officers identify problems at an earlier stage and help them become more preventive oriented also.

As was stated this morning by Harold Brown, Commissioner of LDS Social Services, in referring to a recent talk given by Elder L. Tom Perry, he indicated that LDS Social Services practitioners needed to become more the coaches. I think that's a role that we're going to see more and more of in the future. Social Service practitioners tend to get so overwhelmed with the work that we are not as current on certain issues and research as we should be. We need to reach out a little bit more and get ourselves involved in some stimulating kinds of programs. This can be accomplished by training our staff more, and Val has begun some tremendous thinking in this area where our staff can become better trained.

The main reason for establishing LDS Social Services agencies has been for the licensed work. I believe it's time that we raised the banner in the clinical area, not at the expense of licensed work--we need that--but it's time that we gave more emphasis to the clinical area. If you will read the November, 1974, Ensign, you will note that Bishop Brown surveyed wards in the Church and discovered that the main concern that priesthood leaders had were couples having marital problems. The same conclusions were reached from a survey that was conducted in 1978 in Southern California, namely that the main concern of the priesthood leaders was couples with marital problems. We need now to address that area with more vigor. The majority of calls we get, besides Lamanite students having problems (and those problems that are always going to be perennial), are dealing with the clinical area. In the broad sense, clinical problems are the main concern priesthood leaders have, and I think that that's the area that Social Services should focus on--again, not at the expense of the licensed area.

To better accomplish this, it will be necessary to orient priesthood leaders in larger numbers. However, we can only orient or train priesthood leaders at their request. We're not to go out and ask them.

One last comment. LDS Social Services can be the main resource system for the Church in social-emotional problems. It's our responsibility to identify resources that are appropriate so that when priesthood leaders call us we can either evaluate or consult with them about the case, and where necessary as part of the treatment team concept, refer them to facilities that they can use.

I would like to see LDS Social Services viewed, then, not just as the place to go that has all the answers, or as the first call that should be made, but as part of the treatment team, having certain skills and expertise that can be offered in the licensed area or in the clinical area. And when the situation calls for services not offered by us, we will be ready with a list of qualified and proven resources to which to refer priesthood leaders with their member cases.

Brian Swinton

To many ecclesiastical leaders, the first time they're sitting across the desk or next to someone who is expressing the feelings of depression or saying in essence, "I'm useless and unless I find a solution, I'm going to take my life," it comes as a shock. Likewise, a case of self-abuse or hospitalization as a result of an overdose. These are the kinds of things that since 1973, from time to time, I have been involved in, as most of my ecclesiastical work is done with singles. And so I have a certain bias toward LDS Social Services personnel and other practitioners. I have seen, on a weekly basis, as an ecclesiastical leader, practitioners in both the private sector and the Church sector who have been used to dealing with different problems like these.

There are some aspects of Social Services that I'm not too familiar with, such as the adoption areas, and

the clinical areas. As I contemplated saying a few things, I thought it may be important to capsulize what I saw from a priesthood leader's eyes as the main issues.

First, any ecclesiastical leader, with the exception of those few who have been through some educational training, is a neophyte in the area of doing some of the counseling that needs to be done. And he recognizes that fact about the first time he has an emergency. I think we have learned over time to use basic, true Church principles, but we also recognize that at some point we need professional help. And so the frustration for most ecclesiastical leaders is, as I see it, initially in three areas: First: What am I going to do with this person sitting by me or in front of me? That question is often answered in terms of who I know. I've asked, in preparation for this talk, some of my bishops and others and found that most of them do not have the resources to even know where to turn. They answer by calling upon LDS Social Services and when asked, "Do you know anyone other than LDS Social Services?" the answer is often, "No." So Church Social Services is presently getting burdened with most of our problems.

Second, most ecclesiastical leaders don't even have an understanding of the capabilities of any practitioner, whether they are in Church Social Services or out in the community. When we hire an accountant, a lawyer, or any other specialist from a business standpoint, we know that person's credentials; we know something about them; we know them from reputation. However, in an ecclesiastical sense, we have a person with a problem but we don't know enough about the practitioners to make a comfortable judgement. That, for most leaders including myself, is a real frustration. I know the names of a few people--but I don't have any idea or understanding of their training, their specialties, their background, and their emphasis. The question we're asking as ecclesiastical leaders, whether you've got a drug problem, a homosexual problem, a depression problem, a suicide problem, or any other problem, falls in that great composite we call "social problems." And we end up calling the only person we know, generally a person in Church Social Services. And when we call, we expect that the answers will be forthcoming.

Third, is the area of cost. One of the questions that each bishop has to ask is, "what's the capacity of the person to pay. And if I call a private practitioner, how do I use my fast offerings, if at all?" And so the normal reaction, again, is to call Church Social Services with the notion that they can solve any problem.

In summary, the ecclesiastical leader really wants to have more understanding of the program, more information about the practitioners or where, specifically, to go for answers. We really need help in serving our parishoners. From this group in particular, which is made up of both practitioners inside and outside LDS Social Services, we also need help in educating ecclesiastical leaders in some of the following areas.

