Issues in Religion and Psychotherapy

Volume 11 | Number 2 Article 13

11-1-1985

AMCAP Journal, Volume 11, Issue 2, 1985

AMCAP Journal

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Recommended Citation

Journal, AMCAP (1985) "AMCAP Journal, Volume 11, Issue 2, 1985," *Issues in Religion and Psychotherapy*: Vol. 11 : No. 2 , Article 13.
Available at: https://scholarsarchive.byu.edu/irp/vol11/iss2/13

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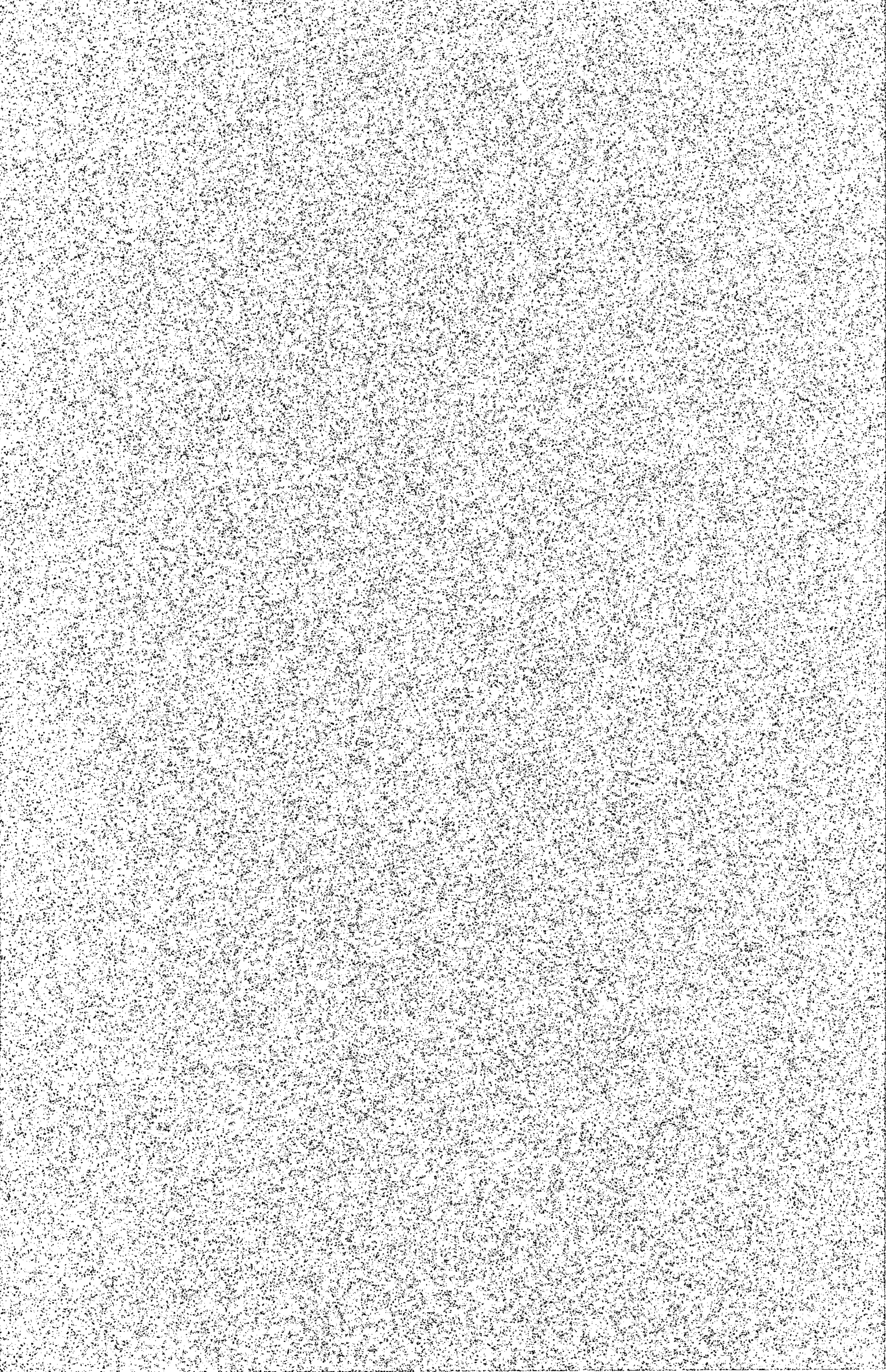

NOVEMBER 1985 ISSUE

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ASSOCIATION OF
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b) To encourage and support members' efforts actively to promote within their other professional organizations and the society at large, the adoption and maintenance of moral standards and practices that are consistent with gospel principles.

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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 20 double-spaced typed pages. Style should follow the Publication Manual of the American Psychological Association (third edition). Authors should keep a copy of their manuscripts to guard against loss. Three copies of the manuscript should be sent to the editor:

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EDITORIAL

Recently I was reading the Foreword of the *Publication Manual of the American Psychological Association,* 3rd Ed. (1984) and noted that APA receives for consideration for inclusion in its 18 journals approximately 6500 manuscripts per year. Approximately 1400 (22%) are accepted for publication. This means that they receive an average of 361 manuscripts per year per journal. We usually receive less than a tithe of that number for the *AMCAP JOURNAL.* Would that we would receive even 100 manuscripts per year. While increasing the amount of reading and reviewing, it would certainly simplify publication of a high quality journal and make it much easier for each issue to be published on time. For this issue we had 15 manuscripts to consider and returned 40% to the authors either for rewriting or not being considered acceptable. Even with the small number of manuscripts received, I was talking with a very respected LDS academic psychologist who had just read our March 1985 issue. He commented, "That is a really good issue. Many of the articles are better than many of those found in the accepted professional journals." His comment was, of course, very gratifying.

Thanks to each of the authors of the manuscripts for this issue of the Journal. We trust that you will find a number of ideas of value to you within them. While all of the papers in this issue were presented at one of our conventions in 1984 or 1985, the one by Brother Bruce Brown is a significant revision and amplification of his presentation.

Again, we invite you to submit any manuscripts you have written, or may write. We accept theoretical, research or practice-clinical manuscripts. Also, if you read any published articles that you think may be especially valued by our readers, please send us a copy(ies) so that we may consider reprinting them. Further, please encourage your colleagues to write and submit their manuscripts, or if you prefer, send us the name(s) of those whom you believe have significant contributions to make to the Journal so that we may contact them.

Thank you.

A ROAD MAP TO HOPE

ELDER JOHN K. CARMACK
A member of the First Quorum of the Seventy
Presented at the AMCAP Convention.
3 October, 1985

I approach you in a humility born of struggle. My life as a lawyer, a people's lawyer, brought me into daily contact with people from all walks of life—people with legal problems and people with emotional problems. Some were serious! One of my first cases after I went into the private practice of law was straightening out a mess left by a friend whose pain finally led him to commit suicide. He made one last try to pay his mounting gambling debts by a trip to Lake Tahoe, then took his life leaving a note to his wife that she should bring her problems to me, and I would solve them. There were enough problems to go around, but eventually, as is true with most problems, we saw them through together. I think I shall always be haunted by the memory of Karl coming to the Westwood Ward, gazing steadily at me as I was involved in an activiity with other ward members, then leaving suddenly—the night before his suicide.

Years later another client, unable to withstand the pain of loneliness caused by the hospitalization of his wife due to a severe stroke which took from his wife the ability to speak, put a bullet through his head leaving a similar note directing his heirs to me to handle the problems remaining. He was probably a typical passive, dependent personality type. Emotional pain, whether caused by financial distress, loneliness, or dozens of other dirty tricks which life plays on us, is real. In extreme cases, it is life threatening.

One of my close Los Angeles friends, a man of high ambitions and ideals, was married to a woman who worshipped him. When he restlessly sought excitement through female companionship outside the home, she tried every way she could to let him know that she could not stand the pain and shattered ego brought about by his infidelity and rejection. Finally, in despair, she apparently used the only weapon she felt was available to her which was to take her life. In effect, by her suicide she was saying, "John, I told you I was deeply hurt and you continued right on doing what I couldn't accept. Maybe you will now realize that I meant what I said." These are some of the more sobering experiences of my twenty years of practicing law in Los Angeles. One learns a lot, but there is also a growing humility and a tendency to abandon the feeling that you or your philosophy is preeminent and that you have all of the answers to people's painful struggles.

I struggled as a lawyer to help people in trouble. Usually, the solution to people's problems was not entirely legal, but required spiritual and psychological human assistance as well. The most difficult part of practicing law was dealing with the complexities of human nature. It was also the most rewarding. Getting a number of business partners to come together in a common cause to solve a legal partnership dispute against another equally complex set of humans with varied objectives is often how a law suit is settled or won after a court battle. Some of the most satisfying experiences of my life have been assisting and guiding human beings in their struggle to find peace, meaning, and success in their relationships with other human beings.

But I also experienced pain myself and learned humility when I discovered that I had insufficient tools or wisdom to solve a particularly thorny case, or when I failed in an attempt to understand and

help another human being. Additionally, when one's motives are impugned, more painful lessons are learned. Apparently, there is no other way to truly grow, evolve, and develop but by actual experience under the loving tutorship of a God committed to the principles of free will or free agency. We learn only incrementally. We find a piece of the puzzle here and a piece there. The Lord put it well when he said:

> "For precept must be upon precept, precept upon precept; line upon line, line upon line; here a little, and there a little: For with stammering lips and another tongue will he speak to this people . . . [Not to imply that He is deficient in language, but He has to use words we understand]
>
> "But the word of the Lord was unto them precept upon precept, precept upon precept; line upon line, line upon line; here a little, and there a little; that they might go, and fall backward, and be broken, and snared, and taken." [Which is how we often react as He tries to guide and inspire us by telling us things we should know.] *(Isaiah 28:10,11,13.)*

But in this tutorial experience, we should not be too hard on ourselves and others. We will often be clumsy and fail, but if we stop and think about it, we will realize that the Lord has not been successful with all of his children either, at least in this life. Some are rebellious, others disobedient, weak, full of unruly appetite; some cannot bring into their lives discipline while others are disciplined but intolerant. Some are even influenced by evil forces in their actions and in their choices. I know of no one to whom God has entrusted all of the answers to the questions we of the priesthood and we of the professions represented here grapple with. But we keep learning and never stop trying. Progress is apparent in knowledge of the principles and tools which can help, but the number in need of such assistance is multiplying.

There is a nice theological debate about whether God gains new knowledge. I know the answer theologically, but I wonder if even God, Himself, having created this world in which to test his children and tutor them through experience, sometimes feels like shaking his head in wonder at the reaction of men and women to circumstances they face.

We get some hint of God's work in the great Moses 1:39 statement that God's work and glory is "to bring to pass the immortality and eternal life of man." How patient and kind he must be as we stumble and fall and grow from gracelessness to grace.

Since we are partners in that work, that also becomes our work and glory.

Just when I thought I knew something about mankind, I was sent out into the mission field and was given 450 missionaries to work with over a three year span of time. These missionaries were mostly young adults, but also included brothers and sisters of all ages. This taught me in a more intense way about man, his complexity and varying nature.

One could easily be overwhelmed with the variety of circumstances one faces in the environment of a mission. People "oh" and "ah" at the exotic geographical assignment a couple is given in the mission fields of the Church, but the geography has little to do with the real work of a mission president. It is the inner workings of men and women which form the grist and become the essence of a mission. The glory of a mission is not just in the number of converts baptized and confirmed having obtained a testimony and hope in Christ, although that is very important, but the glory is in the growth and development of the missionaries who are placed in the charge of the president. It becomes a "bully" laboratory for a committed couple. And that growth is incremental—here a little and there a little. Fortunately, one begins to gain a perspective of human needs and those needs begin to fit into recurring patterns after a time. This makes possible a more intelligent and effective approach to the challenges faced daily in a mission. About the time your education fits you for the challenge you are released to return home, probably never to be called upon in a similar challenge again. Such are the ironies of life.

Nevertheless, so individual and varied is the growth which the missionaries experience that one almost becomes sympathetic to the existentialist school of thought which, in its religious dimension, holds that religion involves a decision which must be made separately and individually by each person, usually without conclusive evidence.

I am not an existentialist philosophically, but I have tried to understand that movement built upon pioneer thinkers such as Soren Kierkegaard, a Danish protestant theologian and philosopher, Frederich Nietzsche, the great German philosopher, and others. I particularly like the notion widely held by extentialist thinkers that man is free because he makes choices and that he is responsible for those choices. Therein lies growth and development. Man does seem to be "condemned to be free." And with that freedom comes variety. The variety of problems seems to be increasing as our families undergo turmoil, separation, and as roles of father and mother become blurred and confused.

In a great talk given in Washington, D.C. by Harold M. Voth, M.D., senior psychiatrist and psychoanalyst at the Menninger Foundation in Kansas, he asserted that:

> The crucible from which all life springs is the family. The events within the family can make or break the individual and collectively, civilization . . . not only must the family survive, but its internal workings must function in ways that turn out strong men and women—not weak ones who eventually become casualties of one form or another or who may work actively against the best values and traditions of our country.

Dr. Voth continued by analyzing the means by which families lead children to maturity. He also observed that often a child born biologically a male or female does not receive the resources, development, and shepherding to bring harmony between the biological and psychological sides, " . . . thereby developing a solid sense of maleness and femaleness." Of course, malfunctioning homes bring these and a variety of other problems into the lives of missionaries who enter into the Lord's service. Many of their problems can be worked out by the individual, but we must assist a growing number towards maturity and spiritual health. My term as a mission president has allowed me a peek into a cross section of our homes. That squinty peek into our homes has basically warmed my heart and left me optimistic. But there is also a dark corner or two which is worrisome.

Perhaps it is a miracle that we turn out as many maturely functioning men and women as we do both now and throughout our history, but this is an alarmming time when the civilization we love and the values we have held dear in the past are in grave danger. Such studies as "New Rules," by Yankelovich and "Mega-trends," by Naisbitt document some of the enormous changes in the principles accepted as the norm by people today. A mission president and his wife, receiving a sampling of presumably our best youth, nevertheless encounter a seemingly endless stream of problems faced by young and old. Our bishops have much the same experience. The glory comes as they see so many triumph and grow in ways which are so subtle that they can only truly share their feelings with someone having like experiences. The roles of spiritual father, leader and counselor become, to a mission president and bishop, laboratory training not unrelated to that which professional psychiatrists, psychologists, counselors and therapists experience. All of us marvel at man's capacity to grow, his complexity, and the endless opportunities to tutor, treat, rescue, assist, and serve.

I now borrow from a concept articulated by M. Scott Peck, M.D. in his splendid book "The Road Less Traveled." We are constantly trying to help each other along life's road by a number of means such as teaching people to delay gratification thus allowing them to experience greater good, helping people establish personal discipline, teaching them to give and receive love, and gently leading people to bring reality into their lives. To help us

along that road of life it is essential to have a true road map—a map which is constantly being made more accurate and true and which must be kept current. As the world changes, our map must be updated.

To illustrate, suppose you are a tourist who wants to explore Salt Lake City. Suppose you have a twenty-year-old map of the city. None of the high-rise buildings we see in Salt Lake City today even existed twenty years ago. To tour Salt Lake City with an outdated map which does not show the new buildings would be confusing and unhelpful. We need to see things as they are. We would insist that our map of the city be up-to-date and accurate.

Joseph Smith gave us this inspired definition of truth: " . . . truth is knowledge of things as they are, and as they were, and as they are to come." That definition is simple, but profound.

Henry Eyring told his son as he was about to start his study of mining engineering at the university:

> I'm convinced that the Lord used the Prophet Joseph Smith to restore his church. For me, that is a reality. I haven't any doubt about it. Now, there are a lot of other matters that are much less clear to me. But in this church you don't have to believe anything that isn't true. You go over to the University of Arizona and learn everything you can, and whatever is true is a part of the gospel. The Lord is actually running this universe. (*Reflections of a Scientist*, Henry Eyring, pp 6 & 7.)

This is a virile kind of religion. It is constantly being updated with new knowledge and is made more and more accurate and true. This is the gospel in which I can believe and which I trust.

President Kimball taught:

> The gospel is true beyond all questioning. There may be parts of it we do not yet know and fully understand, but we shall never be able to prove it untrue for it includes all truth, known and unknown, developed and undeveloped. (*The Teachings of Spencer W. Kimball*, p. 24.)

I feel a person is healthier if he has a road map for life which is basically true. The more fairy tales and the more out-of-date myths there are on one's road map, the more it will be like the rocky or sandy soil of Jesus' parable of the seeds, or as the jelly-like understructure of Mexico City, which made conditions so much worse for people during the earthquake. On our road map leading to health and ultimately back to God, we must have truth and reality.

We inherit so much excess baggage from homes where love, discipline and faith do not sufficiently exist. This hurts us. It is not easy to correct a map created by years of cynicism, hypocrisy, cruelty, indulgence, or indifference in a home. And in a home in which unwittingly faith is undermined, faith often does not appear on our road map.

Now, I would like to broaden the perspective of my remarks, building on the Peck analogy. If our road map ends at the state line, we are ill prepared to move beyond the boundaries of our state. We become a prisoner of those boundaries. Our planning for a nation-wide road trip is severely handicapped under those circumstances. Our road map is deficient. We don't even know which road within the state to take which will lead us toward our destination, whether it be east, or west, or north or south.

Paul said it well: "If in this life only we have hope in Christ, we are of all men most miserable." (I Cor.15:19) It helps to know where we are going and whether there are roads with which we need to connect in an adjacent state. There is power in a more complete map. Author Robert Bolt, in his "Man For All Seasons," had Sir Thomas More say to his executioner as he put on the black mask before the terrible axe was raised aloft, "Friend, be not afraid of your office. You send me to God." A more complete road map coupled with faith in Christ casts out fear and cowardice. In our work we need to remember that our road map should include events and guiding principles before our birth and after our death, to the extent these events and principles are known, and quietly build it into our system.

Elder Bruce R. McConkie, with a solid and correct road map, gave his last ounce of strength in preparing and presenting that great faith promoting sermon last April. He was a bright and living example of one who followed his road map into the next life. We can call what he became a living example of "hope," which he once defined as " . . . the desire of faithful people to gain eternal salvation in the kingdom of God hereafter." He added that "hope is always centered in Christ."

If our road map contains a look at the next world, somehow it helps bring perspective and reality to this one. C. S. Lewis once said, "If you read history you will find that the Christians who did most for the present world were just those who thought most of the next." He added, "Aim at heaven and you will get earth thrown in; aim at earth and you will get neither." (*Mere Christianity*, by C. S. Lewis.)

Some amazing and wonderfully constructive things happen when people get this perspective which we sometimes call a testimony. It is the work of prophets and missionaries to carry this message so that it changes the hearts and road maps of all inhabitants of this world who will not harden their hearts.

Yet it is not always possible for missionaries, prophets, and even the constant and loving service of parents to help those hard cases where neuroses, character disorder, and psychoses are deeply rooted. All can benefit from the sympathetic interest and love of another man or woman and from the administrations of the priesthood. But some of the people are so sorely afflicted that their problems can only be helped by "fasting and prayer," and many require highly trained and skillful professional experts in rebuilding horribly distorted and damaged maps. Many will never be well until released from the damaged conditions created or inherited in this life, despite all church leaders and counselors can do. We have constant need of those who develop professional expertise in helping with these harder cases.

No particular school of thought in your world is preeminent in my experience. Effective professionals can come out of any number of disciplines and often the doctrine of a particular discipline merges into experience and thus becomes unique to that person. A great and wise bishop can often do more than a professionally trained person. Bishops can and do handle most of the problems brought to them. This should continue to be so. However, a professionally trained person who is humble and caring can often be of great assistance to a priesthood leader, and can provide help to suffering individuals which is not readily available even from a righteous priesthood leader.

I well remember an elder serving with us who would have the equivalent of a seizure at every zone conference as he was confronted with the example of great missionaries performing brilliantly which heightened his own anxiety and affirmed his low self-esteem. It took a counselor, a psychiatrist, a social worker, love from home, Sister Carmack teaching him how to read and overcome the effects of dyslexia, and the power of the priesthood to see him through a mission. No one part of the puzzle was preeminent and any missing part would have resulted in failure. Added to all of that was fasting, prayer and faith.

A sister with a severe psychosis could not stand the rigors of a mission. Relief from its burdens and responsibilities could bring respite from pain. Professional help and ecclesiastical caring combined to help with that decision and a caring home was the peaceful setting needed for healing to begin. Perhaps she will never be psychologically right until the Savior Himself takes her into his arms.

Again, C. S. Lewis captured the thought well: "If I find in myself a desire which no experience in this world can satisfy, the most probable explanation is that I was made for another world." One can keep a proper perspective and avoid discouragement in working with people if one keeps in mind that death does not end life and that a great physician will sometimes have to complete work commenced here.

I have a few suggestions for your consideration as we humbly approach the task

of assisting the Lord in bringing joy to people in place of sorrow and misery, in helping to bring to pass man's immortality and eternal life:

1. Build into people the ability to solve problems and meet life's challenges with courage and hope, knowing that a better life exists beyond the borders of this one.

Joseph F. Smith once said:

> After we have done all we could do for the cause of truth, and withstood the evil that men have brought upon us, and we have been overwhelmed by their wrongs, it is still our duty to stand. We cannot give up; we must not lie down. Great causes are not won in a single generation. To stand firm in the face of overwhelming opposition, when you have done all you can, is the courage of faith. The courage of faith is the courage of progress. Men who possess that divine quality go on. They are not permitted to stand still if they would. They are not simply the creatures of their own power and wisdom; they are instrumentalities of a higher and divine purpose.