We need to know some basics about the method of solving a particular problem, the method that you're going to take as a practitioner. We need to know something about the content of the method so we have a sense of what will take place. We also need to know the time table involved, the follow-up procedures, and the reasonable expectations for change and improvement.

Time and time again we see a person with a problem, we call an "expert," and we see the person back in our office three weeks later saying, "They didn't do anything for me." We often may have unrealistic expectations of what those practitioners in the private sector and in the Church Social Services can really do. What we need is some additional information. Simply stated, "What can be done, how will it be done, and what should we be doing from an ecclestiastical standpoint to assist?"

I would make the following recommendations to this group or any group of LDS practitioners on any level who would listen:

First, I believe that ecclesiastical leaders need to be trained. We have started to do that here in University Second Stake by bringing in individuals and calling together high councilors and bishoprics and having training sessions. The purpose of these sessions is to train those of us who are neophytes in some basic kinds of understanding of what's happening and why. I think that's helpful. At least it gives us a feel for how well we are doing and how far we can go, and at what point we have to break off and go for expert help. These training sessions should be used wherever the Church exists.

Generally, private practitioners feel uncomfortable about going to ecclesiastical leaders and saying as they hold out their card, "I'm in the business." In fact, we understand that most practitioners feel this would be unethical. I just want you to know that as an ecclesiastical leader, we need to know who you are, what you are, where your specialties are, what your credentials are, and how you approach the problems. Some way or another, this information has to get to ecclesiastical leaders. We can't always sit back and wait until an ecclesiastical leader, in a moment of emergency, remembers that he knew someone in the ward that he used to be in who had something to do with social problems or counseling. But I'm afraid that's what we're doing very often.

Secondly, I think that we need to, and Ken has already pointed this out, deal with the whole idea of prevention. We are generally seeing people across our desks who are past the point of prevention and need some clinical help. We have to, in a unified way, begin

to deal with that. I hope this body will do what it can do to begin to develop and encourage the implementation of programs that ecclesiastical leaders could use in prevention programs.

A *third* area that I've touched on and I'm just reemphasizing, is that we need lists of private practitioners. For most of us, LDS Social Services and their telephone number is the only thing we know. We need to know what private practitioners are available. Cory has pointed out that there are some areas that, in fact, private practitioners may be better able to handle than LDS Social Services itself. We need to know some of those people and their specialties.

A *fourth* area is that we could surely use some manuals, some other materials--very basic, straight forward--we're not trying to become psychologists or social workers ourselves, but we could use some fundamental material. This group could be the entity that begins to develop this type of material in conjunction with LDS Social Services. It would be a great asset.

And *fifth*, we need to be able to sit down, one on one, as ecclesiastical leaders with professionals to learn some basics about counseling. I'm not talking now about just the general kind of training, but the one-to-one counseling. Church Social Services is, in my opinion, doing a good job of this right now, but in the outlying areas of the Church, I think some of you private practitioners could really help. We've called to our high council a psychiatrist, and he has become a valuable resource. You private practitioners need to make a living, hence, it's unfair to use your services extensively for no fee. I think that it's important that you know that most ecclesiastical leaders realize that. It is not uncomfortable for me to go to someone with whom we deal in the stake as a private practitioner and for me to say to him or her, "I need some help," and for them to say back, "But it's going to cost a certain amount," and we talk about the amount and arrive at a fair fee. I think too often we expect you private practitioners to give all of your time, or significantly more of your time than we should.

Those are some areas of need that I see and I think this group can greatly assist the ecclesiastical leaders in many of these areas.

Rich Cannon

I'm a bishop in one of the wards in President Swinton's stake. I must say that the program of training that he's provided for us has been extremely helpful to me personally. I would have to second his thoughts and feelings. Still, the area in which I feel the most inadequate is in evaluating those members who sit across the desk and in determining when they should be referred and to whom. I remember one evening getting a call from a young man in my ward who said he needed to talk. I asked him to come to my home because my wife was out and I was baby sitting. As we were sitting in the front room, there was some work being done on my house and an air-conditioning system was being removed from the basement. As this young man was explaining to me very vividly these horrible dreams of torture that he was having nightly, my 15 month old pulled the grate off of this air-conditioning system and went eight feet into the basement. I ran downstairs and picked him up and he wasn't scratched or hurt, but as I walked upstairs, I thought, "That's just what this young man needed to see!"

What options are available in dealing with someone like that? How seriously ill is he and where should we refer someone who obviously has emotional problems beyond the scope of ecclesiastical counseling? Fortunately with him I said, "Well, have you ever had this before?" and he said "Yes." I said, "Well, who helped you?" and he told me the name and I said, "Let me get him on the phone." Not always do we have that option open to us and as it turned out, in the long run probably it was still not the best option. He eventually ended up seeing someone else (a psychiatrist) and being helped tremendously.

Those very difficult, serious problems are seldom encountered, but now, after a little more than two years as a bishop, they are not completely new either. I would say that in those two years there have been probably eight or ten people who have had serious emotional problems and needed professional counseling. They, in fact, had more than just mild depression or some of the minor adjustment problems that we often deal with.

The training in terms of how to deal with those people, in the resources that are available to us, in who we can call and say, "Hey, I have so and so with this kind of a problem. What do I do?" is extremely helpful. LDS Social Services has been particularly helpful to me and I believe other bishops in our stake in dealing with members with serious mental and social problems. Homosexuality problems are some of the most difficult. LDS Social Services has been most helpful, both as trainers and in using a combined professional and ecclesiastical approach. These people often need new friends and a lot of support and we've even engaged other people in our ward in helping some of these people deal with that issue. Sometimes, if the professional is comfortable about including the ecclesiastical leader in the counseling of the member, it can be beneficial not only to the member, but to the ecclesiastical leader. The next time the issue arises, he may be much more capable of dealing with that issue and may actually ask for another audience with you in dealing with it with other members in his ward.

One problem that I've encountered: the professional will give us a 27-point program--and my brain doesn't work after about five points. I think that

the member's doesn't either, so that the program of communicating needs to be as simple as possible and still get the job done. In those kinds of difficult issues, it becomes very helpful to meet jointly with the professional counselor.

What about the confidentiality of those situations? Someone mentioned a release of information. I would hope that the communications are such between both the member and the bishop and the ecclesiastical leader and the counselor that there's a fairly open flow of information, except in some circumstances where that flow of information may jeopardize the correction of the problem, or the treatment of the patient, at which point the counselor should be very free to say, "Bishop, it's time to back off--I can handle this better on my own." And I would feel very comfortable with him saying that if he would define for me how I might be helpful in an ecclesiastical way. More often than not, I think joint treatment of the patient or the member can be very helpful and that can only occur when that flow of information is free.

The other thing that I've found helpful is to separate the ecclesiastical and gospel-directed counsel from the professional counsel. We can then define the lines of responsibility in the patient or member's life and at times it becomes easier for them to sort out exactly what the issues are in terms of their adjustment problem. Again, that takes good communication between the bishop or the ecclesiastical leader and the professional.

In summary, my plea would be that you train us to recognize problems and help us deal with those problems that are minor, that we might be able to deal with, and recognize those that need to be referred. President Swinton and the high councilor in our stake designed a questionnaire in which we asked, in those six areas of personal preparedness, what the individual needs were of the members of our stake. It was interesting, there were five questions in each of the six areas: Social, Emotional, and Spiritual Strength questions ranked as the top five with both the men and the women. All five questions were ranked higher than any other question on the questionnaire, which was interesting to us. Students identified those areas as the most difficult areas in their lives to deal with. We need help in knowing how we can more effectively help them deal with problems of loneliness, isolation, and depression, which they often have.

Sharon Staples

I'm Sharon Stapes and I work in an institutional setting, educational-institutional setting, as well as in private practice, and I have also worked in LDS Social Services for a number of years. I think that in the interest of time (the comments I was going to make have already been made) I'll just summarize briefly what I have heard here this afternoon. And that is that each of us, regardless of where we are and where we serve, needs to know the strengths and limitations of the resources around us. We need to know what the limitations and strengths of LDS Social Services are and how we can best use them to help the members of the Church. The same is true for private practitioners. What strengths do each of these practitioners have that we can rely on to help the person who's coming to see us? I think if we were all better informed as to who is doing what and to what degree and why, then the improvement of the client who may come to us would be enhanced. I think we just need to be aware of our own skills, our own weaknesses, and where we can turn to get the best help for the individual member of the Church.

A number of questions and comments from the audience preceded the following:

Summary and Conclusion (Val MacMurray)

In conclusion, I'd like to express appreciation to Allen Bergin who invited us to address this topic, one that I think is extremely important. I'm new to LDS Social Services. I was invited to join them just a little over a year ago, and when you're new in anything, you always have a little honeymoon phase where, if you put your foot in your mouth, it's simply written off as ignorance. I will invoke that honeymoon prerogative here. One of the things that I found, coming into the LDS Social Services system, is that there's a schism between those who are in the system and those who are outside the system, whether they're Church members or not. One of the things I hear from those in the system is: "Those outside LDS Social Services, even though they are members of the Church, are too secular in their approach...And we're a little afraid of that." From the community professionals, I hear comments like: "I'm not sure LDS Social Services practitioners are competent or adequate in their professional training." So I hear allegations going back and forth. If, indeed, there are schisms or differences, as I've suggested, I think it would be well for us to begin to make positive assumptions about one another, while, at the same time, recognizing limitations and strengths. If we do that, there can be an orchestration of our best resources to assist members. In areas of weakness there needs to be an openness and willingness for further training or simply to function in areas of personal competence.

What about the future? What are we going to do when we have 8 or 9 million members of the Church? It's absolutely clear that there is never going to come a time in the Church when we put an agency in every stake. Economically it's impossible; it's just not feasible. And so, it seems to me, we do have to begin thinking of other approaches that will expand what we know and what may be useful to our people.

continued on page 36

HANDLING VALUES CONFLICTS WITH LDS & NON-LDS CLIENTS

James C. Hurst, Ph.D.*

Presented at the AMCAP convention
October 2, 1980

First, I would like to indicate how pleased I am to be with you. I want you to know that I do not stand before you as a self-proclaimed expert in the area of values or values conflicts but I, as you, have done a good bit of thinking about the area, primarily as it has impacted my own therapy and the administrative work I do. What I would like to do today is share with you some of the conclusions that I have reached concerning values and their role in therapy.