I think President Smith said it even better than Winston Churchill's famous speech to his school, Harrow, in which he had experienced so much pain and failure. He came back heroically as a great world leader and told the students eagerly waiting for the world famous orator, "Never give in; . . . never, never, never, never give in." People need that message, and it seems more effective if a road map of hope is built into their program.

I saw a sister in Los Angeles Stake last June with whom I had spent many hours helping in a small way with a major psychosis when I served as Los Angeles Stake President. She was measurably better than I remembered her being five years earlier. She had never stopped trying and many others had never given up on her.

2. Be humble, which is easy in this business of working with people, and let us be wise enough not to put all of our eggs in one basket. The Lord works through many agencies, and people, and wise priesthood leaders. While putting primary faith in the holy priesthood, know that fasting, prayer, therapy, proper use of drugs, medical help, psychology, and every available assist will sometimes be needed. Trained people should never succumb to the tendency to think they are wiser than everyone else, especially Church leaders assigned to help. A great attitude is one of humbly and professionally contributing as circumstances allow.

I don't know what I would have done without the medical and counseling assistance given the missionaries in my charge. On the other hand, I thank the Lord for the agency of the priesthood which was of primary help day in and day out. In the hard cases it was a combination of every kind of assistance we could find which finally opened the door.

3. Let's remember that good homes and mature, loving parents are the salvation of our society and work toward building them. Without them, civilization and mankind as we know them are doomed. This is the great problem of our age. Interestingly, the prophets saw this fact and launched extensive family help long before it became apparent that this would be our great need. How blessed we are to have prophets! Let us never be weary of following them, even when we know them as men with human weaknesses. And let us build parents and sound marriages and let us assist children to become mature adults and loving, wise parents. If we don't, the whole earth will be utterly wasted at His coming.

4. Finally, let us build road maps of truth and reality, including in those road maps the content of life as it existed before we came here and after we leave. Let us build hope in Christ, and a testimony of things as they are both by reason of our earthly senses and by reason of our spiritual senses.

I testify that life is eternal and that there is a gospel road map which will bring us home again. I applaud those of you who are humbly striving to help people with their distorted and cruelly deficient road maps, which often they inherited as a consequence of being placed in disastrous homes by a loving God who valued an

environment of freedom of choice in which difficult problem solving would build us. Most humbly, we are grateful that He sent His son to accept our burdens and to give us hope and in due course freedom from pain, promising that special peace which passeth all understanding. In the end, as Corita Kent observed, "to believe in God is to believe that the rules are fair, and there will be wonderful surprises." Without that assurance, this life would appear to promise only a continuation of unfairness and cruelty which seems to be a necessary part of the marvelous process of growth in this life.

Thank you for your crucial and enormously useful part in the road map to hope and the process of healing.

AN ALTERNATIVE TO "UNCONSCIOUS MENTAL PROCESSES"

BRUCE L. BROWN, Ph.D.

I have been a student of psychology now for twenty-two years. As far back as I can remember, I have had a lingering question: "How can such an important characteristic of mankind as the unconscious mind escape any mention in the scriptures." After all, if our actions are controlled by a part of us that is beyond our awareness and our introspection, then a knowledge of this unexperienced "agency" is essential if we are to have a correct understanding of the meaning and purpose of life.

The question has not seemed urgent, but it has been perennial. I have heard a number of trivial answers to the question over the years (like "the scriptures also don't mention the existence of an hypothalamus or a pituitary gland"), and I have heard a number of testimonials from clinical practitioners as to the reality of the Freudian unconscious, but the question has still remained.

I do not dismiss lightly the *observations* (clinical anecdotes as well as *some* of the research findings) upon which "unconscious" theory is based. But I do doubt the "received view," the commonly accepted theoretical explanations that are given for such observations, and I have for as long as I can remember. I am now quite sure that these theoretical explanations of such observations are wrong, and wrong in a fundamental way.

My view of theories in the behavioral sciences has evolved into a general rule—if you are going to bet on one, bet that it is false. The only question is how much of it is false. For me the major issue has not been how to deal with or "integrate" such theories with my most deeply held beliefs. I view theories as only scaffolding, helpful in finding otherwise overlooked observations. I see no reason for trying to reconcile or integrate psychological *theory* to one's faith. The major issue, I believe, is to seek to understand how *observations* that have been corroborated convincingly and repeatedly can fit within the revealed perspective of eternal man.

During the middle 70s I was part of a research group at BYU in which a number of us jointly pursued topics related to the question of "unconscious mental processes". Much of my current thinking on these issues has been shaped and influenced by the ideas of the colleagues in that group. Although we only met for a year or two, my own research and writing were enriched for many years after by the ideas that came out of those meetings.

It wasn't until almost five years after those meetings ended that some things began to come into place for me with respect to the lingering question of the "unconscious". A number of ideas converged in a kind of "aha" experience, and for the first time I began to see a clear alternative to the "split psyche" kinds of explanation. It wasn't something I was ready to try out on someone else. I couldn't find words for it. But I felt that my own question was settled in a way that was personally satisfying.

In the years since then, I have tried to integrate that inchoate but illuminating insight into my research and writing, and I even tried to explain it to others in a BYU forum address (Brown, 1983) and later an AMCAP talk (Brown, 1985). But it is a complex and many-faceted collection of ideas, and it is always an unsatisfying experience to try to explain it in a forty-minute lecture. It is certainly not an

original contribution (if such really exists), but an integration of the work of a number of theorists in psychology and philosophy. A one-semester course where all can investigate a number of sources together is more adequate than a lecture or a paper as a forum for dealing with it. Nevertheless, being an optimist, I will now try to review some of those sources and sketch the outline of those ideas in this paper. The paper will undoubtedly be, from your perspective, too long, and from mine, too short.

If I were to try now to summarize this view in a few sentences I would say that the same phenomena that have been taken to be evidence for unconscious mental processes can be equally well accounted for using simpler and less sensational principles of holistic perception, similar to those put forth by the Gestalt psychologists. The Freudian unconscious is an invention rather than a discovery. *It is an artifact of atomism.* ("Atomism" is the behavioristic fallacy of separating incoming information into discrete stimulus units and human action into discrete response units.) As soon as one looks at perception and human action holistically rather than atomistically, the paradoxes that drive such theorists to posit two minds disappear.

I would further argue that the received cognitivist view is wrong in its implicit assumption that we are for the most part explicitly aware of our thoughts, perceptions and actions. When one views perception this way, then it is surprising to find evidence that some things are perceived without awareness. From within this view, "subliminal perception" is a momentous discovery.

I reject the "subliminal perception as a special case" view. On the contrary, I hold that the great majority of human knowledge and interaction remains inarticulate, tacit and holistic, and it takes mental work to spell it out. In other words most of our mental life is tacit, and the thing to be explained as a special case is how we make *any* of our experience explicit or articulate. We know more than we can say. To articulate what we know or what we experience is a kind of achievement that requires mental work, but it usually falls short of the greater inarticulate knowledge that we have. An attempt to capture human knowledge and experience in a cage of words will often involve distortion and will always be incomplete.

That is the short form of the argument. Now in the remainder of the paper I will try the long form, beginning with a review of the philosophical objections to the psychodynamic view. Armed with these logical arguments against "unconscious" theory, we will look at their relevance to the models of contemporary cognitive and social psychology. Then, after comparing the various forms of the "unconscious mind" concept, in the last half of the paper we will examine an alternative form of explanation based upon Polanyi's philosophy of tacit knowing, Gibson's holistic perceptual theory and some implications of contemporary psychopsychics. The essential ideas of the argument will proceed something like this:

1) Although many clinicians still take the psychodynamic view of mental life as a given, existential philosophers such as Sartre and Fingarette have convincingly demonstrated that this "received view" is logically bankrupt. It is conceptually flawed beyond repair.

2) After a stormy forty year history, the concept of "unconscious mental processes" is now an accepted part of contemporary cognitive science. That is, in almost total disregard of the telling logical arguments against the two-agent psychodynamic view, contemporary cognitive theorists have adopted a version of it in their information processing models. Most cognitive theorists erroneously think that a computer metaphor solves the logical problems, but it does not, and the cognitive models can be faulted on the same grounds as the psychodynamic ones.

3) These issues and arguments are central to a number of research traditions within psychology, including the perceptual defense and vigilance literature, the related subliminal perception literature, the cognitive dissonance and attribution theory traditions within social psychology, and the

"split-span attention" research tradition within cognitive psychology.

4) Within this diverse potpourri of psychological research and theory, two paradoxes can be identified. One has to do with how one can perceive without awareness (the subliminal perception paradox), and the other has to do with resistance.

5) Both paradoxes are an indication of the need for a reconceptualization, a transformation in the way such things are viewed. A proposal will be offered based upon Polanyi's philosophy of tacit knowledge, Gibson's ecological approach to perception and recent developments in psychophysics.

6) This proposed approach is referred to as "transparency theory," but it is really more of a meta-theory. That is, rather than offering an alternative theoretical explanation for old observations, it is a transformation of vision that affects the empirical observations themselves. It involves a more careful reading of the primary data that obviates the need for heavy, occult explanatory burdens like the "unconscious."

Objections to Psychodynamic Theory from Existentialist Philosophers.

Although there has been much interest over the years in providing empirical evidence for the concept of an unconscious, the primary motivation for the concept has not been empirical. Its roots are rather in the ubiquitous observation of *resistance* in therapy and in everyday life. Admittedly there have been many studies over the past 50 years aimed at demonstrating the existence of the "unconscious" or "unconscious mental processes." (Witness, for example, the thousands of studies in the "perceptual defense" tradition.) But the studies have been a search for corroboration of the concept rather than the source of that concept. That is not to say that the concept doesn't have some basis in observation, but its primary basis is subjective clinical experience rather than the results of research.

The clinical phenomenon of *resistance* is closely related to the psychodynamic concept of repression, the concept of "self-deception" from existentialist philosophy, and more informal concepts that come from clinical practice such as "self-defeating behaviors." Although these concepts have come from diverse traditions, there are important similarites. All have in common the observation of apparently purposive actions that seem to be contradictory to the person's avowed intentions. This strange state of affairs can be illustrated by an example from the existentialist Sarte's (1953, pp. 96-98) description of "self-deception" — his well-known example of the woman who colludes in her own seduction. The man's intentions are obvious to anyone but her, and even her own actions indicate some kind of inarticulate awareness of his intentions. Her actions are complementary to his in a way that could only be described as purposive and intentional. Yet one could not describe her protestations of innocence as a lie. Sartre (p. 88) maintains that in a cynical lie one creates for the other a "transcendent" character, a self that does not exist. It is intended only for the consumption of the other; the liar is not himself taken in by it. But she seems to "lie to with sincerity," to be fully taken in by her description of things. When and if her part were to become clear to her, she would be genuinely surprised. But if one were to try to point out her complicity to her, she would not receive the information in the way one would expect of innocence, but would resist and protest. The self-deception phenomenon, then, is distinguished from cynical lying by *surprise* and from ignorance/innocence by *resistance* as diagrammed below:

	surprise	resistance
cynical lying		✓
self-deception	✓	✓
ignorance	✓	

If it is a lie, then it is one that seems to be believed by the liar, hence the term "self-deception." But if we look at the logic of what we have just said, it is clearly

paradoxical. For as the deceiver one must know, but as the deceived one must not. In Sartre's words, "I must know the truth very exactly in order to conceal it more carefully—and this not at two different moments, which at a pinch would allow us to re-establish a semblance of duality—but in the unitary structure of a single project" (p. 89). After giving examples of the ubiquity of the phenomenon he concludes, "Our embarrassment then appears extreme since we can neither reject nor comprehend bad faith" (p. 90). "Bad faith" is the translation usually given to *mauvaise foi,* the phrase Sartre uses to refer to self deception.

One way of viewing the psychodynamic concept of the unconscious is as a way of dealing with the paradox of resistance, the same paradox philosophers refer to as the paradox of self-deception. By positing two minds within the person, it is possible to think of the person as being at one and the same time both the deceiver and the deceived. The resisting client is not one but two, and one part wants to help the therapist deal with the problem while the other blocks his efforts to uncover it. The paradox disappears! It is a shallow and ad hoc way of dealing with the logical problem, but it is amazingly current. As will be shown in the next section, it is closely parallel to recently proposed solutions (Dixon, 1971 and Erdelyi, 1974) to the perceptual defense paradox (which is a special case of the self deception paradox).

Sartre (1953, pp. 86-96) has raised a number of objections on logical grounds to this Freudian way of dealing with the resistance paradox. His arguments are incisive but subtle. On successive rereadings it becomes overwhelmingly apparent that there is no hope for the psychoanalytic model as a way of comprehending "bad faith." Among other objections he argues that:

(1) The act of resistance implies a self-reflective consciousness which could certainly not be characteristic of the raw instinctual impulses that are attributed to the Id. (p. 92)
(2) It cannot be the Ego which resists, for the information is repressed in order to hide it from the Ego. The self-deception would then be entirely conscious. Nothing is added to the logical dilemma by positing an unconscious if this is the case (pp. 92-93). Also, if the repression were an act of the Ego it would also be necessary for the Ego to repress the act of repression and then to in turn repress the knowledge of this second repressive act, and so on to an infinite regress, since the act of repression has implicit within it the reason for repression. (See Fingarette, 1969, p. 114, for a lucid summary of this Sartrian point.)
(3) Freud's positing of a censor "as a line of demarcation (between conscious and unconscious) with customs, passport division, currency control, etc., to reestablish the duality of the deceiver and the deceived" (p. 90) also will not work. It only relocates the paradoxical duality at the level of the censor (pp. 93-94). In other words, the censor must be in "bad faith," which is still paradoxical.
(4) "By rejecting a conscious unity of the psyche, Freud is obliged to imply everywhere a magical unity linking distant phenomena across obstacles" (pp. 94-95). In other words, the act of repression itself is unitary, so how can it be accomplished by separate "minds?"

Perhaps one of the most disturbing questions is how repression could possibly ward off psychic pain. That is, how could a person be saved pain by keeping threatening information from one part of the mind when the defending part of the mind would have to understand the full import of that information? Fingarette (1969) makes a similar point and then asks:

> Once we abandon the notion that defense brings a kind of blissful ignorance to some 'agency' of the mind, the question forces itself upon one: Why should anxiety be reduced by defence any more than, better than, or differently than would be the case if we merely curbed our impulses and/or deceived others quite consciously? (p. 116)

A thorough consideration of the logical issues surrounding the self-deception paradox is beyond the intent of this paper. The interested reader is referred to

the analyses by Fingarette (1969) and Warner (1982). For our purposes it is enough to show that the psychodynamic approach is conceptually inadequate to the task. Before closing this discussion I will describe an approach to the self-deception paradox that represents a substantial advance over the psychodynamic one. Then in the next section I will review some approaches to similar paradoxes in contemporary cognitive psychology and show that the explanations are strangely parallel to the psychodynamic one and fail in similar ways.

In his classic treatment of self-deception, Fingarette (1969) advocates a shift in discussing consciousness from the language of perception to the language of volition. He argues that the crux of the difficulty has been our characterization of self-deception in the passive language of perception, such as "appear" and "see." He proposes that we shift to a metaphor of linquistic or paralinguistic volition, "to say" or "to avow", emphasizing the constructual nature of consciousness. This is very much like Polanyi's (1964, chapters 4 and 5) characterization of articulate awareness as an achievement requiring some mental effort.

Chapter 2 of Fingarette's book is an insightful demonstration of the difficulty of adequately explaining self-deception. He shows that in every case the philosophers who have tried to explain away the paradox have failed in one of two ways. Either they explain it in a way that is not paradoxical but fail to capture the "resistance" aspect of self-deception, or they succeed in capturing the phenomenon only to see paradox return in a variant form. If one "fails to notice," no resistance is involved, and it is simple ignorance— not self deception. One must *refuse* to notice. Nor can one's refusal be acknowledged by himself, even within is own mind. That would be cynical lying rather than self-deception. Self-deception differs from lying in that a person is genuinely surprised when and if his deception is revealed to him.

In Fingarette's volitional model he describes consciousness as "the exercise of the (learned) skill of 'spelling out' some feature of the world as we are engaged in it" (p. 39). His explanation of self-deception turns on a special kind of spelling out which he calls "avowal." To avow is to spell out something that asserts one's identity to oneself. A self-image is the product of this kind of construction, a product of willful action. In building a self-image we not only use some materials, we reject some. With this simile Fingarette intends to account for resistance. But, this account fails in both of the ways he shows that the others have failed. When he speaks of avowing some things and *failing to avow* others, he is speaking of ignorance — no resistance is involved. When he speaks of actively *disavowing*, he is dealing with the self-deception phenomenon alright (resistance is involved), but paradox returns. He slips back and forth between these two without acknowledgement in showing that the simile is both non paradoxical and adequate to the phenomenon of resistance. As he warned early in his book, "There is a particular slipperiness about the object of investigation" (p. 13).

But there is much in Fingarette's account of self-deception that is useful. His proposal that he we shift from a passive vocabulary in accounting for consciousness to an active volitional one is an important advance, as is his typification of the mental acts involved in self-deception ("spelling out" and "avowal") as being primarily linguistic and paralinguistic. Fingarette proposes that Freud came to similar conclusions with respect to the linguistic nature of consciousness:

> I have shown in detail elsewhere (*Self in Transformation, Chapter 1) that whatever the other changes in his theoretical views over the years, Freud always was convinced that language was the essence, or very intimately related to the essence, of preconsciousness and consciousness. This strongly suggests, though Freud never put it this way, that the 'mental act' denoted by 'hypercathexis' is essentially a kind of linguistic or paralinguistic act. It is, I suggest, much the same as what I have called 'spelling out'.* (Fingarette, 1969, p. 121)

In the summary of "transparency theory" in a later section of this paper, I will expand upon this view and propose that self-deception and even many kinds of "mental illness" can be productively understood as particular kinds of nonverbal assertion, that is, as types of paralanguage. (See Brown, Warner and Williams, 1985, for a more detailed explanation of this view.)

The Splitting of the Psyche in Contemporary Cognitive Psychology.

The major body of empirical work on the unconscious has been within the perceptual defense research tradition. Dixon (1971) and Erdelyi (1974) argue that the combined sum of all of this research has firmly established the existence of unconscious mental processes. In his review and resuscitation of the "new look in perception," Erdelyi (1974) sampled over 1000 research publications on perceptual defense and vigilance, "gargantuan proceedings" as he called them, and argued that the disillusionment with this research topic in the late 1950s was premature and mistaken. He went to great lengths to meet the methodological criticisms and to show that even when giving the critics the benefit of the doubt, there is still ample evidence to establish the perceptual defense and vigilance phenomena.

Most interesting for the thrust of this paper is his way of dealing with what Howie (1952, p. 311) calls "the most serious criticism of all"—the conceptual one. This criticism holds that perceptual defense cannot be established empirically because it makes no sense conceptually—it is paradoxical. Briefly put, the paradox is this: in order to defend against a threatening input, the perceiver must already know enough of its content to be intimidated. He therefore hides from himself what he already knows. Worse yet, he also must hide from himself the act of hiding the content, since the act includes his motive or reason for hiding it. Paradoxical indeed! This paradox is obviously a special case of the self-deception paradox, in this case applied to perception.

Erdelyi's answer to the perceptual defense version of this dilemma is to don the mantle of the information processing cognitivist. To an information processing theorist there is nothing at all surprising about parallel processors, even one called "conscious" and another that is not conscious. Nor need anyone feel threatened by animism in admitting unconscious processing in this day and age (Erdelyi, 1974, pp. 3-4), since all of these supposedly purposive entities can be explained mechanistically in terms of computer logic. His argument closely parallels one given a few years earlier by Dixon (1971, pp. 223-229), also a defender of the perceptual defense faith. For both theorists there seems to be an implicit acceptance that reduction to mechanistic entities, either in physiological or computer logic terms, makes the two-agent explanation acceptable. A paper by Dennett (1978) entitled "Why the Law of Effect Will Not Go Away" demonstrates how compelling this kind of argument can be at its best. In this view the artificial intelligence theorist can proceed in his computer program to posit agents, demons, and all kinds of animistic entities, as long as it is remembered that all such things will finally be reducible to "and gates," "or gates," etc., in the hardware language. The old behaviorists insisted upon both parsimony and mechanistic thesis. The new information processing psychologists (closely associated with the artificial intelligence establishment) are content with only one—the mechanistic thesis. They are willing to sacrifice parsimony and multiply agents as long as those agents are ultimately reducible to mechanistic elements.

These same kinds of phenomena have appeared in a much more recent tradition, one of the hot areas of the cognitive psychology of the 70s — selective attention. The development of the evidence and the debates are generally known and will be only briefly alluded to here. The controversy centers on the fate of unattended items in a dichotic listening task: are they processed semantically or are they somehow "filtered" from semantic processing and rejected on the

basis of superficial features? Some (Deutsch and Deutsch, 1963; Lewis, 1970; Corteen and Wood, 1972; Corteen and Dunn, 1974; Inouye, 1975) claim to have evidence for full semantic processing of the unattended channel. Others (Treisman, 1964; Treisman and Geffen, 1967; Treisman and Riley, 1969; Treisman, Square and Green, 1974; and Treisman and Gelade, 1980) claim that unwanted information from the unattended channel is rejected on the basis of *features* of the input, without full semantic processing.