The other night on our way to this conference, we were driving along the rather desolate roads of West Texas and Eastern New Mexico. It was a beautiful night. The stars were in the firmanent and I was alone for a period of time while the other members of my family were asleep. The cool night air felt so refreshing. As I sat there driving in the solitude of the moment, I contemplated a number of things that I value. I contemplated my love for my wife and my children--my home and family activities. I contemplated the gospel and our understanding of the plan of salvation--and that seemed particularly relevant as I looked up into the sky and saw the stars and a portion of the moon. I felt very grateful and very blessed. The reason I share this personal moment with you is my belief that so much of what we do and so much of what we feel and think about is an expression of our personal values. Though it had not been my intent to sit in the solitude of the moment and contemplate that which I value, in fact what I was doing, simply because I was alone and had an opportunity for solitude and reflection, was reviewing values that I cherish. Inevitably our personal value system influences and determines what we think, feel, decide, and how we behave. Our values pervade our lives.

I was reminded of the impact of our values on our behavior in a conversation with another stake president at Philmont Scout Ranch this past summer. We were talking about how there are some people who have a tendency to have such difficulty finding the time and resources to function in church callings. We discussed how various people deal with the difficult challenge of excelling both in a church calling and in their profession as well, and how all too often the church calling receives only what is left over. He said, "You know, my experience is that people will always find time to do the things that they truly value." I was struck with the simplicity and accuracy of his observation. I believe that it is true. That which we value most we ultimately support with our time and talents.

What are these values that play such a crucial role in our daily lives? There are a lot of different definitions of values. Webster defines values as that which is desirable or worthy of esteem for its own sake; a thing or quality having intrinsic worth. Mowrer in 1967 said that values are long-range attitudes, convictions, wishes and faith. Values are principles you live by. Rollo May recently talked about values as symbols around which one's devotions gather. Values are those things which are something of special worth. He went on to say that values, indeed, require decisions.

I have experienced conflict with values relative to time commitments in trying to excell professionally, spiritually, and in church callings. I know that most of you have experienced those same conflicts along with me. I find it very difficult to believe that we could have deep and abiding commitments to our profession or to our religion without eventually running into some conflicts. Some of my conflicts seem insignificant when compared to that described in the 22nd Chapter of Genesis where Abraham is confronted with what I think is a gigantic conflict of values. Abraham was told to take his son and offer him up for a sacrifice. If you read between the lines, you can see that that great prophet was struggling with values that he cherished deeply: a deep and abiding love for his son, Isaac, and a deep and abiding love for his God who was telling him to sacrifice his son. So significant was Abraham's obedience in his intent to offer Isaac that it was immediately after that experience that Abraham was told that through his posterity all the nations of the earth would be blessed. We learn something about both obedience and the struggle with a value conflict. I think of Nephi as he stood over Laban, having been told that he should take Laban's life, and the tremendous conflict that Nephi must have felt even though the scriptures do not elaborate on that conflict, you and I know that Lehi had taught Nephi good and sound principles and that there was a serious conflict of values in the situation he faced. Nephi obeyed the Spirit and took Laban's life. Even

***Brother Hurst is the Dean of Students & Asst. Vice President - Student Affairs at the University of Texas at Austin.**

Father Adam had to resolve a values conflict in his choice between a life with his beloved Eve or a life in the garden. Abraham, Nephi and Adam relied upon the Spirit and eternal gospel principles to deal with their conflicts.

I mentioned earlier that all of us have probably experienced conflicts relative to spending time in our Church callings, in our professions, or with our families. Those are difficult decisions. Some of us have experienced values conflicts that are even deeper in nature. I can remember vividly the day I learned of the revelation that President Kimball had received concerning the priesthood being given to Blacks. The reason it is such a vivid part of my memory is because that had represented for me what was a value conflict. I had learned very early in life from my parents that you share what you have of value with other people. I'd lived during the course of my childhood with 74 foster children who my parents had brought into our home and had seen demonstrated there the principle of sharing that which we value with other people. The result of this circumstance was that I had a tough time and experienced some dissonance because of a practice that restricted our ability to share that which was of greatest worth, the priesthood, with our black brothers. My model for dealing with the conflict was that of Abraham, Nephi, Adam and others--that is, obedience. Nevertheless, in my prayers I talked with my Father about the fact that the value conflict was there and it was hurtful at times for me. And so when the day came when I was in my office at work and a call came from my wife, Joan, who reported that President Kimball had announced a revelation that Blacks could receive the priesthood, I can remember a feeling of tremendous thanksgiving, a feeling of joy and a feeling of resolution as what had been a conflict of values for me was dissipated. There was an added increment of congruence in my life in connection with that announcement.

So it seems that all aspects of our lives interact with our value systems. We certainly cannot separate them from our day-to-day decisions. So, of course, what that means is that as we enter into a therapeutic relationship with other people it is utterly impossible and possibly even preposterous to think that we can rid ourselves of our values. Lowe (1976) concluded that no "intense human interaction, which includes psychotherapy can occur without the expression and manifestation of values." Bergin in 1980 concluded that "values are an inevitable and pervasive part of psychotherapy." Some of these statements are based not only on intuition but on empirical investigation. Even more recently in 1980 Hlasny and McCarrey concluded that a therapist's value system appears to be a relatively pervasive characteristic that has an inevitable yet covert influence on the therapeutic process. Now if you were to look at my notes you would see I have underlined "covert." Values are such an important and integral part of our lives that there is certainly no way we can shed them in an intense, interpersonal interaction such as psychotherapy.

I have not always believed this about values and psychotherapy. As I completed training about 14 years ago, I was deeply committed to keeping my values and my agenda out of the therapeutic process. I was very careful during those years not to intrude in the therapeutic process with what I thought were my values. I worked very hard to listen carefully to what the client was saying and to respond and react only to that which was presented, both overtly and covertly, by the client. I worked very hard to do that and to *not* include my values because I thought that would constitute a distraction, a diversion from good therapy. My belief at that time was that if I could just "stay with the client" and provide my clients with a mirror that was brighter, sharper and clearer than they had ever had in their lives, and that I I could in addition to presenting that mirror through my verbal interactions, provide an environment of safety, that the person within that environment would grow and develop in basically constructive and positive ways. I had a lot more patience in those days than I do now. There were times when I waited and waited and most of the time I found that this type of therapy worked. Some of the time, of course, it did not work. But, if you could observe me doing therapy today, you would, I think, see some significant differences between what I did then and what I do now--relative, particularly, to the expressions of values. Over the years I have found it utterly impossible to keep my own values separate from my therapy. So my own experience confirms the conclusions that values are infused in all that we do, in all that we say. As I look back on those days it is now increasingly clear to me that in my therapeutic endeavors I can identify those client comments that I must have responded to with greater enthusiasm than others. I am convinced that my values were at work as I selected a vocal intonation, or as I selected a piece of content, out of several pieces, to which to react. I have no doubt that my values were very much with me. Nevertheless, my effort at that time was to keep them separate. In that I failed.

Over the years I have learned and concluded several things. I would like to pass those on to you at this time. I've identified six propositions that relate to values and therapy that matter to me and that I wish to share with you today.

The first one, I think, grew out of an interaction I had with Beth, a client of 13 years ago. Beth was a freshman who sought counseling at the university counseling center. Her presenting problems related to loneliness, a hunger for affection and a need for

inclusion. I had only seen her several times when she came in to report that she was several months pregnant. She was then confronted with a decision from among several alternatives. The alternatives Beth identified included having the baby and keeping it, having the baby and putting it out for adoption, and abortion. Other alternatives included marriage, although she was unsure about the identity of the father, or remaining single. Examining the alternatives became the primary focus for the next few sessions. My effort was to be the best possible counselor and therapist that I could be, and in so doing, at that time 13 years ago, I worked very hard to keep myself and my values out of it. I worked hard to help Beth explore all of those alternatives and all of the consequences of each of the alternatives, as best we could. I referred her to people who I thought were crucial to her decision, including a physician, her minister, and an adoption agency. So for several sessions we had some very intense interaction with the intent of helping Beth make the best possible choice. I think one of the reasons I remember the case of Beth so vividly is that Beth's final decision was to have an abortion. I remember that vividly because, although I had made a real effort to be a very good therapist and, according to my beliefs and training at the time, to keep my own values separate from the therapy, Beth's decision elicited a dissonance in me that exists even now. I didn't understand this dissonance that was within me at the time. All I knew was that it was there and that it troubled me. I somehow felt badly about the work that I had done, or perhaps had not done. There was something apparently that I was not attending to, and the experience did not leave me at peace with myself. In 1967 the whole question of abortion was a relatively new issue that was being confronted by professional psychologists. When Beth made her decision I felt compelled not to support it--there was something inside me that would not accept it. Yet I felt that I had no choice but to remain neutral. It seems that my values could no longer be suppressed, yet I could not express them. From this and other experiences I have derived a postulate that relates to the therapist's relationship with self.

> Therapeutic interventions that are consistent with the internal value structure of the therapist will result in more effective therapy than those that are not.

This was what I did not do with Beth. I did not tell Beth who I was, and what my values were at the time in our therapeutic interaction, but I feel now that it would have been appropriate to do so. My values were obviously present. I have no doubt about that, but I feel some regret for not having been overt in my expression of those values. I am not convinced that Beth's decision would have been any different, but I am convinced that the process would have been more thorough, effective and honest. I feel now that my commitment to assisting Beth in dealing with her dilemma would have been honored more deeply.

My second postulate concerning values in is a corollary of the first:

> Therapeutic interventions that are contrary to the value structure of the therapist detract from the therapeutic impact and weaken the therapeutic encounter.

As I reflect back on my work with Beth, I believe that there was in me at the time of her decision a prompting telling me that her decision was not in accordance with established, eternal principles. I think that is what troubled me so much at the time. Again, I'm not sure that Beth would have done anything differently had I expressed my concern about her decision. I do know that I would have been more at peace with myself had I introduced Beth to Jim Hurst and his value structures, and if I had explained to her my concerns for her welfare from my perspective.

A third postulate deals with a dimension of the therapist's spirituality.