Dixon (1971, Chapter 10) and Erdelyi (1974, pp. 11-12) have both recognized that the conceptual machinery used by attention theorists is essentially equivalent to their own accounts of perceptual defense, and on that basis have claimed a rightful place for perceptual defense theory in contemporary cognitive psychology. A major thrust of Dixon's book is the question of why the multitude of subliminal perception studies and perceptual defense studies have been ignored and spurned by academic psychologists while the closely related demonstrations of selective attention have been received as some of the most important cognitive research of the past twenty years.

Early approaches to attention theory (Treisman, 1964) did not involve a "two agent" explanation, but hypothesized a simple mechanistic filter that was preset to reject most words in the unattended channel while letting just a few with lowered thresholds (such as the subject's own name) through. This accounts for the so-called "cocktail party phenomenon" described by Cherry (1951) a few years earlier in which one can be attending to one conversation but then hear one's name mentioned in another conversation and immediately shift attention. Presumably the threshold for one's own name is permanently lowered. But other more recent evidence indicates that the filtering cannot be a "preset" thing, but must be done on the basis of the *meaning* of the input—full semantic processing of the unattended channel. For example, Lewis (1970) showed that even though subjects are not able to recognize and report the words of the unattended channel while "shadowing" (repeating back) the words of the attended channel, still when the word coming to the unattended channel was a synonym to the shadowed word in the attended channel (like "house" and "home") it slowed down the subject's reaction time in repeating the attended word. Of course there is no way for the subject to know that the words are synonyms unless he is processing each unattended word for meaning, and this without awareness. This kind of observation requires a very smart filter, one that processes meaning just as the "executive" or "central processor" does. We are left with a kind of "dual agent" cognitive model.

That these attentional theories would eventually be pushed to posit a splitting of the psyche (comparable to the Freudian one) was anticipated early by Deutsch and Deutsch (1963):

> . . . such evidence as the above would require us, on filter theory, to postulate an additional discriminative system below or at the level of the filter, perhaps as complex as that of the central mechanism to which information was assumed to be filtered.

With evidence (such as that from Lewis's study) indicating that the "filtered" unattended information is in fact processed semantically, we then ask what the "central mechanism" can do that the "filter" can't. If, as Dixon and Erdelyi suggest, this "filter" is also implicated in perceptual defense, then it must have knowledge of the whole personality structure of the person in order to discriminate threatening from non-threatening inputs. What started out in attention theory as a simple mechanistic filter is pushed by observations (such as those of Lewis, 1970; Corteen and Wood, 1972; Corteen and Dunn, 1974; Inouye, 1975) into becoming a system capable of dealing with meaning —a second mind, a bifurcated psyche reminiscent of the psychodynamic one. *How ironic it is that the academic psychology that spurned the "Freudian fictions" a generation ago now posits similar entities. But they are made respectable by*

the promise that they are reducible to Boolean logic and can be modelled on a computer. It seems acceptable to multiply "processors" to the extent necessary to account for the phenomena (with little concern for elegance or parsimony) as long as each one is ultimately explainable in physicalistic terms.

There have been objections within mainstream cognitive psychology to this kind of theorizing. Neisser in a 1976 book criticized the attentional theories of the preceding decade, primarily on the basis of their mechanical passivity. As he said in the introduction to *Cognition and Reality* (1976):

> The last of the questions that generated this book concerns the conceptions of attention, capacity and consciousness. In writing cognitive psychology a decade ago, I deliberately avoided theorizing about consciousness. It seemed to me that psychology was not ready to tackle the issue, and that any attempt to do so would lead only to philosophically naive and fumbling speculations. Unfortunately, these fears have been realized; many current models of cognition treat consciousness as if it were just a particular stage of processing in a mechanical flow of information. Because I am sure that these models are wrong, it has seemed important to develop an alternative interpretation of the data on which they are based . . . (pp. xii-xiii)

Neisser's 1976 book was strongly influenced by the perceptual theory of J. J. Gibson. In his classic 1966 treatise, *The Senses Considered as Perceptual Systems,* Gibson argues that to divide human action into discrete stimulus and response units is much too glib. Motoric action is an integral component in perceptual processes. Likewise, there is much perceptual feedback needed for skillful motor action. The passive "camera model" of perception comes from basing theory primarily upon visual perception. The motoric component is much more obvious in haptic (touch) perception. We must feel in a purposive way in order to perceive the shape of things. He argues that a subtler but similar motoric initiation is present in vision. Gibson also opposes "atomism," the isolation of single stimulus (or response) units, arguing instead for an active search and sampling of an "optic array" (or auditory or haptic array).

There is an important parallel between the way Sartre and later Fingarette have objected to the mechanistic Freudian way of dealing with the self-deception paradox by splitting the psyche, and the objections of Gibson and Neisser to similar models in information processing psychology. Fingarette's proposal, that much of the problem in dealing with the self-deception paradox can be avoided by changing from a passive visual metaphor to a volitional one is also parallel to Gibson's proposal for a shift to an active volitional model of perception. We will see in what follows that this approach, when combined with Polanyi's concept of tacit knowledge, does indeed open the way for a more adequate conceptualization of so-called "unconscious mental processes." But before considering Polanyi, we will examine one other place these phenomena have been studied within psychology.

Self Deception in Social Psychology.

Self-deception and related phenomena have also been studied within the field of *social* psychology but under other names. "Cognitive dissonance" (Festinger, 1957) is obviously related to self-deception theory. One of the typical experiments (Festinger and Carlsmith, 1959) is to have subjects perform a very boring task such as turning over spools for half an hour then paying them either one dollar or ten dollars to convince incoming subjects that it is an interesting task. Contrary to behavioristic predictions, the subjects who are reinforced less, the one-dollar subjects, actually come to believe their own statements, that the task was interesting, more than the ten-dollar subjects, the ones who are reinforced more. The usual explanation is that the ten-dollar subjects have adequate explanation for why they would deceive incoming subjects, but that the one-dollar subjects must do some rationalizing to "reduce the

dissonance" by convincing themselves that it really was an interesting task.

The phenomenon would be better titled "moral dissonance," since it is more than just a contradiction within the subjects' beliefs. Their supposed collusion with the experimenter in misleading incoming subjects (while actually being deceived by the experimenter) is an indictment of their integrity. But the usual way of discussing the findings is to argue that whenever a person holds beliefs that contradict one another, that person will be motivated to alter one or the other of the beliefs to restore balance to the cognitive system. I propose that when the dissonance is *only* cognitive, involving no moral culpability on the part of subjects, the effects would be quite different, and for that reason "moral dissonance" or "ethical dissonance" would be more apt terms for the phenomenon than "cognitive dissonance". I further argue that the phenomenon could even better be given Sartre's familiar term of *mauviase foi,* or self-deception.

In the era when cognitive dissonance theory was invented there was much less concern about experimenter ethics. The paradigm is a curious one for many reasons. The experimenter deceives subjects in order to catch them in a self-deception. In order for the study to "work," the subjects must be deceived about the true purpose of their participation. The most interesting thing about this whole line of experimentation is that the cognitive dissonance theorists do not mention or seem to notice the paradoxical nature of their subjects' actions. Certainly at some point in time the subjects noticed that the task was boring. What could they possibly say to themselves to later be convinced otherwise? And even if they could somehow successfully "repress" the contradiction, would they not also have to repress the repressive act, to an infinite regress?

A few years ago Gur and Sackheim (1979) published a paper entitled "Self-Deception: A Concept in Search of a Phenomenon" in which they set as their task to give adequate empirical evidence to support the self-deception concept as it exists in the philosophical literature. But I would argue that there has been adequate empirical precedent for the concept for some time now, even in some of the most major traditions of cognitive and social psychology. What is still missing in the psychological literature is a noncontradictory *theoretical* treatment of the phenomenon.

It is curious to note that although Festinger did not discuss his "forced compliance" studies in terms of their relevance for the concept of unconscious mental processes, later investigators in that research tradition did. Festinger accounted for his findings in terms of "dissonance" as an aversive motivational state that the person will seek to reduce. But Bem (1967) argued that the hypothesized drive was an unnecessary one, that all of the findings could be explained more simply in terms of environmental contingencies. He maintained that the person observes his own actions and then attributes cognitive and emotional states to himself just as he would in explaining the actions of an observed other. In several simple studies he demonstrated a very obvious thing: not only will a person believe his own statement more when paid less for giving it, but a second person observer will also believe the person more when he sees that the person was paid less for saying it.

But it was not Bem who saw the implications of his work for unconscious mental processes. In a 1977 *Psychological Review* paper entitled "Telling More Than We Can Know: Verbal Reports on Mental Processes", Nisbett and Wilson picked up on Bem's point (that we have no private access to the causes for our own actions but rather infer those causes from our observations of those actions, just as we would do in explaining the behavior of another person). In the intervening ten years between Bem's 1967 *psychological Review* paper and Nisbett and Wilson's 1977 one, Tversky and Kahneman's (1974) demonstration of the irrationality of decision making under uncertainty became well-known and Kelly's attribution theory (1967, 1972) called attention to attributional bias in social judgment. The case

against accurate introspection of one's mental processes was growing. Nisbett and Wilson (1977) reviewed a number of studies in the cognitive dissonance tradition, the learning-without-awareness literature, helping behavior research, and other areas — all demonstrating that people are not aware of the processes and reasons underlying their judgments. Altogether, they give impressive evidence for Mandler's (1975, p. 241) statement that the "analysis of situations and appraisal of the environment . . . goes on mainly at the nonconscious level."

Nisbett and Wilson are aware that the studies they review converge with the subliminal-perception/perceptual-defense research. They give a brief summary of that literature and comment (p. 239) that Dixon and Erdelyi were successful in obtaining a new acceptance for perceptual defense phenomena on the grounds of convergence with the selective attention and filtering research. They also mention the logical paradox problem of this literature, but like Dixon and Erdelyi they erroneously conclude that an information processing account resolves the paradox (see p. 24). The computer metaphor is a seductive one. Somehow it seems that if a computer "filters out" threatening information that we don't have to worry about how it could have been recognized as threatening without it first being received. Actually there are two paradoxes here, one having to do with perceiving below the threshold of perception (and it will not be easily dismissed by saying the person perceived it but forgot, as Nisbett and Wilson do on page 240), and the second having to do with resistance. Subliminal perception involves only the first, but perceptual defense involves both.

Before outlining an alternative way of dealing with these phenomena and these paradoxes, it may be helpful to examine the relationship between the concepts of subliminal perception, perceptual defense and self-deception.

A Comparison of Concepts.

Dixon's (1971) book not only reviews the perceptual defense and vigilance literature but the more general topic of all subliminal perception. *Perceptual defense* is a type of *subliminal perception*, but a special type that involves not only subliminal perception but also something akin to the clinical phenomenon of resistance. *Subliminal perception* simply involves perceiving "signals" that are below the usual threshold of perception. But *perceptual defense* involves a kind of refusal. Threatening information is not perceived even though neutral information at the same "amplitude" can be perceived. We can view perceptual defense, then, as a special case of subliminal perception. It is subliminal perception (of the threatening nature of the input) plus resistance. It involves refusing to perceive, but this refusal must be based upon some knowledge (ostensibly subliminally perceived) of the threatening nature of the input. It is also, then, a special case of the self deception paradox. The person must in some way know the information in order to refuse to learn it.

Figure 1 is given to clarify the relationship of four concepts: (1) unconscious processing (or as we prefer to call it "tacit knowledge and action"), (2) subliminal perception, (3) self-deception and (4) perceptual defense and vigilance. Many philosophers have made the point that terms such as these are "theory laden." That is, the terms themselves contain more than a description of the phenomena, they "buy into" a particular way of explaining those phenomena. In proposing an alternative theory, it is a difficult choice between using the old terms in order to have continuity with previous literature or choosing new ones that express the alternative explanation. I have stayed with the terms "subliminal perception" and "self-deception" to keep continuity with previous work (even though those terms don't adequately reflect how I view the phenomena), and I have also kept the term "perceptual defense," but I have abandoned the term "unconscious processing" (in favor of "tacit knowledge and action") because it is too far from the way I will explain such phenomena. The meaning of the term "tacit" will become more clear as we

examine Polanyi's philosophy in what follows.

Figure 1 is meant to show that the self-deception phenomenon is a special case of tacit knowledge and action. That is, to account for it we will first have to have an adequate general theory of tacit knowledge and action. The concept of self-deception involves tacit knowledge, but it also involves resistance.

Subliminal perception can also be considered to depend upon an adequate theory of tacit knowledge and action. It deals with the application of such a theory to the process of perception. Perceptual defense also deals with tacit perception, but tacit perception where resistance is involved. In that way it can be thought of as a special case of subliminal perception (subliminal perception plus resistance), and also as a special case of self-deception (the perceptual manifestation of self-deception).

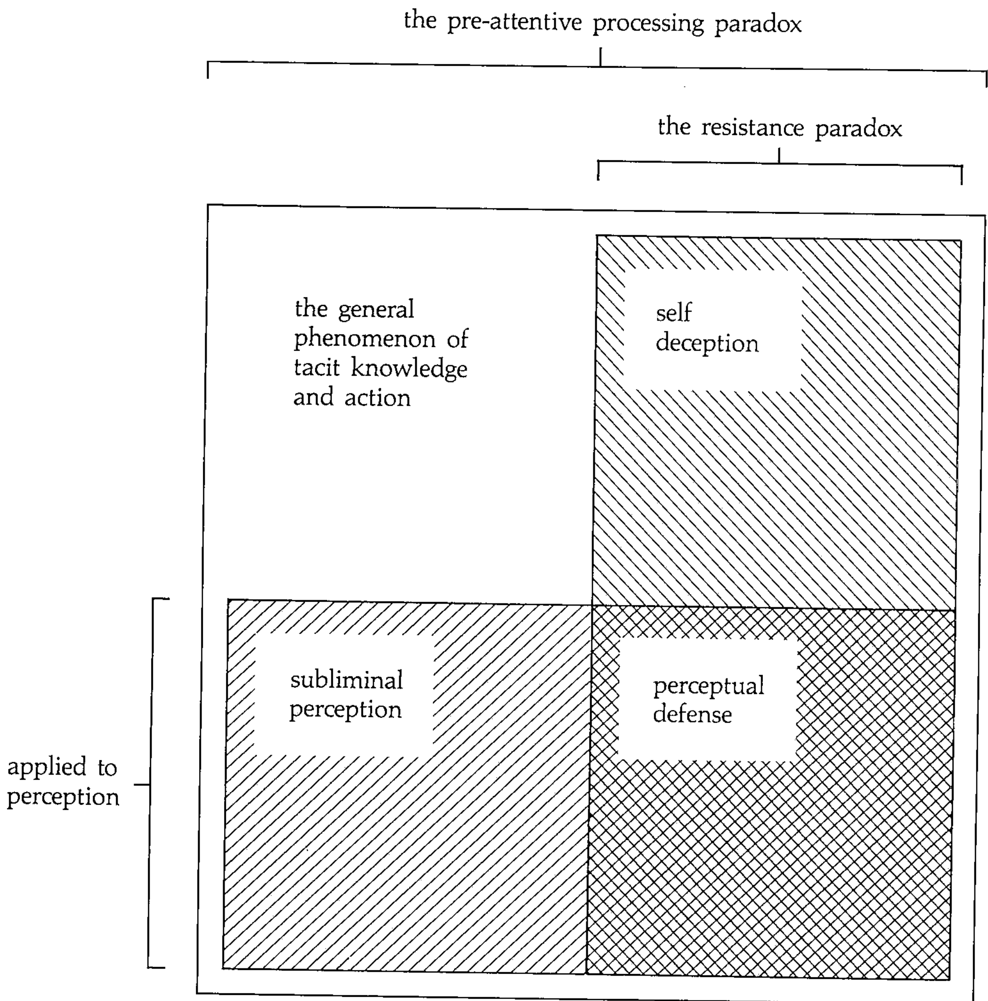

Figure 1. The relationship of the concepts of tacit knowledge and action, self deception, subliminal perception and perceptual defense to one another and to the two paradoxes.

Neisser and Gibson have both been resistant to the perceptual defense phenomenon. Given the confused way it has been treated in the psychological literature, that is probably to their credit. But it can be shown that phenomena that both of them acknowledge as *bona fide* involve the very same paradoxes. Gibson (1966) in his influential theoretical account of perception makes a brief allusion to these issues in a section entitled "The Muddle of Subliminal Perception." He says,

> Certain experiments purported to show that an observer could perceive meanings or suggestions unconsciously, or could discriminate them without awareness of the sensory difference between them. This seemed to imply unconscious defense mechanisms governing perception as well as motivated behavior—wishful perceiving. But to say that one can perceive in order not to perceive is a logical contradiction. Something is wrong somewhere. (p. 291)

It is clear from this quote that Gibson did not see a distinction between the subliminal perception hypothesis and the more restrictive hypothesis of perceptual defense.

Neisser in his 1967 book on cognitive psychology also gives perceptual defense short shrift and is roundly criticized by Dixon (1971) for ignoring the mass of evidence for the phenomenon. In his 1976 book, *Cognition and Reality*, which is based in large measure on Gibson's work, he avoids the issue altogether, except as his discussion of attention in Chapter 5 is relevant to the same issues. Neisser and Gibson are certainly justified in rejecting the conceptual muddle of the subliminal perception literature, but curiously, Neisser's own account of "preattentive processing" in his 1967 book involves the same logical contradiction that underlies accounts of subliminal perception. He proposes a rapid kind of pre-processing in perception that is used to decide whether a more detailed "figural synthesis" is in order. But how could such a decision be made without knowing the content of what is to be perceived, and if it is already known, what could further processing accomplish?

Actually what I am discussing here is not just one paradox, but two. The first and the easiest to resolve is the paradox of tacit knowledge and action and the special case of it called "subliminal perception." In this paper a resolution will be proposed to this paradox in terms of "transparency theory," a view that draws upon Polanyi's philosophy of tacit knowledge, Gibson's view of the nature of perception and findings of contemporary psychophysics.

The second and more difficult paradox is that of self-deception and its special case in the perceptual domain, "perceptual defense." This paradox is a more difficult one to explain and the phenomenon is a more complex one, for it involves all that we encounter in a general theory of tacit knowledge and action, plus one other thing—the phenomenon of resistance. Although there will be some suggestions about this paradox in what follows, an explanation of the resolution of this paradox will not be attempted in this paper. The interested reader is referred to Warner (1982), and also to the outline of some of his arguments that appears in the chapter by Brown, Warner and Williams (1985).

Polanyi's Two Kinds of Knowing.

In his classic philosophy of science book, *Personal Knowledge*, Michael Polanyi (1962) wrote two brief but profound chapters on cognitive theory (Chapters 4 and 5). The work has insights into the subtleties of human cognition that far surpass the current work in information processing. His approach has much in common with Gestalt psychology, but he explains more than perception, and his view of man is more telelogical than the Gestalt one.

One of his most important explanations concerns the two kinds of knowing: *tacit* and *explicit*. It may seem unusual that one would propose cognitive theory in a philosophy of science book, but his intention seems to be to show the limits of scientific knowledge. Science deals with

explicit knowledge. The business of science is to produce knowledge that can be specified, verbally transmitted and publically verified. But that is not the only kind of knowledge that is of value to a culture. Indeed, even the art of science itself, the way in which effective science is conducted, is not specifiable but must be learned by apprenticeship.

To clarify what is meant by tacit knowing, he gives the example of the crafts of medieval Europe. The half literate Stradivarius created violins superior to anything that can be produced today, despite our technological advances. Yet one who has this skill would never be able to put it into words. It can only be learned by apprenticeship. For that reason many of the most valued crafts of the past have been forever lost. Similarly, in British Common Law the decision of the judge is often of greater value than any reasons he can give for that decision, for the actual reasons are assumed to be subtle and unspecifiable. This kind of "unconscious," if we wish to still call it by that name, is much different than the kind proposed by psychodynamic theory. Whereas the psychodynamic unconscious is hypothesized to consist of primitive and irrational urges that must be tempered by the rational ego, the kind of "unconscious" we are here describing is in a sense much higher and more rational than our specifiable knowledge, or "conscious" mental life.

This kind of unspecifiability is related to what one has in mind when saying, "I have a clear idea, but I just can't put it into words." Polanyi expressed it succinctly with his maxim, "We know more than we can say." We could refer to this first way knowledge can be unspecifiable as *ineffability.* Polanyi (1962, p. 56) discusses a second way knowledge can be unspecifiable, which he refers to as *logically unspecifiable.* As an example of this he points out that a skilled pianist could certainly identify each of the chords that he plays in a given piece, but may not be able to do it, even to himself, while still playing. In other words, he can focus on the whole performance or on a part, but not on both at the same time.

There are, then, two ways that our own thoughts, precepts or actions may be unspecifiable to us. They may be ineffable or they may be logically unspecifiable. The concept of something being logically unspecifiable is explained in terms of two kinds of awareness: *focal awareness* and *subsidiary awareness.* In order for the pianist's performance to proceed smoothly, he must focus on the totality, the Gestalt of the piece, as he proceeds, with the particulars being relegated to subsidiary awareness. If he were to focus too intently upon any part, the performance would falter, the sense of context would fail.

When a skilled carpenter hammers a nail (p. 55), he is aware of both the hammer and the nail, but in different ways. He attends through the hammer to the nail. The hammer becomes like an extension of his body, such that he doesn't focus on the feelings of the hammer against his palm, but focuses through them to the contact of the hammer with the nail. The contact of the hammer against the nail is in focal awareness and he is subsidiarily aware of the feelings of the hammer against his hand. The nail is the object of his attention but the hammer is an instrument of attention.

Polanyi's description of language in these terms (p. 57) is particularly insightful. When we read, words become instruments of attention with the underlying meaning as the object of our attention. If we focus instead on the individual words, we fail to get the apprehension of the whole. It is thus possible to read too slowly. We can identify every word separately, but there is no coherence to the whole, and we go over it and over it without comprehension. In Polanyi's words, "all particulars become meaningless if we lose sight of the pattern which they jointly constitute."

He refers to this as "the transparency of language" and describes it in this way:

> My correspondence arrives at my breakfast table in various languages, but my son understands only English. Having just finished reading a letter I may wish to pass it on to him, but must check myself and

> look again to see in what language it was written. I am vividly aware of the meaning conveyed by the letter, yet know nothing whatever of its words. I have attended to them closely but only for what they mean and not for what they are as objects. If my understanding of the text were halting, or its expressions or its spellings were faulty, its words would arrest my attention. They would become slightly opaque and prevent my thought from passing through them unhindered to the things they signify. (p. 57)

I have briefly summarized five concepts in Polanyi's account of cognition:

(1) two kinds of knowledge—tacit and explicit

(2) two ways knowledge is unspecifiable—ineffable and logically unspecifiable

(3) two kinds of awareness—focal and subsidiary

(4) two ways we attend—*to* objects of attention and *through* instruments of attention

(5) the transparency of language

I will now incorporate these concepts, together with some insights from Gibson's theory of perception and some recent findings in psychophysics, to propose an alternative account of "unconscious mental processes."

The Rudiments of Transparency Theory

Up to this point in this paper I have detailed what I think is perhaps the single most important unresolved matter in psychology—the phenomenon referred to as "unconscious mental processes." I prefer to refer to it as "tacit knowledge and action." It is, as recognized by the "new look in perception" theorists of the 1950s, the issue that brings together areas of psychology as diverse as psychophysics and psychodynamic theory. It extends to the central problems of attention theory in cognitive psychology, to recent directions in social psychology having to do with how we judge the actions of ourselves and others, and to the philosophical literature on self-deception. There are many manifestations and many aspects of this problem as diagrammed in Figure 1.

In what remains I will outline a general approach to psychology which we have called "transparency theory" (Brown & Williams, 1983; Brown, Warner & Williams, 1985; Brown, 1986) after Polanyi's discussion of the "transparency of language." The theory has applications to perceptual and cognitive psychology generally, as well as fields as diverse as clinical psychology and second language acquisition theory.

To adequately explain the theory and its relationship to the theorists mentioned above would require a number of papers longer than this one. It will be sufficient for my purposes to summarize seven major premises of the theory in contrast to the traditionally received views within psychology (as shown in Table 1, page 31) and briefly explain each.

The first "received" premise to be challenged is the assumption of "atomism," the proposition that the entire sensory array consists of discrete stimulus units and that human action can be understood in terms of discrete response units. It is interesting to note that Charles Taylor has shown in his very influential philosophical treatise *The Explanation of Behavior*, 1964, that teleological explanations of behavior are only circular when one assumes atomism. We are arguing that it is this same fallacious assumption that makes "multiple processor" models appear necessary in accounting for the results of "subliminal perception" studies. We propose that every demonstration of the existence of "unconscious mental processes" or "subliminal perception" rests upon this assumption.

If this can indeed be demonstrated, we have another profound irony. Whereas the thousands of studies of subliminal perception and perceptual defense in the "new look" tradition were intended to empirically verify and defend the concept of an unconscious against behaviorist skepticism, those very demonstrations only have force as arguments of unconscious mental processes if one assumes atomism. That is, the empirical

Table 1. The premises of transparency theory in contrast to the received view.

Seven Received Premises:	*Seven Premises of Transparency Theory:*
1. Sensory input can be considered as discrete stimulus units and behavior can be considered as discrete response units. (Atomism)	1. We do not see or hear discrete "snippets," but we intentionally draw information from the "optic array," "auditory array," etc. Human action is also a patterned whole. Our fundamental mode of perception and action is tacit. (Tacit Holism)
2. Information below the usual threshold level is processed unconsciously. (Subliminal Perception)	2. There are not sensory thresholds. Detection of a weak stimulus is rather a continuum. Every quantum of light is "percieved," and every minute change in amplitude of sound. (Signal Detection Theory) There are discontinuities in perception that can be mistaken for sensory thresholds, but they are predictable from temporal and spatial context and the personality and emotive state of the person. They can be used as mirrors of cognitive style.
3. Perception is determined by the sensory input altered by past experience or learned biases. (Naive Realism)	3. Our purposes are reflected in our perceptions. Perceptions are also responses, an act of will. (Constructive Alternativism)
4. Behavior is caused by or altered by physiologically determined emotional reactions. (Psychologism)	4. Much of what passes for emotion is more like a nonverbal language by which we accuse, blame and assert. At least some emotion is therefore a response, and act of will. (Agentivism)
5. There are separate information processing systems for cognition and emotion. The emotional system is faster. (Fragmentation of the Psyche)	5. Every change in the Gestalt is perceived, but parts are not noticed without mental work which takes time. (Physiognomic Perception)
6. Dichotic listening studies have had important implications for attentional theory. Although the subject is not aware of what is said in the unattended channel, there is evidence that at least some kinds of information can get through. This is usually explained in terms of a filter that lets some things through and blocks others. (Fragmentation of the Psyche)	6. Active perception makes some aspects of the sensory array "ground" rather than "figure". The "figure" is in focal awareness and the "ground" is in subsidiary awareness. A change in the ground will alter the percept of the whole, but perhaps not be noticed as a part. That would require attention and mental work. In the artificial situation of dichotic listening, time constraints preclude articulate awareness of the unattended channel but it has an effect on the whole. (Tacit Holism)
7. We think we know the reasons for our actions, but it is illusory. Contingencies determine our choices and we give ourselves rational reasons for why we made them. (Implicit in this view is the premise that intentional action must be introspectable, articulately specifiable.) (Epiphenomenalism)	7. Most intentional action is tacit, not articulate nor articulable. To introspect what we have done or why we have done it requires mental work of a kind that we seldom do. But even when we do it, our explanations will always be inadequate for the same reasons that we cannot adequately explain any skilled performance—such knowledge is unspecifiable. But that does not mean that the action was not agentive and intentional nor that it was caused by environmental constraints. (Tacit Holism and Agentivism)

demonstrations and arguments only have force from within a behavioristic (or other atomistic) framework. As soon as one gives up on this assumption of atomism, then a divided psyche or a second mind or an "unconscious" is not needed to explain the observations.

The major opponent of atomism within mainstream academic psychology is Gibson (1966). In a paper dealing with Gibson's "ecological optics" theory, Neisser (1977) argues that the revolutionary nature of Gibson's idea has not been fully appreciated, that "his innocent-sounding suggestion that we make a new description of the stimulus would render that whole century of theory obsolete" (p. 17). It seems natural enough, he continues, for psychologists to first consider the simplest experimental situation, a single stimulus and response. He goes on to show that in the case of perception (as well as the learning of nonsense syllables and animal conditioning) the strategy has backfired in that the unnatural and impoverished "punctate stimulus" situation has led to unnecessarily complex perceptual theory.

In a parallel way we propose that if one begins by assuming atomism, it will necessarily follow that he will eventually be pushed by empirical demonstrations to posit something like an unconscious component to the mind, or a filter. It will be necessary to in some way fragment the psyche. He will then conclude that there is adequate empirical evidence for "unconscious mental processes" when that construct is in fact an artifact of the atomist assumption.

But we will begin in another way, siding with Gibson that perception involves active "information pick-up" from a total optic array (or auditory array, etc.) with the apprehension of parts requiring mental work. This last statement is really a combining of Gibson's holistic theory of perception with Polanyi's account of focal vs. subsidiary awareness. We propose that most of what we perceive at any one time is in the background, tacitly apprehended in the service of some other focal goal. For example, in driving a car we focus on only certain parts of the optic array, most of what we "see" becomes subsidiary background. We will refer to this premise as *tacit holism.*

The second of the received premises, the hypothesis of subliminal perception, is not only a contradiction in terms ("perception below the lower limit of perception"), but it is based on a psychophysical concept, the threshold, which no longer has adequate empirical support. One of the major contributions of contemporary psychophysics in the 1950s and 1960s was to quantify the step function hypothesis of threshold theory (the "two-state" model which proposes a point of discontinuity at which we begin to hear, see, etc.) and the opposing continuous function hypothesis of signal detection theory (the "multistate" model which proposes a continuum of detection from "no signal" up through increasing magnitudes of signal). The psychophysical functions for these two models are shown in Figure 2, page 34. The signal detection theorists (Tanner and Swets, 1954; Swets, Tanner and Birdsall, 1961; Green and Swets, 1966) demonstrated that the "two-state" model gives rise to an ROC curve ("receiver operating characteristic curve") that has two facets with inflection at the "ideal" decision point, while the multistate model gives rise to a smooth continuous ROC curve (which is under certain conditions an "isosensitivity" curve). They found no perceptual data that would fit the two-state ROC curve, but rather all that they tested fit the multistate continuous curve. In other words when the threshold model is made mathematically precise in this way, there are no data to support it.

In a classic study of the minimum amount of light necessary to be detected, Hecht, Shlaer and Perinne (1942) demonstrated that ten quanta absorbed by the retina are sufficient for detection. In a recent update of this work in terms of signal detection theory, Sackett (1971, 1974) has demonstrated that retinal absorption of a single quantum is sufficient for detection to take place. Actually this could have been anticipated from the signal detection theory demonstration that

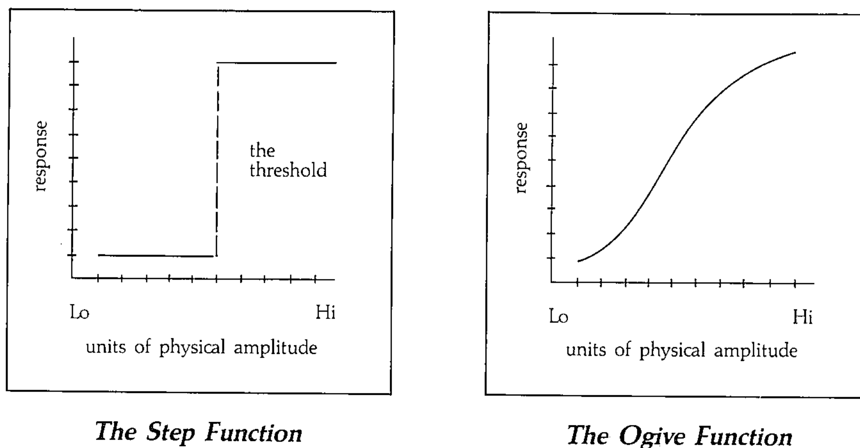

Figure 2. A comparison of the step function of threshold theory with the ogive function of multistate theory.

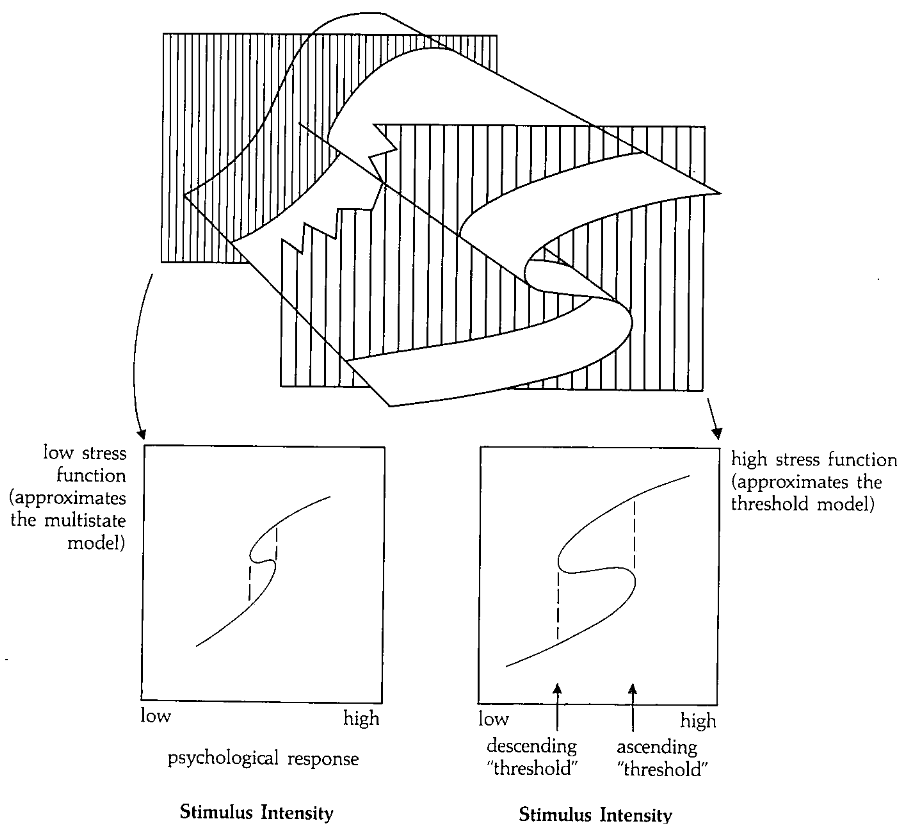

Figure 3. The cusp catastrophe as the general case incorporating both the multistate model and the threshold model.

there is no psychophysical evidence for a threshold. If detection of a weak stimulus is a continuous function of amplitude rather than the step function posited by threshold theory, any increase is enough to be detected given enough signal and noise trials. It becomes a statistical problem of probability to show detection of a weak stimulus rather than a perceptual one.

But the classical psychophysicists had good reason to take the concept of a threshold seriously. When one arranges weak stimuli in an ascending or descending series (the method of limits), it *subjectively seems* that there is a point of discontinuity, a place where the present stimulus seems noticeably louder than the ones before, even though the series are equidistant in amplitude. The ascending series has a different "threshold" or point of discontinuity than the descending series. For years psychophysicists have just averaged these, but the distance between the two is in fact much more interesting than their average. Using a three-dimensional model called the "cusp," one of the seven fundamental surfaces in Thom's (1975) topological system that is called Catastrophe Theory, Inouye (1978) has demonstrated that the distance between the ascending discontinuity (or "catastrophe" as Thom calls them) and the descending one is much different for schizophrenics than for normals. Earlier psychophysical studies of schizophrenia had failed in the expectation that schizophrenic thresholds would differ from normal, but with the Catastrophe Theory approach Inouye has shown that schizophrenics do differ psychophysically from normals. They perseverate more. The distance between their ascending and descending points of discontinuity is greater. It has also been demonstrated that a normal person under stress has a greater interpoint distance than when not under stress.

The cusp catastrophe is nothing more than a three dimensional surface with an ogive "lazy S" curve at one end and a "hard S" at the other as shown in Figure 3, page 36. It is geometrically the general case of which both the threshold model and the continuity model (shown in Figure 2) are special cases. The continuity model is, of course, identical with the lazy S end of the surface, and the hard S end has two thresholds, one as one ascends from left to right (as shown in Figure 3) and one as one descends from right to left. The "high stress" function (a cross section from the surface) shown in Figure 3 is characteristic of schizophrenics and the "low stress" function (the second cross-section behind the first in Figure 3) is characteristic of normals.

We amend our position, then, to say that there is a threshold (or rather multiple thresholds), but it is cognitive rather than sensory. Thresholds are a mirror of emotive state and cognitive style. What has been discovered is no more than an example of the complementary perceptual processes of assimilation and contrast put forth years ago by the Gestalt psychologists, but this time with a topological way of predicting when assimilation (not noticing a difference) will occur, and when contrast (exaggerating a difference) will occur. And it becomes a useful index of personality and psychological state.

Gibson has made a profound contribution in providing the concepts to begin the work of a holistic analysis of perception, but it is not altogether clear how to turn his concepts into experiments. The topological surfaces of Catastrophe Theory provide a way of making precise predictions about the ways in which judgments are predictable from spatial and temporal context. They are qualitatively precise parables, or "canonical forms" that can be directly tested in perception research as well as in person perception from voice research (as outlined by Brown, Warner & Williams, 1985).

Our objection to the third received premise which we have pejoratively referred to as "naive realism" is in one way parallel to Gibson's objection. He also has rejected the traditional typification of perception as "sensation colored by conception or past experience." But our proposed alternative premise is one of the

places where we most differ from Gibson and from Neisser. Gibson does move us forward from "information processing" (as though information were pushed through us) to "information pickup" (an active selecting perceiver), but he doesn't specify how it happens. As Hamlyn (1977) has pointed out, although Gibson moves in the direction of active holistic perception, he finally leaves the self, the agent, the perceiver out of perception. In his description of information pickup he claims that the senses functioning as perceptual systems "can obtain information about objects in the world without the intervention of an intellectual process" (Hamlyn, 1977, p. 13). This leaves one hard pressed to extrapolate Gibson's theory to abnormal psychology. He deals only with veridical perception, certainly not that which is "pathological." Neisser (1976) also admits the Piagetian concept of a perceptual process of accommodation (altering schemata to fit incoming information), but not the complementary process of assimilation (altering incoming information to make it fit preexisting schemata), and is also therefore not able to account for pathological perception.

But the alternative premise that we offer is much more radical than just including Piaget's concept of assimilation. We are not proposing that the person's perceptions are altered according to existing intentions, beliefs, etc., but that they are acquired in the first place in a form that reflects intentions, beliefs, etc. That is, we are proposing that our perceptions are a reflection of personality and that they are an act of will, every bit as much a response as an input. We are agreeing with Gibson in rejecting the view that perceptions are just sensations colored by past experience and bias, but we differ from him in our insistence that the particular information that will be picked up and even the way it is experienced will be different for different persons, it is a reflection of intention, personality, and cognitive style. The perceptual or sensory experience in its rawest form is already an expression of the person and the person's state as demonstrated by Inouye (1978) in the psychophysical studies referred to above.

Although this is a radical proposal it is not without precedent in the clinical and philosophical literature. A number of theorists (Kelly, 1955; Rychlak, 1981, p. 466; Warner, 1982) have also proposed that we can choose to construe our circumstances in a number of ways ("constructive alternativism," Kelly called it), and much else will be determined by that particular choice. Kelly's personality test, the REP test, is based upon the premise that we can best understand a person by understanding how he views significant others. This kind of perception, the way a person perceives another person, is at the highest level of what could be referred to as perception, whereas the psychophysical demonstration is at the lowest, but we are proposing that at both levels and everything in between the person and his intentions are written upon the way he perceives. We see things as we are, not as they are.

The fourth premise of transparency theory is somewhat like the third. We are proposing that many emotions, like perceptions, can productively be considered as response rather than a cause of response. The psychologistic view of emotions has them as biologically based reactions that cause behavior: "His anger caused him to do it." Although we will concede that many emotions, such as fear or grief, are very much toward the automatic reactive side and have a strong biological basis, others like anger and depression can be better understood as a kind of intentional nonverbal message. Anger can accomplish a number of things. It can be an effective way of accusing another since it is an intentional message that poses as involuntary (Warner, 1982). And, as Solomon (1977, p. 284) has argued, "anger is a great equalizer, judging one's antagonist as an equal. To be angry with a child is to treat him as an adult . . . to be angry with a superior is to raise yourself to his level." Likewise depression can have instrumental uses. This approach to the emotions can have important implications for nonverbal

communication research (Brown, Warner & Williams, 1985).

The fragmentation of the psyche by the "information processing" psychologists had become quite complete by the 1980s. Not only do they posit conscious and unconscious processors, but also separate systems for cognition and affect, and evidence has it that the affective system is faster (Zajonc, 1980). We propose that the same results can be explained alternatively in terms of a part/whole distinction and that what Zajonc has demonstrated is that the most primitive and fundamental kind of perception is holistic, that it takes mental work to notice parts (premise 5).

The Gestalt psychologists noticed this phenomenon long ago and referred to it as "physiognomic perception." The basic idea is that we do not look at a face and notice the glaring eyes, the grinding teeth, the red flush and conclude that the person is angry, but rather the impression of anger is immediate and unmediated and the component parts are only noticed afterward if at all. "We must assume that features like 'threatening' or 'tempting' are more primitive and more elementary contents of perception than those we learn of as 'elements' in the textbooks of psychology" (Koffka, 1928, p. 150). Likewise, the statistician Chernoff (1973) has shown that complex multivariate data can be apprehended much more quickly in the form of stylized human faces than in traditional graphs. The Gestalt of a human face has an immediate, tacit meaning that precedes any notice of parts.

Rather than positing a fast emotion-processing system and a slow cognitive one, the empirical evidence can be explained by saying that perception is essentially tacit and holistic and that explicit notice of elements and parts requires mental work. In a recent voice study Feldstein and Bond (1981) demonstrated that when subjects are given the task of judging the speech rate of voices that are in fact equivalent in rate but vary in terms of frequency and intensity, they will judge higher frequency voices to be faster and higher intensity voices also to be faster. (See also Bond and Feldstein, 1982.) But we would argue that judging rate or intensity or any other single feature of voice is not a very natural thing for a person. The impression from voice is much more global. When pressed for a judgment we can make it, but the dimension we think we are judging may not at all be the one the experimenter is varying. Such attention to a part requires mental work, but it will not be very accurate without practice and feedback.