> Therapeutic interventions that reflect mutual trust and respect between the therapist and his or her Father in Heaven enhance the effectiveness of therapy.

I noted earlier that I did not feel at peace with the therapy I offered Beth. My own conclusion is that my therapeutic effort left me more spiritually dissonant because of what I withheld of myself. I think it's becoming more acceptable in the world of psychology to talk about values relating to God and the role of religion and diety in our therapy. I think a number of years ago we would have been taken less seriously by our colleagues in identifying these kinds of postulates. I, for one, feel indebted to Dr. Bergin and others at the Values Institute at BYU who are providing very important leadership relative to the acceptability of considering the variable of the therapist's spirituality as an important component of effective therapy.

A fourth postulate deals with therapist-client morality. If spirituality is a construct describing interactions between man and God, so morality is a construct describing the characteristics of man's relationship to man.

> Therapeutic interventions that create mutual trust and confidence, that enhance open communication and understanding between the therapist and the client result in a more powerful therapist and more effective therapy.

I have already reported to you that I was not at peace with the spirit at the conclusion of my therapy with Beth. I must also report that I did not feel at peace with Beth. My hunch is that if we could have talked with her after that experience, she would probably have given some basically positive

evaluations of her experience with therapy, but had I evaluated it, I probably would have talked a bit about a discomfort I had, based on the feeling that I let Beth down--that I had, at a time when it was perhaps most inappropriate, divorced myself from my spiritual makeup and separated it from the therapeutic encounter. If I were to do it again, I would do it differently. My therapy would reflect more accurately the postulates I have listed thus far. It would have made a difference to me, and I feel confident that, even considering the worst circumstance, it would not have hindered the therapeutic encounter with Beth. Beth, by the way, was not a member of the Church--and Beth and her family did not report any value at that time that was discrepant with abortion.

Another counseling situation emerged that has led to a fifth postulate. Rob and Jill had experienced some marital discord. Jill came reporting that she had had sexual intimacy with a colleague in a city nearby. I made a real effort to reflect and explore what was troubling them. I assisted both of them to face the consequence of their actions and confronted them with the discrepancies betwen their behavior and the religious faith that they espoused. Over a period of time they were able to resolve the conflicts and today are still married, but I know their marriage is still struggling to build back a degree of trust that was badly damaged during that period of unfaithfulness. Postulate number five describes a way I would have worked differently in dealing with the value conflict I personally experienced in working with them.

> Therapeutic interventions that deal overtly with value conflicts between the therapist and the client lead to greater trust and confidence, and enhance communication and understanding between the therapist and client, and thereby result in more effective therapy than those that do not.

With Rob and Jill I think that if we had reached down into their souls and asked them to evaluate their therapeutic experience they might have felt a bit of disappointment. That is *my* perception and may reflect simply my own disappointment in me in that I was not much more overt in verbalizing the value conflicts that I was experiencing with them. I think if I were to do it again, I would be more assertive in stating what my values are. I think that Rob and Jill might have been disappointed that I didn't rise up in indignation and confront them with the huge discrepancy they were living with. It's true, I can feel a sense of gratification in the fact that they are still together, their children are still there, and apparently doing very well, but I'm disappointed that in that period of value conflict I was not more overt in disclosing my values and letting them know who I was and what I believed. I believe my therapy would have been more powerful and more effective had I done that.

Postulate number six:

> Therapeutic interventions that overtly confront value conflicts that exist between the client and the client's primary group (spouses, family, friends) is more effective than therapy which does not confront these conflicts.

Well, how might these various postulates make a difference? Let me indicate to you one other situation that existed that I think left me at greater peace with the Spirit and with a better feeling concerning the therapy that I was providing. More recently, two women sought me out for therapy. They were in a homosexual relationship. They described themselves as lesbians. They sought me out, having heard about my therapy from others and not knowing any more about me than that. Their presenting problem was one of interpersonal conflict. Their goal was to resolve that interpersonal conflict with the intent of learning how better to manage their lesbian "marriage". There were issues of trust, devotion, dependence and external pressures that were all pertinent. I listened to them for the better part of two hours in the initial session so that I could be sure that I understood what their goals were. At the conclusion of their presenting problem, I introduced myself to them. I told them who I was and what I believed and what I valued with regard to homosexuality, heterosexuality and intimacy. I talked with them about some of my knowledge, fears and doubts relative to lesbian relationships, and I acknowledged that although I ascribed to their terminal value system, (which basically was to have happiness, joy and satisfaction in life) I had to depart from them when it came to the instrumental value system that they expressed--a lesbian relationship. I indicated I would work with them, but that my goal would be different than theirs because I had concluded as part of the introductory sessions that part, at least, of the reason they were together was because of deficits in their interactional and attitudinal skills with regard to heterosexual friendships. I indicated I would work with them, but it would be in the direction of providing them with the freedom to leave each other and go their separate ways. They agreed to therapy on these terms--one was much more favorable than the other. They went through a therapeutic process that lasted six months. About three months into the process they did split. One person moved away and I lost touch with her. The other person, I learned sometime later, did marry and presently has a family. Reviewing the six postulates listed in this paper, I think my therapy was much more compatible in this instance than in my two earlier examples, and I feel more at peace with the Spirit.