We are now ready to deal with the contradictory results of the dichotic listening studies (premise 6). Whereas Treisman (1964) provides evidence that the subject cannot even accurately identify the language in which the unattended words are spoken, Lewis (1970) gives evidence of full semantic processing of the unattended channel. The two seem contradictory, but this is exactly what Polanyi would expect on the basis of this concept of the transparency of language. It is not necessary to notice words or even the language identity of the words to have an apprehension of the meaning. Skilled reading involves attending *through* the words (the instruments of attention) to the meaning (the object of attention). (See Brown, Inouye, Barrus and Hansen, 1981.)

In the Lewis (1970) study, the subject is not able to identify specific words from the unattended channel (they are not in focal awareness) but rather it is shown that synonyms slow down his reaction time. In an atomistic analysis of the situation the results are mysterious. We have evidence of a stimulus affecting the person's response without the usual awareness of having been perceived—presumably it was processed unconsciously. In a holistic analysis it is simple—an unnoticed part can alter the apprehension of the whole. The fragmentation of the psyche into conscious and unconscious processes is a natural result of considering perception in terms of discrete stimuli rather than a patterned whole.

One can argue that the whole cognitive psychology enterprise called "attention theory" is a way of patching up the mistaken premises of 50 years of

behaviorism. As Kahneman (1973, p. 2) has confessed, "Indeed, the main function of the term 'attention' in post-behavioristic psychology is to provide a label for some of the internal mechanisms that determine the significance of stimuli and thereby make it impossible to predict behavior by stimulus considerations alone."

Likewise, we need not conclude from the evidence reviewed by Nisbett and Wilson (1977) that because our attributions of reasons for our choices and actions are in error, that the actions are in some way "caused by behavioral contingencies" or are otherwise nonintentional (premise 7). Most intentional action is tacit. To try to articulate what we have done or why we have done it requires mental work, but will always be inadequate.

Consider a misunderstanding between a husband and wife. Usually the two will not agree afterward as to what caused it, what part each played, and in general what happened. A great deal of what happens is tacit and involves nonverbal communication. Even if the couple agree as to what happened, their agreement and their description will have a strong note of arbitrariness to it. An interpersonal occurrence of that kind is a very subtle thing, only a small part of which can be summarized with words. To summarize it requires mental work, and there are many such possible summaries, each distorting or missing much of what really happened even as it clarifies. So also, any person's description of himself or even of another person is an attempt to put what is essentially global and tacitly experienced into a package of a few words. Even an insightful characterization will distort and fall far short even as it may capture a part in explicit language.

Summary.

In this paper I have reviewed some of the objections to the psychodynamic model from the existentialist philosophers and argued that they have adequately demonstrated that the psychodynamic explanation of repression fails on logical grounds. I have also tried to show that many contemporary cognitive and social psychological models are also based on a two-agent or split-psyche form of explanation and can be faulted for the same reasons. Like the psychodynamic model, they also lead to paradox, and of course it makes no sense to look for empirical confirmation of a theory or model that is logically contradictory. In the last part of this paper I have outlined an alternative account of the empirical findings that are often used as evidence for unconscious mental processes. I closed the paper by spelling out seven premises of this approach in contrast to the received view.

Sometimes even after I have given the contrasts between "them" and "us" that are displayed in Table 1, someone asks if the transparency theory approach is really anything more than exchanging the words "tacit vs. explicit" for "unconscious vs. conscious." In summary I will mention four major differences between the transparency theory view and the currently received view in cognitive psychology:

(1) The information processing view is like the psychodynamic one in that it involves a split psyche, two agents in the head. Of course they do not describe it in those terms, for they are using a computer metaphor and talking about "processors." But once all of the evidence is in, the "filter" must have all of the discriminative properties of the "central processor", the conscious mind. They have in effect a two agent model. Our explanation involves only one agent and explains the "nonconscious" nature of some inputs in terms of the structure of the act being carried out by the person rather than bifurcating the mind into a conscious component and a nonconscious component.

(2) The received view in cognitive science considers "processing without awareness" to be some kind of discovery or anomaly with the usual case being explicit awareness of and a veridical registering of all that one perceives. This is, of course, also true of psychodynamic theory: the Unconscious is viewed as some kind of major scientific discovery that waited for the dawning of the twentieth century. It comes as a kind

of revelation to modern man that there is much more lurking in the depths of his mind than he had ever supposed. But we argue that the Unconscious is an artifact of mistaken assumptions rather than a discovery. It is a product of misreading the nature of resistance in the primary clinical observations. Likewise, the empirical demonstrations of unconscious mental processes are an artifact of assuming atomism. In contrast, transparency theory holds that our primary mode of perception is tacit and holistic, such that it requires some mental work to notice components of the perceptual Gestalt or to make them explicit. Apologists sometimes use eye-blinking, breathing, or heart beating as evidence for the existence of unconscious processes. But that is using the word too broadly. One certainly wouldn't credit Freud with discovering that kind of unconscious process.

(3) If one wishes to refer to Polanyi's concept of tacit knowledge as "unconscious" it must be recognized that it is a very different kind than what Freud describes. The Freudian one is primitive and irrational, the "pleasure principle" rather than the "reality principle." But Polanyi describes tacit knowledge as super-rational, much subtler and wiser than that which we can make explicit. Indeed he characterizes the great challenge of science as seeking to make explicit more and more of the wisdom of tacit apprehension and the subtleties of skilled performances.

(4) The "two-agent" explanation has the effect of cutting off inquiry, or at least pointing it in unproductive directions. Once you have said that the person took in the information unconsciously (thus attributing the inability to articulate the information to the structure of the person's mind) where do you go next? But if instead the reason for the person's inability to articulate the information is to be found in the structure of the act being carried out or within the structure of the perceptual information available to the person, we have a challenge to understand that structure and explicate why some aspects of a performance or a perception are articulable and some are not. We are well on our way to an adequate psychology of skills.

Recently transparency theory has been applied to the growing literature on second language acquisition (Brown & Williams, 1983; Brown, 1986). It provides a theoretical justification for many of the major second language observations of the past twenty years. For example, the concept of "objects of attention" vs. "instruments of attention" is foundational to the observation that one acquires language skill much more efficiently if the language is used as a tool in doing something else rather than being the focus of direct study. The old psychodynamic concept of unconscious is a "tack on" as far as language learning theory is concerned, it leads to no such insights.

It took us fifty years in the development of American psychology to see that behaviorism was going nowhere. Hopefully it won't take another fifty for us to see that excessive mentalism justified by a computer metaphor, with multiple processors in the mind, also isn't going anywhere. I am of the opinion that the major reason psychological theory has progressed so slowly and been of so little help with our practical problems is because it has been plagued by heavy, occult explanatory burdens like the so-called "unconscious mind" and by mistaken assumptions like atomism.

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PERIODIC MADNESS: IDENTIFYING AND TREATING PMS

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Presented at the AMCAP Convention, 4 October, 1984

Last week I picked up my copy of *Premenstrual Syndrome* by Ronald V. Norris, M.D. and browsed through it. Having been a patient of Dr. Norris in Boston and having been interviewed for his book the following year, I paid particular attention to the case study of the Mormon woman in Salt Lake City who had experienced recurring cyclic headaches, depression, irritability, and fatigue. Her marriage had been strained, and she had suffered pain and unexplained low self-esteem—in spite of her productivity and satisfying life as a homemaker and freelance writer. Dr. Norris described the troubled life of this Mormon woman and her otherwise happy family, in subsequent sections of his book.

Somehow, I find it ironic that the very woman described in such painful terms in a physician's book is now standing at a podium at the Institute of Religion—where I once served on the board of the LDSSA. For me (who once thought I was crazy) to be asked to address such an astute group of mental health professionals is a twist that I would not have predicted fifteen years ago. But then my husband, Mike, was a member of a student ward bishopric, and I was plugging along as his dutiful, supportive wife. With each passing month, I developed headaches, fatigue and mood swings that were predictable enough to be a way of life.

While serving on the LDSSA board, I was waiting for a missionary and writing frequent letters to him. I have often thought how interesting, yet disquieting, it would be to reread those letters, and see in my own handwriting what this missionary (who subsequently became my husband) observed as cyclic changes in my thinking, behavior, and outlook on life.

After I married, graduated from the university, and embarked on my career as a home economics specialist and journalist at the *Deseret News*, the mood swings worsened—especially after giving birth to my first child. I stayed home with the baby and wrote a weekly newspaper column, but had increasing difficulty meeting my deadlines because of intensifying headaches, depression, fatigue, and irritability. Some days I felt out of control, and there seemed to be no explanation because my life was so very full, so, I sought medical help. My obstetrician, who is an active Latter-day Saint, prescribed an antidepressant. He said the birth of that baby had caused a biochemical imbalance in my brain. The medication was very expensive and gave me temporary relief from the symptoms, but not long-term relief. Soon I was experiencing the mood swings again.

Then came the birth of our second child, subsequent postpartum depression, a move into our first home, and an untimely calling to be Relief Society President at the age of 25. After two years of full-time monitoring of compassionate service, opening socials, visiting teaching districts and three boards (this was before the consolidation schedule), my husband was promoted, and we moved to the Seattle area.

Within the year we moved again—this time to Washington, D. C. I became pregnant with our third baby. My symptoms worsened, and my ill health put a strain on my marriage. Here was this young father who thought he had married a woman with a sense of humor, a positive outlook on life, a high energy level

and productivity, and even a degree in home economics! She should certainly be able to keep a house clean, put nice meals on the table, and be a responsible wife and mother. Unfortunately, he witnessed each of these traits slipping away. After a bad "spell," I would ask how he had the patience to live with me. He would always say—"You know, I think I can handle this, as hard as it is for both of us, because I always know you'll bounce back."

In Washington D.C., I continued to seek medical help. I remember paying $400 for lab tests, only to be told that my blood chemistry was normal, and that my physical exam showed nothing unusual; so if I had these mood swings, I should see a psychologist. That bothered me. I had thought of myself as a person who had self-control and self-direction. The need for psychotherapy didn't fit my agenda.

My experience with psychotherapy was not too helpful. I would call the therapist's office on a really bad day and say, "I don't know what is the matter with me. I am feeling dreadfully low and shaky for no reason. I need to come in and talk to somebody." The receptionist would say, "Well, sure. The next available appointment is in ten days." She would book me and I'd show up ten days later, having a totally different outlook on life, feeling marvelous, and the therapist and I would both wonder why I was there.

After five years away from Salt Lake Valley, we returned to our hometown with three small children. With each child birth, I had become worse. I was questioning my value as a wife, mother and a person, because I would have two or three horrible weeks each month, then an inexplicable recovery for a week before the blackness would set in again. I began to fear for my sanity. I couldn't control the swings. When I felt well, I felt so well that I couldn't cry if I tried. I wondered, "Am I crazy?" Something inside me said "No, there's something wrong with your body chemistry, but how could that be true if specialists across the country hadn't caught it."

One day, in an hour of despair, I called the University Medical Center, the Department of Reproductive Endocrinology. They couldn't see me for three months. I said, "I don't think I can wait three months." My feelings about myself, and what I perceived as my husband's and children's feelings about me, had created enough pain in my life that I couldn't continue. I am sure that I was not actively suicidal, but I sometimes fantasized about driving around Parley's loop on a rainy day and accidentally slipping off the cliff. I told the receptionist, "You must refer me to someone who can see me sooner. I can't go through this any longer." She referred me to a specialist who was able to see me the next week. When I described my symptoms, he said, "That's PMT. Have you ever heard of Premenstrual Tension?" I hadn't. "Let me first reassure you that this problem is not in your mind. It is a very real biochemical problem, probably a hormone problem, and there is a treatment that works." Since there was (and is) no blood test for PMT, the timing of my symptoms, and other factors, confirmed the diagnosis.

That twenty-minute visit to a doctor's office was a turning point in my life. Imagine my elation, to hear a doctor validate what I had known all along, in spite of other doctors' skepticism.

Unfortunately, the treatment he recommended was a hysterectomy. His theory was—the way to treat a menstrual problem is to put an end to menstruation. That made sense, but we had wanted more children. Still, I believed I wasn't the best mother to the three we had because of my medical condition, and I thought I had no choice but surgery. But I asked, "Isn't there anything else I can try?" He said, "Well, you might try vitamins, but I can assure you they won't work." I went to the medical library to read up on the B vitamins and took massive amounts for a couple of months, but had no relief at all. I called the doctor and said, "Schedule me for surgery. I can't go through this one more month."

That was four years ago. I had the surgery at LDS Hospital. This part of my story is something I seldom share, but it is appropriate with this group. The night

before surgery, I had had all the preliminary exams and interviews, the doctor had visited and was very hopeful about the prognosis. He left, and in a moment, the room seemed lighter. I was struck with the realization that, whatever the outcome of this surgery or whatever else happened to me, I would have a part to play in bringing hope into the lives of other women who had the problem.

I thought surgery would be the turning point. Unfortunately, several weeks after the surgery and the dangerously high doses of estrogen that were surgically implanted in my body as a follow-up treatment, I realized that the course I had taken (which had given temporary relief) was not the ultimate solution. In fact, I continued with what I now know is PMS, Premenstrual Syndrome. Severe headaches, depression, irritability, mood swings, a sense of being out of control, fatigue, clumsiness, mental confusion—all the symptoms I had before had returned, only with greater severity. Not only that—I was no longer able to have children. I was angry; I felt betrayed again by the medical profession.

At that time, I was writing a weekly column for the *Deseret News* on psychological case studies. One week I wrote about PMS. Within a week of the publishing of that brief article buried on page C-11, among the grocery ads, I had about a hundred phone calls or letters. Journalists don't often get that kind of response to articles, especially an avalanche of phone calls and letters saying, "Help me. You just wrote the story of my life. Who are you? What is PMS? Where can I find help?" Though I had limited answers based on limited experience, something told me to take down the names and phone numbers of these women. I said, "Let me contact you when I have more information. I wasn't about to tell all of them they needed a hysterectomy. Since this was a Salt Lake City newspaper, most of my readers and callers were Mormon women. They had the same cyclically-timed symptoms and the same feelings of guilt about not measuring up to the high standards set for them.

I kept that list and, Type A personality that I am, I kept going up to the University Medical Library, barely understanding what I was reading. After a few months, I saw an article in the *Journal of the American Medical Association* about PMS and a clinic in Boston that was soon to open. The treatment did not involve surgery and the medication (progesterone) was benign. I ran home and called Dr. Norris. I bombarded him with questions. He was very kind, in fact, he was travelling through the West the next week, and made arrangements to meet me. I interviewed him and wrote another article, which brought a few hundred more urgent calls and letters.

I flew to Boston for medical care at the country's first PMS clinic. While there, I wondered how could I have PMS if I no longer had a menstrual cycle? Dr. Norris explained that PMS originates in the brain, not in the reproductive organs. Therefore, I was still treatable. After my screening and diagnosis, I went through a lengthy recovery period during which I was regulated by medication, and I learned and implemented the necessary dietary and lifestyle changes. Regaining control of life was exhilarating.

Well, I could have lived happily ever after, except that I still had a list of the names of a few hundred women awaiting my help. Those women couldn't all fly to Boston. Then I heard about a doctor at the University of Utah who specialized in the hormone problems of women and had shown an interest in PMS. I scheduled an appointment, not as a patient, but as a healthcare consumer advocate. I didn't interview him, I interrogated him. I wanted to know his background and credentials; I wanted to know why he cared about PMS and what he was willing to do about it, and if he was sincere. He wanted to know about my case study. He was very curious, but as most scientists would be, somewhat skeptical. We met regularly, and he treated me as a colleague. This was a surprising and welcome change, considering my history with doctors and the fact that I was a lay person. With the help of this Dr., William R. Keye, and a few other

zealous PMS patients, I founded a PMS support group in Utah which, after time, led to the formation of the National PMS Society. Assisting in the national group was PMS recovery patient, Lindsay Lakie, from North Carolina.

Soon thereafter, Dr. Keye and other clinicians developed a medical program for the evaluation and treatment of PMS. I was asked to be the clinic administrator. The Utah PMS Center is now in its third year of operation and has recently moved into the LDS Hospital System. (Another irony, considering that LDS is the hospital facility where so many of my family's PMS-related problems were treated.) Salt Lake City was one of the forerunning cities in the recognition and treatment of PMS. Probably more women were helped here in the early 80's than anywhere west of the Mississippi.

Together, my colleagues, fellow PMS sufferers, and I have learned some interesting things about Premenstrual Syndrome:

1. PMS impacts on self-image and, consequently, impacts on friendships. As a Mormon woman with PMS, I didn't have many close friends. This wasn't the type of problem most women would want to talk about in Relief Society. The symptoms of PMS don't fit the "ideal Mormon woman syndrome." To feel so depressed and lethargic that you can't keep your house clean or enjoy your children, but having to fake being able to do it anyway puts one in a genuine state of conflict. I hasten to say that after being so involved in women's healthcare I have numerous close friends now, many of whom also have PMS. We have a great time helping each other and openly discussing the realities of life.
2. Not all women have PMS. There are several different kinds of women: those who don't have PMS, and they are grateful; those who don't have PMS and wish they did, because it would be a neat explanation for their difficulties; those who do have PMS, but don't know it; those who have it and know it, but won't admit it to anyone or do anything about it. Then there are those courageous few who have PMS and are seeking and finding appropriate help.
3. PMS impacts on marriage. In our community, there is a high degree of commitment to marriage. Families victimized by PMS also have a high commitment to marriage. For all the turmoil these couples go through—the marriages usually survive.
4. PMS impacts on children. One of Dr. Keye's patients gave him a picture her preschool daughter drew of her at both phases of her cycle. One looks like a wicked witch, the other, a fairy queen.

   My mother had severe PMS. She functioned on 'half-a-cylinder' three weeks out of the month. Then during her good week she'd feel guilty about the previous three, so that the whole month was somewhat of a drain. As a result of those experiences, I had resolved, early in life, to have an experience different from my mother's. I would be active in the Church, because the Church would bring me all the happiness that she, being inactive, had not had. And since my mother had never felt well enough to be an accomplished homemaker, I made up my mind to obtain a degree in home economics. Unfortunately, my career decisions didn't change my genetic inheritance.
5. PMS is probably hereditary. As you interview your clients, from what we have learned at the PMS Center, you ask about their childhood, their mother's, and their own mothering style. The PMS problem seems to be hereditary. Is PMS a learned behavior or a biochemical event? Doctors don't know even yet what causes the disorder, let alone what cures it. But there are some common points of agreement that are building blocks for understanding. The current definition of PMS is a clustering of physical, emotional, and behavioral symptoms that are somehow linked to biochemical changes in the brain, recurring cyclically, month after month, in the premenstrual phase. Classically, there are one or two symptom-free weeks per month.

One of most common questions a patient asks is, "How do I know when my symptoms are severe enough to require medical help?" To me the answer is simple. If the symptoms are significantly disruptive to the quality of a woman's life, she needs a doctor. We're not pioneers crossing the plains, who have to put up with our sorry lot. We don't have to live with this. There is help available. And there are many things women can do on their own to bring relief, such as eating a balanced diet, reducing stress, and exercising.

The Mormon woman sometimes has difficulty complying with these recommendations, since it's hard for her to admit to having a problem such as PMS in the first place, and since she often puts herself last in the nurturing department.

Even for women who have a symptom-free phase each month, there are residual discomforts all month long. A woman who suffers for fifteen to twenty years from a chronic, biochemical problem that causes her behavior to change is going to lose trust in herself and have some difficulty even during her good time. The proposed etiologies of PMS, none of which have been proven, but all of which are potential causes—include everything from intolerance to environmental antigens, altered neurotransmitters, pituitary dysfunction, biochemical disturbances, and intolerance to stress.

After two years and two-thousand clients, physicians at the Utah PMS Center have begun to wonder if each of these components doesn't play some part in the explanation of PMS. Perhaps there are several different syndromes under the PMS umbrella.

A hundred or more symptoms have been associated with premenstrual syndrome, but we'll discuss the more commonly reported ones. Ninety-eight percent of the patients in Dr. Keye's first study reported fatigue, frequent headaches, (all types—migraine, tension, sinus—) bloating, decreased urination, breast tenderness, increased appetite, acne, and anxiety. May I add that this is anxiety for which there is no explanation. A woman may have a comfortable life, a loving husband, wonderful kids, freedom from financial problems; she may even have a fulfilling career. She likes her neighbors. But she wakes up some mornings with an overwhelming sense of anxiety and gloom. An equally inexplicable symptom is anger. The children are great; they play in the sandpile, bring home good report cards, practice their instruments, and she'd just as soon scream at them as look at them, blowing up over things that didn't bring a second glance the week before. Depression, sensitivity, rejection, guilt, pessimism, feelings of being overwhelmed—these symptoms are common during the luteal phase of the menstrual cycle for women with PMS. Dissatisfaction with one's appearance, loneliness, and rapid mood changes are also symptoms.

The most commonly reported behavioral changes (sometimes reported by the husbands) are nagging, craving sweets, restlessness, poor concentration, withdrawal from friends and community, taking the phone off the hook, locking the door, dimming the lights, and going off alone into a corner of the house.

Hysteria sometimes occurs. As you may know, hysteria comes from hyster, the Greek word for uterus. Someone long ago made a connection between a woman's cyclic physiological changes and behavioral extremes. Other symptoms are decreased judgment, increased sleep, intolerance, and mental confusion—you may walk into the kitchen and wonder what on earth you are doing there. Obvious interpersonal difficulties result. Suicide is a reported tendency.

Clearly if female patients are reporting these symptoms in a cyclically timed pattern, it is certainly worthwhile to question them further about PMS.

Dr. Keye learned in his first study of 256 PMS patients at the University of Utah, that PMS symptoms can begin at puberty, childbirth (the most common time of onset), following a life crisis, during amenorrhea (the cessation of the period), following a tubal ligation. Birth-control pills can make PMS worse, as can

emotional stress, increased age, and even tranquilizers.

Fifty percent of the women in Dr. Keye's study reported PMS symptoms in their thirties. Most of them had three, four, or five children. When Dr. Keye shows these statistics across the country, he gets some snickering from colleagues who are unaccustomed to seeing women with so many children. But if childbirth can bring on or exacerbate PMS, I wonder if more women in the Church community suffer from PMS. The majority of women began having symptoms post-partum. The second largest group reported symptoms at puberty, and the third most frequently reported cause was stress. The average patient in the study suffered more than eleven years, before finding help, had symptoms fourteen days out of the month, and had seen more than three doctors for care. Most of the patients in Dr. Keye's study (81%) were married, and most were still on their first marriage. Forty percent of all women of childbearing age are reported to have symptoms, with ten percent suffering to the degree that they are in trouble and in need of medical help. That ten percent represents about 20,000 women along the Wasatch Front.

Those with a history of toxemia during pregnancy or post-partum blues have an even greater chance of having PMS, and a more severe case of it. One of the most dramatic bits of research we encountered was a study in Great Britain in 1959 involving autopsies on 100 deceased women. Scientists studied hormone levels in the uterus to see where each woman was in her menstrual cycle at the time of death. Statistically, 50 percent of those women should have died during their follicular phase (or the time of well-being according to the PMS definition), days one through fourteen, and 50% should have died in their luteal phase, days fourteen through twenty-eight (the difficult time for women with PMS), but no matter the cause of death—accidents, suicide, or natural causes, 84 to 92 percent of these women died during their luteal phase, those crucial two weeks before menstruation. Something very real is going on at that time. Dr. Hammond will now explain the psychological implication of PMS.

D. Corydon Hammond

The question of how to evaluate PMS is crucial to treatment. As we present at conferences around the country, I believe we are one of the foremost sites in the United States in the development of innovative protocols and methods for evaluating Premenstrual Syndrome. When you advertise that you work with PMS, you tend to primarily attract the moderate to more severe sufferers. Therefore, most of the women that we see are disturbed psychologically, sometimes severely. Approximately two-thirds of the women we screen have been suicidal, and at least one-fifth have made a suicide attempt.

The diagnostic issue that we must determine is whether we have a woman with major psychiatric disorder, PMS, or a psychiatric disorder which is intensified by PMS. Research has shown that retrospective patient reports of symptoms coinciding with the luteal (premenstrual) phase of the menstrual cycle are very inaccurate and cannot be trusted. Therefore, we must depend on prospective charting of symptoms. We use a special premenstrual calendar on which patients chart their emotional, behavioral and physical symptoms by degree of intensity for a couple of months. If we find a premenstrual clustering of symptoms, with a symptom-free period (or decline in severity of symptoms) in the follicular phase (immediately following cessation of menstrual bleeding), then we have evidence of the likelihood of a premenstrual disorder. We will also gather a social history, spouse interview, conduct marital and personality testing at both phases of the menstrual cycle, and analyze medical results. If a premenstrual pattern does not exist, but perhaps there is evidence of marital discord, psychopathology, or medical disorders, we still want to determine the nature of the problem and refer for appropriate care.

My work in the specialty of evaluating and treating sexual dysfunction has made me comfortable in working with

specialists from other disciplines, and in this sense, has been good preparation for working with premenstrual syndrome. Non-physician mental health workers should not be trying to evaluate this condition by themselves. Similarly, physicians lack the skills they need to evaluate the psychological and marital symptomatology of patients with moderate-severe PMS. This is a complex medical-psychological problem requiring thorough evaluation by an interdisciplinary team. Medical evaluation is essential. For example, one woman complained of premenstrual headaches as one of her primary symptoms. Evaluation found that she did not have PMS, but that she did have a brain tumor.

Our formal evaluation includes completing a PMS calendar; thorough physical examination and lab tests; mental status examination, Minnesota Multiphasic Personality Inventory, and a marital screening instrument, all of which are administered at both phases of the menstrual cycle; spouse interview to determine his perceptions and to assess the impact on the children and family system and a patient background history. The background history includes assessment of secondary and tertiary problems related to work, family, social interactions, etc. The medical history includes information about infertility, miscarriages, pregnancies, menstrual history, and use of medications and contraceptives. We want to know the age at onset of PMS, the duration of symptoms, how the condition has progressed, and if it has become worse at some of the typical times, such as following the birth of children.

The PMS calendar is individualized in the sense that the emotional, behavioral and physical symptoms that are most prominent for each individual patient are selected by them to be rated for two months. They are rated daily, with a rating of zero meaning the sympton is not present, and the severity rated from one to seven (severe). Symptoms may include things like craving for sweets, dizziness, fainting, violence, backache, hostility and anger, depression, anxiety, insomnia, or feeling overwhelmed.

The usual pattern of symptoms in patients with PMS shows a symptom free period after cessation of bleeding, followed by an increase in the presence and severity of symptoms after ovulation, becoming worst immediately before the start of menses. Another frequent pattern is seen in the patient with a psychological disorder that is accentuated by PMS. This patient will show a baseline of a moderate level of problems (marital discord, depression, thought disorder, anger) which are exacerbated in the week or two before menstruation. If any of you have worked in inpatient psychiatric settings, you are probably familiar with the phenomenon of many women being admitted premenstrually, and beginning their periods shortly after hospitalization. Finally, some patients think they have PMS, and even hope that PMS may be the explanation to their baffling problems, but upon careful evaluation we can find no relationship between their symptoms and the menstrual cycle. Not all women have PMS. I suspect less than 20% of women have PMS sufficient to cause them such distress, and that likely only 5%-10% of women experience this syndrome in the severity we commonly encounter at the PMS Center.

We conceptualize the symptoms that are charted on the PMS calendar as primary symptoms. However, we also evaluate secondary problems that have stemmed from the primary symptoms: low self-esteem, feelings of inadequacy, withdrawal from family and friends. A woman may withdraw from her children because she never knows when she will explode. She knows that she becomes so paranoid and hypersensitive that her behavior is unpredictable, and so she also begins to avoid friends and withdraw from associations at work. This, of course, further accentuates her depression. Another secondary problem is guilt. When you have just been a shrew for two weeks and terribly hurt people that you love, it is difficult to immediately get over this depression and guilt. Thus many women with

severe PMS will continue to have some of these symptoms even during their "good" times.

Tertiary or third level problems also occur after a while, for example, when PMS begins to interfere with occupational and educational activities. A major producer for a national television series was filming last year in a nearby state. She came to the PMS Center when she was essentially incapacitated at the film site. Marital problems are also typical tertiary problems. As marital therapists, we should routinely ask questions about whether some of the symptoms get worse at certain times of the month. Have any of you seen couples where you make some progress for two or three weeks and everything looks optimistic, and then suddenly everything blows up again? Parent-child relationships, child and husband abuse, financial problems—all of these areas can eventually be influenced by PMS.

In the area of marital adjustments, we have used the Locke-Wallace Marital Adjustment Test because it is a brief and rapid screening tool. The Spanier Dyadic Adjustment Scale would be another such instrument. The mean score on the Locke-Wallace for average couples is 100. Well adjusted couples score 135, and couples in problematic relationships score below 100. In our PMS population, at a "good" time of the month (follicular phase), couples scored 103—just above average. However, during the premenstrual phase, the score dropped to 71. As any of you know, who have used this instrument, when you have a couple who scores 70, you have a lot of therapeutic work to do. In over a dozen years of experience in marital and sex therapy, I have never seen marital adjustment test scores that are as low as some we see in PMS patients.

In studying marital adjustment during the menstrual cycle, in PMS couples we generally see the degree of conflict and anger intensify, communication decline (as the patient and her spouse withdraw from each other), shared activities dramatically decrease, decision making patterns shift with the woman becoming more dominant, and usually the sexual interaction declines. Commitment to the relationship also decreases in the luteal phase. Often the woman indicates that if she had to do it over, she would not marry at all, and men often indicate that they would marry someone else. At a good time of the month, one-third of our couples had below average marital adjustment. Premenstrually, however, 81% rated their marriage below average.

I believe that marriages where significant PMS is present are heavily influenced by an intermittent reinforcement schedule. Most of you remember from your experimental psychology classes that intermittent reinforcement is the most powerful type of reinforcement schedule. In PMS marriages we have intermittent reinforcement in two ways. The good times often keep the marriages together and maintain some degree of hope. After all, things aren't absolutely terrible. For half the month, the relationship may be fairly good. However, after a couple of good weeks, just as optimism is being encouraged and they are beginning to draw closer, everything falls apart again. Thus pessimism is reinforced about whether the marriage will ever get better. With the birth of subsequent children, the couple may be further tied to the relationship by both the children and their closer feelings due to the absence of PMS symptoms during pregnancy. But, PMS is frequently exacerbated following the birth of each child. The PMS marriage can be a relationship of tremendous ambivalence, moving toward and away from each other. Spouses are often afraid to get too close. Their trust level is often very low as they anticipate what have become inevitable blow-ups. Many of the relationships need marital therapy, with a focus on anger management training, conflict resolution training, and general marital communication and enhancement work.

Some of our most fascinating results have been in examining the Minnesota Multiphasic Personality Inventory at the two phases of the menstrual cycle. The vast majority of MMPI's were highly valid at both testing times in the menstrual

cycle. On the ten clinical scales, there were significant increases premenstrually on eight scales (Hs, D, Hy, Pd, Pa, Pt, Sc, Si) at a .001 level of probability or beyond. It is not uncommon to see women appearing very normal on the MMPI in the follicular phase, having no T-scores over 60. Then, two weeks later, they may be in the 75-95 T-score range on five or six scales.

As another way of evaluating the MMPI's, we rated them for overall level of psychological disturbance. They could be rated normal, mild, moderate, or severely disturbed. A psychologist colleague and friend, Dr. Gary Jorgensen, blindly rated them along with me. Our inter-rater reliability was .96. In the follicular phase ("good" time), 44% were moderate or severely disturbed. In the luteal phase, 92% showed moderate to severe disturbance psychologically! On the basis of our findings, I expressed the belief at the 1984 American Psychological Association annual meeting that we can no longer ethically test women psychologically without asking them if their symptoms may vary with their menstrual cycle. This has important implications for court and child custody evaluations.

There is much we don't know about PMS. My own sense is that we will eventually discover multiple etiologic factors, which may include genetic, neuroendocrine, immunologic, and also psychological and background factors. There is some preliminary evidence that early sexual abuse may be a predisposing factor, and we certainly need to screen this population for psychological-sexual trauma.

One of the most effective treatments appears to be natural progesterone suppositories. We see improvement in about four-fifths of the women taking natural progesterone, although it certainly does not eliminate all symptoms in all women. For many, it helps control and modulate the symptoms; for a few it seems to have little effect. Other drug treatments also appear effective part of the time and are the subject of experimentation.

Psychological treatment and support also appears vitally important. These patients are often at risk for suicide and generally feel overwhelmed with anxiety, anger and depression. One of my innovations for them has been the use of self-hypnosis training as a self-management skill. Self-hypnosis can often be used for ego-strengthening and for anxiety and anger management. In a preliminary group of PMS patients trained in self-hypnosis, at six month follow-up they rated self-hypnosis as being almost exactly as effective and helpful as progesterone. Support groups can also provide encouragement, hope, and a sense of universality, as well as supplying education about diet and exercise. And, as we already noted, after experiencing the ravages of PMS on their marriage for ten or fifteen years, many couples need relationship enhancement work, in addition to individual help.

In closing, let me request, please, that you ask about premenstrual syndrome. Questions about the relationship of the menstrual cycle to symptoms should be just as routine as inquiries about suicidal ideation, sexual dysfunction, or marital distress. Then, when PMS is suspected, refer the patient to an interdisciplinary team for careful evaluation. I believe you will encounter PMS in your patients far more than you might anticipate. In four different studies of female patients with a history of major affective disorder, two-thirds of them were found to have premenstrual syndrome.

Patty Cannon.

Symptoms of PMS seem to stem from a variety of sources: the day of menstrual cycle, life stress, sleeping, eating, and exercise patterns, plus compliance with medical treatment. If a woman has only mild PMS, cutting out caffeine and sweets and taking up jogging may help her to manage the symptoms nicely. Dr. Leathanna Dalton in London, who has treated 30,000 women with PMS during the last thirty years, visited Salt Lake City in the Fall of '83. We had been having difficulty with a few patients who were not

doing well on the standard PMS treatment protocols, and her first question was: "What are these women eating? How often are they eating?"

So I called them all up and asked. The answers: sweets, salty foods, and caffeine; not much in the way of protein and complex carbohydrates. They were skipping meals. Fasting can be as hard on these women as eating junk food. If these women eat six small meals per day consisting chiefly of proteins and complex carbohydrates, they will do much better regardless of medication. "Food is medicine," says Dr. Dalton.

At the Utah PMS Center, we begin with patients by showing educational videotapes, giving nutritional information, giving them support and counseling when necessary, and having them chart symptoms in a menstrual calendar. Patients who come to our clinic do not receive medication until the diagnostic visit, which occurs once the patient has had a complete physical, psychological testing, and has charted symptoms for 6-9 weeks. Without such screening, it's pretty tough for a physician to make a definitive diagnoses.

D. Corydon Hammond, Ph.D.

A lot of physicians have read one journal article on PMS and are anxious to prescribe medication. I think these patients need very careful evaluation, not a shoot-from-the-hip diagnosis. One woman I treated a few months ago had gone to her gynecologist, told him she might have PMS, and on the basis of reading one article—he changed her birth control pill to one with more progesterone. Well, that is a synthetic progestogen, not natural progesterone. There is a subtle chemical difference which can make a rather dramatic difference to the patient. Also many times, progesterone will be prescribed in doses that are unlikely to be helpful.

Patty Cannon.

Many people are alarmed by hormone therapy of any sort because of some of the obvious things we learned about synthetic estrogens. Two studies in Great Britain demonstrated that progesterone was no more useful than placebos. Dr. Dalton was concerned because for thirty years she has been prescribing this medication with good results. So she went to the researcher and asked to see how the studies were designed. She determined that the studies had been improperly designed, and in some cases, the participants didn't even have PMS.

Psychotherapists will appreciate hearing about the woman who went to her therapist and described her ups and downs. "Well," he said, "let me tell you something, you are either crazy or you are not crazy, but you are not crazy part of the time."

Other than the factor of multiple child birthing experiences, the Mormon woman should really be the last one to develop the symptoms associated with PMS. With a sensible health code and a strong supportive family life, the severely suffering Mormon woman very likely has a medical problem. Women who complain of severe premenstrual symptoms, marked psychological reactions, disturbed interpersonal relationships, or other unusual circumstances need and deserve the evaluation of a multi-disciplinary team to bring about proper recovery.

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THAT RESPONSE TO LOSS THAT WE CALL 'GRIEF'

KATHLEEN R. BUNTIN, B.S.

Presented at the AMCAP Convention 5 April, 1985

A few weeks ago, a dear friend telephoned. "Will you talk to my neighbor?" she inquired, after a few hasty preliminaries. She described the neighbor, of whom she had spoken briefly in the past, and the problem. I agreed to listen and suggested some times when I would be available.

Since the publication of *The Living Half* (1984), a book describing my experiences following the death of my husband, such requests no longer surprise me. This woman whose husband had filed for divorce was not the first to call for help, nor was she likely to be the last. There was the young man who had turned to alcohol following the untimely death of his brother; the teacher whose husband had become sexually involved with another woman; the man severely depressed following a major career change; the professional woman facing disfigurement following facial cancer; the father of a stillborn infant; a young woman whose father remarried only weeks after her mother's death; the divorcee who deeply desired remarriage but who flitted from relationship to relationship each beginning a new hope, each ending a painful reminder of her father's emotional desertion of her as a child.

There is a common thread that leads these to seek for someone who they feel would understand. That thread is grief. In one way or another, they have all experienced a loss and are grieving for that thing which was and is no more.

I cannot remember the first time I grieved; I can remember vividly the first time I labeled it as such. It hit me like a bludgeon right between my emotional eyes and sent me reeling in pain and confusion. It was months before I could speak its name, before I could begin to understand it, and months more before I could see it as a process of going through and not staying in, a healing and not a dying, a road to growth and not insanity.

Elizabeth Kubler-Ross (1969), a pioneer in grief work, first began to notice the predictability of grief when she worked with the terminally ill. She observed that each patient, regardless of length or type of illness, age, gender, economic status, or religious persuasion, seemed to go through a certain process in coming to terms with the reality of impending death. As Kubler-Ross chronicled those grief stages she found that while all patients went through the stages at different rates and intensity, they *did* go through all of them.

Grieving, then, is a predictable psychological process; it is letting go of a loved or cathected thing; it is making real within oneself a fact that, though hard to accept, already exists. In that context, the process may be observable in psychotherapeutic work involving the acceptance of any reality when such reality involves the giving up of a familiar, though dysfunctional, cognition or behavior. It is certainly observable in those obviously loss- related life crises such as death, divorce, severe financial reversals, serious illness, surgery, and physical handicaps.

Shock

The first stage of the grief process is the initial shock. It can last from a few hours to several weeks. Physical symptoms can include light-headedness, nausea, shaking, crying, hyperventilation, fainting, weakness of limbs, inability to focus thought, numbed affect, blurred vision, ear ringing, and a sense of being outside

of oneself watching the occurrence in a dispassionate manner.

The mourner may need to be sedated at this point, but care should be taken not to give the message that the drug will take all the suffering away. Grief is an extremely painful process, and there is no easy or fast way to speed through it. The mourner must feel the pain, not avoid or deny it, in order to heal. The therapist should facilitate the process by helping the client get in touch with his feelings to understand where he is in the process. For the therapist to listen and reflect with empathy and honesty is also comforting to the client. Because we are such a death and pain-denying society, significant others tend to pull away from a mourner's suffering. The therapist may be the only person who really hears and allows the client to own his pain.

Denial is often present in this early shock stage and may continue for many months. If this is the case, the therapist needs to help the client see the reality of the situation before the grief work can truly begin. Denial is recognizable in that the client appears "stuck" and is not moving through the grief process. There may be a sense of emotional tension, nervous energy, physical symptoms such as extreme weight loss, and irrational behaviors and cognitions. Examples of denial include the widow who slept, fully clothed on her couch for 18 months before she would return to her bed, the mother who wrote a weekly letter to her son for over a year following his death, and the child who included a stillborn sibling in his family drawings five years after the fact.

Some therapists have found it necessary to take a strong reality-based approach with clients who are too long in denial. The rationale is that if the client can be prodded into anger (another stage of the process to be discussed later) he can begin to move again.

Latter-day Saints may prolong the stage of denial by allowing their knowledge of a life after death to forestall their acceptance of the mortal death. It is this "I know I'm going to see her again" testimony that outsiders see at the funeral which causes them to assume the mourner has strength which, indeed, he may not have. Later, when the shock dissipates and the reality that "she is not coming back to this life" hits, it may look and feel like a regression. The mourner and his significant others may doubt his testimony and/or his sanity. Professionals often have clients referred to them at this point by friends and family who say, "He was taking it so well, but now he has fallen apart." The therapist should reassure the client that this is progression and not regression, and that he now will be able to begin the real grief work that will allow him to heal and to grow. LDS clients who haven't made that transition may be helped to see within the context of the gospel the reality that death is as much a part of mortality as is birth and that the change it brings must be accepted and dealt with.

The next three stages—guilt, anger, and depression—are not on a clearly defined continuum. They tend to overlap, fluctuate and flow into one another; the guilt may produce depression which may turn into anger which may be turned inward to guilt and depression again, and so on. Some mourners feel all three in fairly equal amounts; others may be especially hard hit by one stage while only slightly aware of another. It does appear, however, that all grievers experience all the stages to a lesser or greater degree, and for the grief process to be truly therapeutic, stages cannot be rushed or skipped.

Guilt

The guilt stage is all those "if only's" or "I should have's" or "Why didn't I's." The therapist can facilitate the process of passing through this stage by first helping the client look at the rationality or irrationality of the guilt. By having the client reexperience the event about which he feels guilty, the therapist can ask the client if the choice made was a logical choice *given the knowledge the client had at that moment in time.* (We all have 20-20 hindsight). If it was a proper choice and the client still feels guilty about it, the therapist may help by challenging the irrationalities.

But what if the choice was *not* proper, even given the more limited knowledge of the past? Some therapists regard all "shoulds" and "oughts" as irrational, but that is a difficult stance to take with an LDS population. Even the position that the past is over and unchangeable and should be forgiven and forgotten is difficult unless the client is given the opportunity to own and to work through his guilty feelings. The five steps of repentance—recognize, remorse, confess, recompense, and forsake—are as applicable here as in any other situation involving guilt. The therapist can facilitate the process with techniques such as the Gestalt "empty-chair" to allow the client to confess and ask forgivenesss of the deceased and by helping the client find opportunities for recompense here and now (like Ebeneezer Scrooge's repaying Feziwig by being more generous with Bob Cratchet).

One therapist, working with a divorced client in the throes of guilt, asked her how long a "sentence" she would need to serve for the "crime" of being the only divorced person in her family! After pointing out that even criminals sent to prison have a set sentence, he helped her work out an appropriate "term" to serve after which time she gladly "pardoned" herself.