Brothers and Sisters, we are going to be confronted with value conflicts. For my own part, the postulates that I have mentioned have helped me with some of my decisions. I hope that by sharing them with you

they cause you to think and that together we can become more efficient and adequate and in tune with the Spirit relative to how we deal with value conflicts in our own lives and in the lives of the clients we assist.

I pray the Lord's blessings on all of us that we will be able to succeed. I am convinced that the work we do is of vital importance. I am also convinced that we need the help of the Lord if we are to be fully effective in our important and, at times, sacred role as psychotherapists.

REFERENCES

Bergin, A. E., Psychotherapy and religious values, *Journal of Consulting & Clinical Psychology*, Vol. 48, No. 1, 1980.

Hlasny, R. G. & McCarrey, M. W. Similarity of value & warmth effects on clients' trust and perceived therapists' effectiveness, *Psychological Reports*, 46, 1980, pp. 1111, 1118.

Lowe, C. M. *Value Orientations in Counseling & Psychotherapy: the Meanings of Mental Health*, (2nd Ed.) Cranston, Rhode Island: Carroll Press, 1979.

May, R. Values & valuing: a telephone interview by the editor with Rollo May. *Voices*, Vol. 13, No. 3, pp. 18-21, 1977.

Mowrer, O. H. (Ed.) *Morality and Mental Health*. Chicago: Rand Mc Nally, 1967.

continued from page 10

about future empirical results in this situation. The overall change which had begun was that these persons, in Turner's language, had begun to accept themselves as valued identities, whole and not fragmented. Their increasing sense of self had begun to merge with a role--or roles--which were true and devoid of worldly error. I am confident that when this merging of true self and true role reaches a certain point, then healing in the Savior's terms, especially as he describes it in III Nephi 9, has occurred and change is virtually irreversible.

All I claim for the present is having made rather strenuous efforts to understand and help. Much more work needs to be done. I would enjoy collaboration with those who are willing to struggle with the problem; that means also reading the literature. I believe we can deal with this important matter in ways which are professionally correct and yet harmonious with the restored Gospel of Jesus Christ.

continued from page 14

and ethical life, not only in his personal life, but in his professional practice. In summary, we are suggesting that one way our therapy might be different from the mental health center's or the local clinic's is in our firm stand in behalf of obedience to one's conscience. We teach the client to listen to his heart (or, if necessary, we teach his heart first), and then "bear witness" of the responsible and productive life which will follow.

Secondly, the Latter-day Saint counselor has at his disposal a precious therapeutic tool--one which is gained only through proper preparation. This is the Gift of the Holy Ghost. Our clients simply ought to feel better--more at ease, more loved, more understood--in our presence than anyplace else. Why? Simply because the Holy Ghost creates a calming influence, an atmosphere where one may feel free to unburden himself. There really ought to be something different about us, depending upon our individual spirituality.

Of even more importance is the matter of revelation. Though an L.D.S. therapist who is not serving as an individual's priesthood leader does not have the right to receive confessions nor direction as to where one might serve in the Church, etc., we sense strongly that the Lord is eager to reveal information or insights to those therapists who expect it, ask for it, and live worthy of it. A young woman came into L.D.S. Social Services with a serious problem. Her mother reported that she had been vomiting constantly for four weeks, that she was rapidly losing weight. After praying over the matter (before the girl came into the office), the worker felt inspired to ask a particular question to begin the interview. The young woman gave a perfectly normal response to the query, but the Social Services worker noticed something in her eyes that led him to ask another question. Suddenly he had the impression that the girl was guilty of immorality, though he had no reason to suspect this or no tangible means of tying this transgression with the vomiting. The next series of questions were also "given" to him. Within a very short time the girl said: "My boyfriend and I have been doing some things we shouldn't have. I kind of think this might have something to do with my throwing-up."

Frankly stated, why shouldn't we have the Father's direction in working with these people? These are His children, and He desires their happiness and well-being. If we live for it we can serve as instruments in His hand in this business of recovering and building and saving souls.

QUO VADIS?

President Joseph F. Smith taught: "Our young people are diligent students. They reach out after truth and knowledge with commendable zeal, and in so doing they must necessarily adopt for temporary use, many theories of men. As long, however, as they recognize them as scaffolding useful for research purposes, there can be no special harm in them. It is when these theories are settled upon as basic truth that trouble appears, and the searcher then stands in grave danger of being led hopelessly from the right way." (*Gospel Doctrine*, pp. 38-39.) We sincerely feel that the day has arrived for us to climb down from the scaffolding long enough to examine the current status of the building under construction. Perhaps it is not yet time to tear down the scaffolding in wholesale fashion, but it is at least time to assess our

progress. We have begun work toward a book which aims at the removal of such scaffolding. We are dealing with each major theory of human behavior and indicating how each is either at best deficient or at worst perverse, when the measuring device is the Restored Gospel. In addition, we plan to discuss how the revelations of the Lord should guide therapeutic practice. That idea is both thrilling and threatening. Be that as it may, we affirm that the time has come to begin the slow but steady turn toward that glorious society of Zion, in our professional practice as well as in our religious lives. "For it shall come to pass that *the inhabitants of Zion shall judge all things pertaining to Zion.*" (D&C 64:38.)

continued from page 18

Christensen, H. T. Changing sex norms in America and Scandinavia. *Journal of Marriage and the Family*, Vol. 32, Nov. 1970; 616-627.