It may be helpful to remind the client that, as with all repentance, the process and the growth are for the client, not the deceased.

Anger

Anger is typically a difficult stage for Latter-day Saints to handle. Because we are culturally taught that anger is "bad," we are practiced in denying anger rather than owning and constructively releasing it. The therapist's first job may be to help the client become aware of his anger. Anger may be masked under guilt and depression or under physical symptoms such as ulcers or migraine headaches. As mentioned earlier, it may take "stirring up the hornet's nest" to get the client moving out of denial or depression and into the anger stage.

Once released, anger can be frightening to the client and his significant others. The therapist's role includes allowing the client to express anger in his/her presence without judging or reacting personally, as others in the client's life will likely do; teaching the client that anger is a normal and acceptable part of the grief process, thus assuring him that he is not "bad" nor "going crazy," and helping the client develop some acceptable ways to release the anger, such as vigorous physical exercise, the use of batakas in therapy, creative expression, etc.

As the anger becomes more controllable, the therapist may want to deal with the client's "Why me?" sense of injustice from an existential prospective, if that seems appropriate, or he may want to teach Ellis' A-B-C relationship of event, perception, and emotion. We cannot always control what happens to us; we can control how we perceive and react to what happens.

Depression

Depression in the grief process is symptomatically similar to other depressions. There is a stated sense of helplessness and hopelessness. The tendency is to live in an idealized past and to seek "to be normal" or "the same" again. There is great anxiety about the future and therefore a wish not to think about it, even a feeling of wanting no future and of having thoughts of suicide.

Because of the very real possibility of suicide, depression is perhaps the most dangerous stage of the grief process. Statistically speaking, people *do* die of grief as Victorian novelists once claimed. Widowed and divorced people die from every major cause of death at a faster rate than their married counterparts. Suicide rates for widowed males are higher than for any other group in the country (Lynch, 1977). Widowers are most at risk the first six months; widows, during their second year alone.

Depression unchecked can become a vicious cycle with an emotionally depressed state leading to lack of concern for physical well-being, which, in turn,

leaves the mourner run-down and therefore more susceptible to emotional depression. The therapist needs to break the cycle, and a good place to start is with the physical aspect. "Homework" assignments, for example, of keeping a food diary to insure proper nutrition, getting prescribed amounts of fresh air and exercise, or making a visit to the medical doctor should help. Vitamin supplements, special diets, or anti-depressants may be prescribed by the M. D.

Clients may need to be taught that recovery comes in small bites, not big gulps, and that life always goes forward, not backward. The client can be "normal" again if he or she is willing to redefine "normal" under new circumstances. Therapists may also help the client reach small goals by setting up simple, achievable, and easily recognized behaviors and having the client act "as if" he or she is already achieving that goal. "One day at a time" (or "one hour at a time," if necessary) is a good place to start. In the beginning the goal may be, not happiness, but less unhappiness. As progress is made and growth perceived, most grief-induced depressives will ultimately move toward happiness.

Resolution

Grief psychologists tell us that one hour of emotional stress is as draining as three hours of physical labor (*Theos* magazine). During the grieving process intense amounts of energy are invested in going over the past with the only reality the mourner knows being that world of pain inside of himself. As he gradually works through that pain and begins to tentatively look away from the past and toward the future, he is approaching resolution.

The role of the therapist during this final stage is to help the client accept that progress has come "line upon line" and will continue to do so. As the client experiences a perceived "relapse" into depression or anger after having resolved those issues, the therapist can help him see that what he feels is not truly a relapse or "a going backward," but still "a going forward" and learning and growing. It is helpful to illustrate the process not so much as an emotional roller coaster (although that's what it feels like) but as a spiral, looping back on itself, with ever-decreasing loops, the "highs" lasting longer and the "lows" coming less frequently. As the client continues to develop his own strengths, the therapist can begin terminating the relationship, taking care to prepare the client for this new loss and subsequent grief.

In addition to personal therapy, the LDS professional can serve a valuable role as a resource consultant to ecclesiastical leaders such as bishops and Relief Society presidents who, although they deal with grief in the front lines, may not understand the process. Loving, caring people can innocently increase the pain of grief by saying or doing counterproductive things.

Because of the LDS understanding of the Plan of Salvation, we often think that as Latter-day Saints we should be immune to the doubts, fears, and pains of life. As LDS therapists, we know this is not the case. We react to loss in the same predictable way all do who are in the mortal condition. The scriptures are full of testimonies to that effect.

Job, who is remembered for his great patience in tribulation, knew grief. Observe the recognizable depression, guilt, and anger as Job said:

> Let the day perish wherein I was born, and the night in which it was said, There is a man child conceived.
>
> Why died I not from the womb? Why did I not give up the ghost when I came out of the belly? (Job 3:3, 11)
>
> Oh that my grief were thoroughly weighed, and my calamity laid in the balances together!
>
> For now it would be heavier than the sand of the sea: What is my strength, that I should hope? . . . is wisdom driven quite from me? (Job 6:2-3, 11, 13)
>
> When I lie down, I say, When shall I arise, and the night be gone? . . . My days are swifter than a weaver's shuttle, and are spent without hope.
>
> Therefore I will not refrain my mouth; I will speak in the anguish of my spirit; I will complain in the bitterness of my soul.

. . . thou scarest me with dreams and terrifiest me through visions: So that my soul chooseth . . . death rather than my life.

I have sinned: what shall I do unto thee, O thou preserver of men? . . .

And why dost thou not pardon my transgression, and take away mine iniquity? . . . (Job 7:4, 6, 11, 14-15, 20-21)

. . . how should man be just with God?

Behold, he taketh away, who can hinder him?

If I had called, and he had answered me, yet would I not believe that he had hearkened unto my voice.

For he breaketh me with a tempest, and multiplieth my wounds without cause. (Job 9:2, 12, 16-17)

My soul is weary of my life; I will leave my complaint upon myself; I will speak in the bitterness of my soul.

I will say unto God, Do not condemn me; shew me wherefore thou contendest with me.

Is it good unto thee that thou shouldest oppress, that thou shouldest despise the work of thine hands . . . ?

Thine hands have made me and fashioned me round about; yet thou dost destroy me.

If I be wicked, woe unto me; and *if* I be righteous, *yet* will I not lift up my head. I am full of confusion, therefore see thou mine affliction:

For it increaseth . . . (Job 10:1-3, 8, 15-16)

It is often difficult to be worshipful in the throes of grief or, as Paul said, to "glory in tribulations" (Rom. 5:3). But we do know and accept that tribulation can bring, not only healing, but growth.

As the Savior told Joseph Smith:

If thou art called to pass through tribulation; . . . know thou, my son, that all these things shall give thee experience, and shall be for thy good.

The Son of Man hath descended below them all. Art thou greater than he? (D&C 122:5, 7-8)

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NEW DIRECTIONS IN DISCIPLINE: A GUIDE TO POSITIVE PARENTING WITHOUT THE USE OF PHYSICAL FORCE

ANNE L. HORTON, Ph.D.
Presented at the AMCAP Convention, 3 October 1985

The other day after hearing me give a talk, my 16 year old son made an interesting observation. "Mom," he said, "when it comes to public speaking in your field, you are really in an impossible spot. First off there are no good jokes about family violence so you have to be either inappropriate and tell one or serious and boring like you were today." So I suspect you are in for the latter or even worse—I may be inappropriate and serious and boring.

Recently, Utah women were cited by the news media as being the youngest bridés nationwide and having the largest number of children. Professor Michael Toney at Utah State University, in his recent study of young Mormon and Non-Mormon women, reported similar statistical findings. The disparity between fertility expectations of Utah Mormons and Non-Mormons is significant and reflects the continued emphasis our culture places on the family and children. Yet parenting is changing, and as therapists our concern today must focus on the dynamic family living in challenging times with high tech demands.

Children are our greatest natural resource, yet as sophisticated and advanced as our civilization appears, we make two false assumptions at the outset: 1) everyone has a right to be a parent, and 2) everyone is naturally qualified to raise children. While it is true nature has provided the opportunity for most of us to reproduce, our young parents today often seem to lack five critical ingredients for their success: 1) the desire and value of parenting, 2) positive parenting experience, 3) parenting skills and training, 4) support systems and resources, and 5) a parental understanding of gospel principles.

My topic today is New Directions in Discipline: A Guide to Positive Parenting Without the Use of Physical Force. I realize as I begin that many of you here could address a variety of these concerns much better than I if you were in my place. Therefore, I asked myself what was my primary message to you. I believe it is this. I want to help end physical abuse in the family— particularly in LDS families— in my lifetime. I see you as critical instruments to reach that end. However, we cannot end abuse in our homes until it stops in our minds.

My concern as a researcher has been exclusively with physical violence between family members ranging from the so-called "normal" expressions of force such as spanking a child and throwing a hair brush at your sister up to the deadly use of force such as homicide. All family abuse has two things in common: 1) it is interactional, and 2) it is inappropriate in family relations.

It is important that clinicians and parents understand that there are many types of detrimental interaction in the home. Certainly emotional neglect and sexual abuse are related to child maltreatment, but the dynamics are different from those used in physical discipline. The generic term "abuse" is therefore misleading and limited. Through recent legislative efforts (i.e., Child Protection Laws, Domestic Abuse Acts, Temporary Restraining Orders, etc.), a legal definition of child and spousal abuse has been created. Public agencies, the police, schools and other helping organizations have

targeted their services toward prevention and treatment based on these legal guidelines. Yet many parents and professionals today see a variety of physical methods as acceptable forms of discipline and would not define spankings, the use of a belt or switch, slapping, etc. as abuse.

The word discipline, according to Aline Auerbach, means different things to different people. "To some, it means to regulate, govern, keep in line; to others it suggests a strict way of life from which they must never deviate. To many, the word discipline means simply punishment."

Discipline — What is it?

The big problem today is one of conflicting definitions. Most parents want to respond to the current value placed on raising responsible, law-abiding and obedient children, yet at the same time, they are attempting to uphold the "new" social belief that corporal punishment is no longer acceptable. Regardless of the new laws forbidding abuse, however, our mainstream culture clearly still fosters the attitude that hitting children is acceptable, the demarcation of "normal punishment" and "child abuse" becoming a matter of the degree of physical injury inflicted. Yet reports of extreme physical discipline continue to appear in greater numbers. More families are reported as "at risk" and borderline types of maltreatment plague clinicians as they try to determine where the *threshold of abuse* lies.

Our problem as caretakers is that these State statute definitions are often vague and confusing to the practitioner. They are highly discretionary and rely heavily on clinical identification and assessment. I was pleased to note that this AMCAP Conference is presenting a panel which will clarify this timely and challenging concern, so I will not dwell on it here. However, whether from the standpoint of professional guidelines, ecclesiastical responsibility, or statutory definition, the burden of interpretation ultimately falls upon you and your personal/professional definition of discipline.

In this presentation I will attempt to explore three areas needing particular clinical attention: 1) to illustrate the critical definitional difference between discipline and abuse with an emphasis on your personal clinical position, 2) to offer practical guidelines and clinical considerations for treatment of these troubled families, and 3) to discuss the goals and direction of positive discipline practice.

As professionals, new demands for services require us to define discipline clearly and provide alternative, innovative child-rearing skills for parents unfamiliar with non-physical methods. That may include many of you also. The new clinical mandate focuses on education and prevention for families at risk as well as a treatment framework. Today, professional attitudes toward discipline and abuse will have a profound impact on what care we provide and what diagnosis we make. Which families do we treat as deviant and pathological; which do we identify as needing new skills and education and who do we ignore and allow to continue in their present patterns?

This critical definitional phase is troublesome for clinicians and parents. Both need a vast repertoire combining a knowledge of child-rearing practices, an awareness of cultural and value differences, experience with parenting skills and management programs, understanding of child and adolescent development and psychopathology and family crisis techniques plus their own personal definition of acceptable parenting behavior. These new child protection acts make the victim and his professional partner, whether it is a teacher, counselor, social worker, physician, or police officer, the gatekeepers to enforcement. The success of these new laws depend upon our diagnostic and assessment skills. If we don't see abuse or don't know it when we see it, does that mean it doesn't exist?

The therapist factor is critical in working with these troubled families because what we value dictates what outcomes we wish to achieve in treatment. Self-examination and discovery is particularly vital as we are not only the

problem-solvers, but we must be the problem *definers* as well. Since clients often do not see themselves as having this problem and many are highly resistant to treatment, it is important that clinicians define and assess a treatment clearly. I mention this as therapists have a poor diagnostic history of avoiding this area, and what is done about a problem rests squarely on how and *if* it is defined.

Since you are the major actor in the definitional process, I would like to spend a few moments exploring . . . What part does violence play in your life? How often do you slam a drawer, honk your horn, raise your voice, raise your hand? A wonderful bishop was on a panel with me not long ago, and he was as adamant about ending family violence as I was, or so I thought! Yet on the way out he stopped and said, "Anne, I've been thinking about what you said and I certainly agree. Yet over the years my dad used to take me out when I needed it and use a belt. And I've done the same thing with my boys. Now you wouldn't see that as abuse would you?" There was an uncomfortable pause which grew longer and eventually spoke for itself. Ten years ago I, too, would have defined that action as discipline. Today I define it as abuse. I hope you will too.

Three years ago I decided to put this new definition of abuse into action in my own home, and I recommend this strongly as a first step and affirmation to all of you. I have seven children. One day I sat down with them and explained that we were not going to use any physical force between us anymore. It was relatively easy, because I had never used spanking much. I asked if they could recall my striking them in the past. All of them were able to recall at least one incident. They usually did not remember the interaction, but they did remember the pain and humiliation of being hit. They were still resentful as they recalled it. I then explained that pushing, shoving, throwing car keys, grabbing an arm, blocking someone from entering the bathroom, covering someone's mouth when they were talking, etc. were all abusive. They agreed, and we stopped that level of abuse in our home. The experience has been very helpful, and discipline is now achieved by loss of privileges. There have certainly been times when as a single parent for nine years I felt tempted to strike out, yet I recommend this as a personal challenge and commitment to ending family violence as we approach the turn of the century.

If this is not a problem for your family, I commend you. On the other hand, if your silent response is — there is no way I'll ever do that or even try to do that, I suggest you reexamine your personal belief about abuse. If you can't or won't give up physical discipline, I am concerned about your attraction and commitment to it.

Since the beginning of this country, the definition of child maltreatment has undergone many changes—both legally and socially. We begin with English colonial roots and move into the Human Rights movement of the 60s and the Women's Movement in the 70s. The State has now entered the business of the family, and the "battered child syndrome" has brought gross maltreatment to light. Nonetheless, physicians, social workers, police, and child protective service workers have differed considerably in their assessment practices and recognition of abuse.

There are no easy answers, but in respect to defining abuse I join Dr. Gelles, Dr. Kersey, and others in recounting the following observations related to clinical treatment. Child abuse is not an undimensional entity. There is no single factor explanation for it, and abuse is not all alike. Therefore, treatment also must differ. While abusive families have some commonalities, it is critical to do an assessment which adequately evaluates all factors and identifies the differences. Child abuse is not a pathology in the medical sense. Full medical, psychological, and social information is required to diagnose abuse, and a total family intervention strategy is necessary for treatment.

There are 3 basic beliefs that I believe underlie therapeutic efforts on the part of violent families. I see this as an essential change-oriented treatment philosopy.

1) Domestic abuse is *unacceptable* in any form. This message must ring loud and clear.

   Parents do not have the right to harm their children. Wife beating is intolerable and also a form of abuse to the children.

2) Violent families are not to blame for having this problem. They all need treatment. The attacking adult and the victims both experience feelings of helplessness, low self-esteem, poor sense of control, lack of trust, intense ambivalence, inconsistency and role confusion; expectations and perceptions are faulty. Both the attacker and the victim — the entire family — need help. We must leave the "blame" orientation behind.

3) Each member of a violent family must assume responsibility for change. No one outside the family can bestow peace. The community is responsible to provide help to the violent family and to each of its members. With help, change becomes possible.

A Diagnostic Guide

The initial problem is that it is difficult to establish a working relationship with clients whose principle problem is domestic abuse. In most of these families such defective past relationships have often existed with their parents that they do not trust others.

They are usually convinced that if you really knew them you would hate or possibly destroy them. Thus, though they may long for change, establishing any relationship is very problematic. Some fear the potential intimacy with others, and issues of 1) isolation, 2) trust, 3) dependence, 4) control, 5) seduction, and 6) ambivalence must be dealt with early. Often groups do better with this than individual workers.

Most violent families need explicit education and advice.

1) Re: developmental patterns of children. For instance, kids cry for internal needs, not as a condemnation of parents. *OR*
   toddlers reach for everything in sight because they are exploring the world, not because they desire to break valuable items.
2) Knowledge about marital interactions.
3) Communication skills.
4) Sex education. Timing is critical; ego strength must be considered.

Since time does not allow for more specifics, I have prepared a workshop packet for each of you. This packet includes a copy of 1) The Role of the Therapist, 2) A model of intervention with guidelines for treatment, 3) A position statement on family violence by Richard Gelles, and 4) Guidelines from the LDS church in respect to child abuse.

In assessing violence, it is often the sins of omission clinicians should be held accountable for. You must ask direct questions! Never assume clients will offer information. Be sure to be specific—avoid vagueness.

Clarify the answers and explore the details.

When uncomfortable, we often neglect to do this, and it may receive very legitimate professional criticism. However, it is better to overinvestigate than underinvestigate. Clients are well aware of the importance of this phase of their treatment, and you should acknowledge and impress upon them the critical need for pursuing the information.

Total assessment in working with abusive families should symstematically include the following dimensions in exploring child discipline practices: 1) parent characteristics, 2) child characteristics, and 3) the context.

Discipline is always interactional and involves the values of the parent. Since values are often very strongly held, infractions often trigger highly charged emotional reactions.

Violence is a response, a form of inappropriate communication.

In abuse, the "person" model is still generally held by clinicians. We look to mental illness and character disorders, brain tumors or drug explanations. Certainly, if there are physiological explanations or personality disorders at the root of the abuse, it is the duty of the clinician

to identify the problem accurately and refer for intervention. It is estimated that only about 10% of abusers fall in this category, but certainly appropriate treatment is at hand and is often promising for those few.

Victimology is a fascinating study which focuses on victim characteristics which help researchers and clinicians in identifying at risk populations. Dr. Frodi discovered that premature babies and handicapped children are more likely to be mistreated than "normal" children. This should make intuitive sense to us as these children demand more time and energy from parents. Infants with young, single mothers are even more at risk. There has been much hesitation to look at child victims as part of the abuse interaction because it implies a shared responsibility for the abuse. This is not the intent and must not ever be conveyed to children as victims. However, they are an integral part of the abusive exchange and often provide explanations, not justifications, for abuse. I refer you to Al Kadushin's excellent book, "Child Abuse - An Interactional Event," for further consideration. Today our goal is reuniting families of abuse. The victim is certainly a key actor in that process.

Finally, the social climate, socialization process, cultural factors and prevailing community standards provide the setting on which the family composes their interactions with one another. Families which have a history of child abuse intergenerationally have learned that physical discipline is okay. This includes most of us. Historically, it has been the prerogative of someone larger to use force to bring someone smaller into compliance. Until recently, the law has always allowed private resolution of discipline matters. Certain cultures are also more inclined historically to allow violence. In addition, David Gil (1975) asserts that violence that takes place on a personal level is really a reaction to the violence to which people are exposed in the institutional and social context. The feminists feel it is a response to role socialization. Both groups feel the structure for our society fosters child and spouse abuse. Certainly stress and family crises often contribute as well as must be considered as we try to tease out causation. Adequate assessment demands this attempt to examine causation as it directs impacts on the choice of treatment. Remember abuse differs considerably.

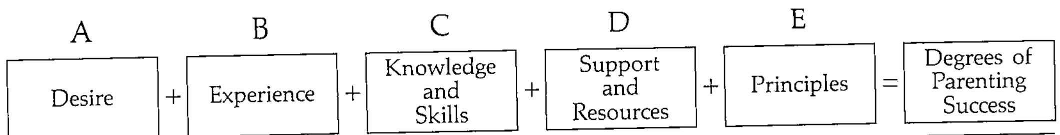
The Future

As clinicians searching for clear diagnostic signs, we also grope simultaneously for ways to remedy and prevent future abuse. I wish to close by offering some important guidelines for the future—the answer I feel lies in *positive parenting* practices without the use of physical methods.

"I, Nephi, having been born of goodly parents, therefore, I was taught somewhat in all the learning of my father" (1 Nephi 1:1). What is a goodly parent? I return now to my earlier concerns in respect to parenting.

Almost all professions dealing with a person's mental or physical well-being require extensive training. Nurses, teachers, doctors, social workers, and psychiatrists are licensed to practice only after years of higher education. Such simple tasks as driving a car, operating a ham radio and wiring a house require licenses before society allows a person to perform them. Today parenting activities are open to public scrutiny and evaluation. New laws regulating parental behavior have opened up a whole new area of social service concern.

Now that the law demands a minimal level of acceptable discipline practices, perhaps all of us as service providers can look to helping parents not blaming them. We may look toward educating them to become "winners" too. Were we to license parents in the future I would look at the following formula:



If we look upon each of these areas as storehouses, we can work with young people to fill in those bins that are empty and increase their supplies. While nothing is as powerful as the positive learning passed on to Nephi by his father, if we can identify deficiencies early as therapists and teachers, we can help our youth develop a full repertoire of parenting needs.