Church of Jesus Christ of Latter-day Saints. *Family Home Evening Manual*, 1977.

Church of Jesus Christ of Latter-day Saints. *Melchizedek Priesthood Handbook*, 1976.

Done, G. B. *A Study of Mormon-Gentile Interfaith Marriages.* Unpublished Doctoral Dissertation, University of Southern California, Los Angeles, 1937.

Deseret News Church Almanac, Deseret News Press, Salt Lake City, 1979.

Goodman, Kristen and Bahr, Howard M. Utah divorce in national and regional perspective. *Discussion Paper Series.* Family Research Institute. Brigham Young University, Provo, Utah, 1978.

Grisez, Germain G. Rational ethics says no. *Commonweal*, Vol. 86, Apr. 14, 1967: 122-125.

Kitche, S. G. *A History of Divorce.* Chapman and Hill Ltd., London, 1912.

Kunz, Phillip R. Mormon and non-mormon divorce patterns. *Journal of Marriage and the Family*, Vol. 26, May, 1964; 211-213.

Locke, H. J., Sabagh, C. and Thomas, M.M. Interfaith marriages. *Social Problems*, Vol. 4, 1957: 320-333.

McConkie, Bruce R. *Mormon Doctrine.* Bookcraft, Salt Lake City, 1955.

O'Dea, Thomas F. *The Mormons.* Published, 1957.

Olsen, V. N. *The New Testament Logia On Divorce: Interpretation From Erasmus to Milton.* Published, 1971.

O'Neill, William *Divorce in the Progressive Era 1880-1920.* Published, 1967.

Shaner, Donald W. *A Christian View of Divorce According to The Teachings Of The New Testament.* Published, 1971.

Smith, Joseph, Joseph Smith tells his own story, 1942, *The Pearl of Great Price.* Church of Jesus Christ of Latter-day Saints, Salt Lake City.

Smith, Joseph, The articles of faith, IBID.

Weinstock, Legal abortions in the United States since the 1973 supreme court abortion decision. *Family Planning Perspectives*, Vol. 7, No. 1, Jan/Feb 1975; 23-31.

continued from page 22

Goldfried, M.R., Lienhan, M. M., Smith, J.L., Reduction of test anxiety through cognitive restructuring. *Journal of Consulting and Clinical Psychologh*, 1978, 46, 32-39.

Hock, R. A., Rodgers, C. H., Reddi, C., Kennard, D. W., Medico-psychological interventions in male asthmatic children: An evaluation of physiological change. *Psychosomatic Medicine*, 1978, 40, 210-215.

Lambert, M. J., *The Effects of Psychotherapy*, Vol. 2, Montreal, Eden Press, (in Press).

Riley, A. J., and Riley, E. J., A controlled study to evaluate directed masterbation in the management of primary orgasmic failure in women. *British Journal of Psychiatry*, 1978, 133, 404-409.

Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S., Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. *Cognitive Therapy and Research*, 1977, 1, 17-37.

continued from page 30

Let me briefly tell you some things that are occurring within the area in which I work. I have just recently been asked to be manager of Research, Development and Management Services within LDS Social Services. This involves responsibility for three major areas: 1) Research and evaluation, 2) Staff development, and 3) Materials development. Let me start with the last one first. We're doing some interesting things right now, trying to develop some materials that are very similar to what we've discussed today.

Currently we are interested in developing and pilot training self-help modules to support the work of ecclesiastical leaders. We are also developing materials that would be useful to the on-going development and training of our own practitioners. This includes materials to increase the diagnostic and consultation skills within our system.

In the area of staff development, we hope to develop a more aggressive training program that would allow professional development leaves for staff so they can re-tool in specific areas and learn new skills in others.

In the area of Research and Evaluation, we have recently initiated a major comprehensive needs assessment and evaluation project.

I mention these activities as evidence that we hope to meet some of the challenges undoubtedly ahead of us in the 80's and beyond. I also think these activities cut across many of the comments, ideas, and problem areas we have discussed as a panel. We started today with the hope of providing some direction and suggestions that would help us in orchestrating available resources for the benefit of those who seek our assistance. It seems to me that a number of the comments made today identify key areas for our continued focus and best problem-solving abilities. In pursuing these, I hope we will do so with both spiritual and intellectual excellence. Thank you.

YOU MAY WANT TO READ:

Hammond, D. Corydon (with F. M. Stuart). Sex therapy. Chapter in Richard B. Stuart, *Helping Couples Change: A Social Learning Approach to Marital Therapy.* New York: Guilford Publications, 1981, pp. 301-366.

Third Request

Our second request for information about your recent publications brought one response (thank you, Cory!) so we are able to keep our promise that we would list such publications in the Journal.

Now that "the ice has been broken," we trust that others of you will respond by sending us references to the recent articles, books, pamphlets, etc. that you have authored and published. Your fellow members want to know.