In closing I want to encourage each of you to make a difference. Protect our children. Protect our future! I have never spoken with an abusive parent that meant to hit him *that* hard or *hurt* her that badly. We are in helping professions. Over my desk at home are two sayings and a song that guide my life. The first saying is "90% of success is just showing up" and I owe that one to Woody Allen. The other is a quote from our football coach at the University of Wisconsin, my old alma mater. It states: "Success is never certain and failure is never final," and so it is with children. As parents we need to persevere. We each have a perfect role model to follow. We have the Gospel. Start tonight with your own family. When anyone hits, everyone hurts—

And the song:

I am a child of God and He has sent me here
Has given me an earthly home with parents kind and dear.
Lead me, guide me, walk beside me, help me find the way
Teach me all that I must do to live with him some day.

I am a child of God and so my needs are great
Help me to understand his will before it grows too late
Lead me, guide me, walk beside me, help me find the way
Teach me all that I must do to live with him some day.

I am a child of God Rich blessings are in store
If I but learn to do his will I'll live with him once more
Lead me, guide me, walk beside me, help me find the way
Teach me all that I must do to live with him some day.

Thank you.

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STARTING AND MAINTAINING A LAY COUNSELING PROGRAM AT THE LOCAL LEVEL

D. JEFF BURTON, MS, PE
Presented at the AMCAP Convention 4 April, 1985

INTRODUCTION

During recent years, strong programs of community mental health have been developed utilizing a combination of professionals and trained lay volunteers. Bellak has called this development the third major revolution in the history of psychiatry (Heilig, 1968). Its success has demonstrated that a trained and caring lay person can exert a personal and positive force for emotional well-being among his/her community. Indeed, given

- ☐ the great need and demand for services,
- ☐ the availability of excellent gospel-compatible counseling techniques, and
- ☐ limited professional resources,

the development of structured lay counseling programs seems inevitable. Lay counseling is nothing new among Mormons, of course. Bishops, stake presidents, quorum leaders, Relief Society presidents, and even home teachers have been engaged in various forms of counseling for years. The Church's Welfare Services Program supports properly functioning local counseling, as suggested in the following quote from the *Ensign* (1983):

> When an emotionally troubled individual cannot find a solution to problems by himself or through the help of the family, he may go to the bishop to receive the help he needs. If a bishop does not have the skills necessary to help those in severe emotional distress, he may call upon people within his ward or stake boundaries who have the necessary skills. . . . The support members provide one another in the Church also helps meet the emotional needs of individuals and helps to prevent many problems which might otherwise occur.

This paper describes one LDS-sponsored lay counseling program and suggests steps for implementing similar programs in other local jurisdictions.

THE ROLE OF THE LAY COUNSELOR

Janet Moursund (1985), in a new book *The process of counseling and therapy,* describes counseling as a process where two people come together to try to understand one another and accomplish something beneficial for one or both of them. Serving in this context, the lay Mormon counselor not only becomes a valuable resource for local leaders but also a friend, a minister, a source of information, a shoulder to lean on, a sounding board, a mirror, an official observer, and, occasionally, an advisor. The lay counselor, working with local leaders (and under the direction of professionals) assists in finding and providing services for those in need. Avoiding the role of judge or parent, he or she provides a model for communication and teaches communication skills to the client. Where sin is involved, the lay counselor gently assists in the repentance process. Knowing personal limitations, he or she relies on prayer, long-suffering, gentleness, meekness, love unfeigned, kindness, pure knowledge (D&C 121:41-43), and other principles of the gospel.

THE ROLE OF THE PROFESSIONAL

Many LDS and LDS-compatible professional counselors and psychotherapists render paid and volunteer service at the

local level. A lay counseling program can add structure and effectiveness to this activity, supplementing the talents and skills of the professional while at the same time removing part of the volunteer load from his/her shoulders. The professional, when involved in a Mormon lay counseling program, becomes an assessor, a reviewer, a guidance counselor, an advisor, and a paid or unpaid resource. He or she may direct the course of therapy, review progress, and provide assistance (or take over therapy) if the requirements of the client become too complicated for the bishop or lay counselor.

HISTORY OF THE PROGRAM IN THE SALT LAKE WINDER STAKE

In 1981, under the direction of the Millcreek Regional Representative, and through the auspices of the LDS Social Services, a lay counseling program was established in the Salt Lake Winder Stake, among others. Much of the credit must be given to Chuck Woodworth of LDS Social Services who organized and trained many of the stake resource couples. The program's objectives were to provide —

- ☐ additional counseling resources for bishops,
- ☐ an intermediate step between local priesthood leaders and the Social Services Department, and
- ☐ a focus for helping-resources at the local level.

A couple was called to serve in the program. They subsequently received training and education in counseling, crisis intervention, group facilitating, communication, and resource gathering. The services, programs, and activities shown in Table 1 have been instituted in the stake since the programs inception.

Table 1. Lay Counseling Program Content
Salt Lake Winder Stake, In place or Planned (Denoted "P")

— Crisis Line

— Bishops Assistance (Assisting bishops on a case-by-case basis)

— Couple Communication Training Program

— Parenting Training (P)

— Counseling Program (one on one, couples, families, handicapped, etc.)

— Referral System (referring clients to professionals)

— Establishing and maintaining resource lists

— Friendshipping Program (using local resources to provide a friend or regular contact, as needed)

— Chronically Troubled Assistance Program (helps bishops with persons suffering chronic and permanent mental health problems)

— Designated Safe Houses Program (temporary and overnight shelter for abused women, children, etc.)

— Young People Assistance (helping youth in trouble: pregnancies, drugs, alcohol, parental problems, runaways)

— Indian Student Placement (assisting students and foster parents)

— Excommunicants Program (counseling those excommunicated or disfellowshipped.)

— Group Resources (P) (group experiences for compatible groups: Young Adults, single women, single parents, families)

— Stake Resource Night (P)

As in all helping programs, there have been successes as well as failures. J. Everett West, Salt Lake Winder stake president, has been fully supportive. To him must go much of the credit for the success of the program. Ward bishops have expressed approval and appreciation widely, but some have also felt hesitation. Clients have expressed satisfaction with services received, but there have been exceptions. Measurable accomplishments include—

- ☐ Over 50 couples have participated in a structured couple communication course (Miller, et al.)
- ☐ Some 60 individuals have received counseling or assistance, ranging from a single phone call to weekly meetings with an individual over a twelve month period.]
- ☐ A number of people have been referred to professionals or clinics for appropriate assistance.
- ☐ A crisis line was established and has been used on a number of occasions.
- ☐ A Bishop's Discussion Program was established which includes scheduled discussions on the topics listed in Table 2. (See below)
- ☐ Crisis intervention classes have been sponsored for ward Relief Societies.

Table 2. Bishops Discussion Program, Topics (Salt Lake Winder Stake Program Content)

Session	Topic
1	Introduction to Stake Program
2	How People Communicate
3	Crisis Intervention
4	Interviewing Techniques
5	The Role of the Gospel in Solving Emotional Problems
6	Counseling Married Couples
7	Counseling Children
8	Counseling Families
9	Available Services: LDS, CSC, etc.
10	Counseling Those Who Have Sinned
11	Counseling Those Who Have Loss of Belief or Faith
12	Encouraging Behavior Modifications
13	Church Calls and Releases —Avoiding Problems
14	Encouraging Better Stewardship
15	Death and Dying
16	How to Get Through to Difficult People
17	Restoring Self-Esteem
18	Dealing with Feelings of Helplessness
19	LDSSS: Unwed Mothers Program
20	LDSSS: Single Parents
21	LDSSS: Indian Placement
22	LDSSS: Adoption
23	LDSSS: Unwed Parents
24	Learning and Teaching in Groups
25	More on Groups
26	On Intimacy
27	Family Dynamics
28	Helping People to Set and Meet Goals
29	Child and Spouse Abuse
30	Developing a Helping Relationship

Each one-hour session consists of:

10 minutes - Review, tuning in, communication skills
10 minutes - Introduction to Topic
30 minutes - Discussion, Role Playing/Practice/Exercises
10 minutes - Wrap-up, Review, Questions

As of April 1985, the Winder Stake program has plans to implement a stake Resource Night which will consolidate some existing programs to a single day and allow for the development of planned new services: resource/discussion groups for singles and single parents, parenting classes, and counseling training for stake resource people.

It should be noted that all program services are completely voluntary for recipients. This is not a church program *requiring* member support. Although bishops may call a couple to take the couple-communication class, most couples participate because they elect to. Even participation in the Bishop's Discussion Program is optional. However, participation in all programs has been strong—overwhelming at times.

STARTING A NEW PROGRAM

To initiate a program at the local level, one must obtain priesthood approval and support. It is imperative that the stake president be contacted first. If the stake president elects not to support a lay counseling program, the program simply cannot be implemented. If the stake president is willing and able, a long-range development plan should be outlined which will meet local needs. A lay counseling program might plan to meet the following goals—

- ☐ aid and enchance existing counseling provided by bishops and stake presidents,
- ☐ provide additional helping resources at the stake and ward level, and
- ☐ take advantage of professional services in a structured manner.

Such a stake program, tailored to local needs and resources, will consume two to three years in initial development efforts, if not more. Table 3 (page 67) presents steps that might be followed in implementing a program. Achieving success in all these activities may take many years. For this reason, individuals called to assist in the program might be prepared to offer years of service.

As with all new and comprehensive programs, problems will arise. Table 4 (page 67) summarizes typical problems likely to be encountered. Professional involvement and direction will help minimize problems. Other remedies are time, prayer, study, education, persistence, and patience.

STAFFING

The selection and call of a program staff are critical to the success of the program. Personal qualities which seem important in this program include

- ☐ faithfulness to the principles of the gospel,
- ☐ commitment to the program and local leaders,
- ☐ an interest in people,
- ☐ a caring, sensitive, and understanding attitude about people's problems,
- ☐ a willingness and ability to participate in personal analysis,
- ☐ the desire to study and learn,
- ☐ flexibility and open-mindedness, and
- ☐ time availability.

The administrator of the program might be the high councilor in charge of welfare services. A former bishop might be a logical choice. A practicing psychotherapist might also be considered, although this could be asking too much of a peron who works all day in the field. The priesthood or sex of the leader seems immaterial because the program is a *local support function* to the priesthood, not an official Church priesthood program.

Professional assistance and guidance is obviously required. This help might come from such sources as local LDS professionals, the LDS Social Services Office, and community mental health volunteer service organizations.

To assist the program administrator, a number of stake welfare resource people should also be called. These people assist as the need arises, e.g., providing friendship to those suffering a problem, assisting in group discussions, providing temporary living space, assisting in crisis intervention, assisting in training programs, helping families involved in the Indian student study program, and lay counseling.

Table 3. Program Development Steps

— Contact stake president.

— Outline a tentative plan.

— Involve the local representative of Church Social Service.

— Introduce proposed program to stake leaders.

— Introduce proposed program to bishops.

— Involve local LDS or LDS-compatible professionals.

— Revise plans to reflect comments of stake leaders, bishops, professionals.

— Call a program administrator.

— Complete plan; establish goals, timetables, etc.

— Call resource couples, as needed and available.

— Locate and tap into community resources; generate catalog of services available.

— Provide training e.g.,
  Community training resources
  Community mental health activities
  University and college courses
  Church Social Services
    Terrance Olson & Lanier Britsch, *Counseling*, vols 1, 2 (Salt Lake City, UT: Deseret Book), two of the best resource texts available for this type of program.
  Other texts and reading material

— Establish local-need activities.

— Provide mechanism for program review and critique.

— Establish reporting methods.

— Establish service programs, e.g.,
- Establish and maintain crisis line.
- Establish counseling programs.
- Establish bishop's training program.
- Find and establish safe houses for abused spouses, children.

— Establish a Resource Night program, e.g.,
- counseling
- training
  - couple communication
  - parenting
  - counseling training
- groups

— Establish or use available communication resources, e.g., stake Relief Society and quorum networks.

— Find funding sources, if required.

Table 4. Typical Birthing Problems

— Overcoming inertia	— Finding time
— Stigma on "counseling"	— Obtaining training
— Interfacing with leaders	— Discouragement
— Finding resources	— Occasional failures

Training and education of those called should be immediate and on-going. Most communities have appropriate training programs available through county mental health agencies, community service centers, universities and colleges, and hospitals. The Church Social Services, for example, provides training when asked.

SUMMARY

This is a local program that can assist priesthood leaders. It represents one approach to applying Christ's admonition to love and care for one another. It provides an opportunity for members to minister to each other's needs. It offers a way for professionals to be involved at the local level without being overwhelmed. It supplies a good method for introducing gospel-compatible counseling techniques into the LDS community and it gives local leaders the opportunity to manage and control such activities.

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S.A.V.E. . . . MORE THAN A FOUR–LETTER WORD

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Presented at the AMCAP Convention
4 April 1985

The use of habit-forming drugs has been identified as a social problem among members of the Church of Jesus Christ of Latter-day Saints (Mormons). To help combat this problem the Church has, among other things, published a pamphlet titled *The Resource Manual for Helping Families With Alcohol Problems.* After several years of research and correlation, this publication was mailed to stake presidents, bishops, and branch presidents throughout the United States and Canada in May of 1984. The manual is an attempt to help curb the use of alcohol and other habit-forming materials. Substance dependency is viewed as an increasing problem among Church membership. It is well understood by the leadership of the Church that the rate of consumption for church members differs depending on location and circumstances. In some of the developing countries the problem appears to be epidemic in nature, while in Utah and other parts of the West, where the Church is better established and where Church membership represents a majority of the population, the consumption rate is typically below the national average.

The viewpoint of Church doctrine is that any position other than abstinence is unacceptable. Because of this strong stand on abstinence, members of the Mormon Church who use habit-forming or addicting substances, seem to develop some unique personality characteristics. This is clearly illustrated in the case of a twenty-one-year-old male who was feeling a great deal of conflict and who sought help from a well-known alcohol treatment program. He was told by his therapist at the treatment center to accept the concept that he was suffering from a disease for which he could not be held responsible, yet his value system was telling him that the use of such materials is looked upon by the Lord as a sin.

His struggle was great, even though neither he nor his family had been "active" in his L.D.S. religion for 15 years, or since he was about six years of age. Such a phenomenon is observed in other religious organizations where a prerequisite of abstinence is a condition for full participation. The focus of this paper will be to try to better understand the dilemma faced by the L.D.S. person who is trying to make his way back into the L.D.S. community after having been dependent on mood-altering substances.

Background

When the Church was first organized, the use of alcohol and other drugs was not identified as being counter to the principles of the gospel. However, with the advent of the Word of Wisdom, the 89th Section of the Doctrine and Covenants, received February 27, 1833, the use of habit-forming substances began to be a point of separation of those in good standing and those not in good standing.

The 89th Section was initially given as a "greeting" and not as a commandment or by constraint, and the use of habit-forming substances was continued for several years after the introduction of the revelation. With further growth of Church doctrine and the development of religious dogma, the solidification of the religious stand against habit-forming materials became progressively more clear for some substances and less clear for others. For most Latter-day Saints and non-members familiar with the Church, it is clearly

understood that the use of tea, coffee, tobacco, and alcoholic beverages are against Church standards. Although this position is presently clear, it has evolved over time and was not so when initially implemented. Not so clear today is the use of cold drinks containing caffeine, addicting prescription drugs, and other items which some feel are wrong but others accept as appropriate.

That the 89th Section of the Doctrine and Covenants was not initially implemented as a commandment was viewed by some Church leaders as a godsend, since many of the early leaders of the Church were users of such substances and some were perhaps even addicted. As stated by Joseph F. Smith, (*Conference Report*, October, 1913, p. 14)

> The reason undoubtedly why the Word of Wisdom was given—as not by 'commandment' was that at that time, at least, if it had been given as a commandment it would have brought every man addicted to the use of these noxious things under condemnation; so the Lord was merciful and gave them a chance to overcome, before he brought them under the law.
>
> Taking a stand more in line with today's traditional view, Joseph Smith, in speaking to the "High Council" (Quorum of Twelve Apostles) in 1838, said, "No official member in this church is worthy to hold an office after having the Word of Wisdom properly taught him; and he, the official member, neglecting to comply with and obey it." (*Teachings of Joseph Smith*, p.117).

The trend for the 89th Section to become a commandment was evidenced when Brigham Young in 1851, after putting the issue of compliance to the membership of a general conference, declared the 89th Section to be a "commandment" rather than merely a "greeting". Even before abstinence from the substances identified in the 89th Section was identified as a commandment by which to judge the worthiness of Church membership, those who abstained were considered more devout and were trusted to hold responsible positions within the Church. This kind of compliance seems to have overshadowed the behavioral manifestations of Church dedication that were observed when many were asked to leave all that they had and move to new locations.

It was while moving west that the 89th Section received more emphasis. Many of the brethren were asked to leave their vices outside of Church buildings, or refrain from spitting and chewing. If the use of such materials, while in church, was necessary, the membership was admonished to do so discretely. (*Journal of Discourses* 8:361,362;1961). From this time forward, abstaining from the use of addicting materials became more a measure of one's religiosity and righteousness.

Research

Current research has found that membership in a church, regardless of denomination, tends to curb one's use of habituating materials. In other words, as church membership and activity go up, the drug use goes down. (Bry, McKeon, and Pandina; 1982). Other studies (Blum and Associates, 1972; Gossett et al., 1972; Streit, 1978) found a significant difference in religiosity between users of addicting substances and non -users. Non-users were much more likely to worship with their families and be active in their churches than were users.

Briscoe, (1966) in a survey of Davis County School District in Utah, found similar supporting data among a predominantly L.D.S. population. In his sample, 60 percent of the non-users attended church regularly, while only 25 percent of the users reported such participation. In a survey conducted by the Utah State Board of Education (1974), most of the students who abstained from stimulants, depressants or hallucinogens did so because of 1) personal beliefs, 2) health concerns, and 3) religious beliefs. When asked specifically about abstaining from alcohol, these same respondents reported their reasons for abstaining were 1) religious beliefs and 2) personal beliefs. This would indicate religious beliefs and values are significant factors in

influencing one's use of alcohol in a predominantly L.D.S. setting.

In a study by Straus and Bacon, (1953), consumption of alcoholic beverages was compared in students from four different religious backgrounds. Included in this study were those professing to be Jewish, Catholic, Protestant, and Mormon. The incidence of consumption was lowest for the Mormon group. Males used alcohol approximately twice as frequently as females. With respect to the complications their use created in their lives, the Jewish group was lowest and the Mormon group was highest. The author of the study concluded that the "Mormon students stood to lose all respect from their Mormon peers even if they had drunk only socially, whereas other groups paid little or no attention to the social drinking behavior." This would suggest that in most of society drinking is not considered to be much of a problem until one loses control and/or becomes offensive to those around him. In an L.D.S. population even the most minimal consumption is looked upon as requiring rather severe sanctions.

It is suspected by some who have studied the alcohol consumption of various groups that a unique quality develops among L.D.S. users. The assumed uniqueness is that when L.D.S. once begin to drink, a higher percentage of them develop a serious drinking problem compared to the general population where less emphasis is placed on abstinence.

It should be noted that much of the material published or spoken regarding "Mormons" and alcohol usage is based on observation and opinion and that there has been relatively little information generated from well controlled objective research. It should therefore be pointed out that reported consumption patterns may be based more on conjecture than on known fact. A good example of this is a statement made by a well known Catholic priest who speaks frequently regarding the consumption of alcohol, and who has made several references to "Mormons" and their drinking patterns. When asked in a telephone conversation for the source of his information, his response was something like "well I'm not sure, but it sounded about right." Probably much of the data reported in and out of the Church too often "sounds about right."

Resources

Since a basic tenet of Mormonism is abstinence from the use of habituating materials, and since simple observation confirms that a quantity of L.D.S. people are addicted to substances that run counter to the above tenet, what resources are available to assist the L.D.S. person in his desire to move from addiction to a life more conducive to good family relationships, sound friends, and inner peace with one's self?

For many new converts to the Gospel, their conversion provides the kind of support that is needed to move into a more peaceful and productive life. However, for those for whom this is not enough, other alternatives must be identified and/or established. Many who have had problems with habituating substances feel too tarnished to go immediately back into the mainstream of the Church, yet they find an emptiness in the offering made by other organizations such as Alcoholics Anonymous. They need a place where spirituality, as they understand it, can be discussed and they can know that there is understanding and hope for them. They need to speak with those who understand what is meant when they speak about their personal experience with the Lord or their Father in Heaven. For many who are attempting to make a return, getting back into the mainstream of the Church is like the child standing at a counter in the candy store with his nose against the glass. They can see all of the good things available to them, but it is still too far away for them to enjoy the benefits.

It is difficult for many returning L.D.S. persons trying to return through AA or similar settings, to enter a smoke-filled room, which to him/her still represents going against God's will or to talk about a supreme power that may be referred to as the "group", an "intangible God" or even a chair or table. Latter-day

Saint people have been taught from early childhood that God is real, that He can hear and understand them and is personal, and that He expects them to behave in certain ways if He is approached by them. The coffee-scented, smoke-filled room, with too frequent use of foul, four-letter words, makes it difficult for one trying to make the transition back, just as the bearing of strong testimony condemning misdeeds in a sacrament meeting may impede the return of the errant soul into activity. What is needed to assist these people as they work their way back into a life which holds dignity and acceptance for them is a place where their misbehaviors can be understood, yet where the familiar is truly familiar and accepting.

In November of 1983, a new program was introduced in Weber County, Utah, by a group of people who were interested in helping those who had become chemically dependent to bridge that gap which had kept them from enjoying congruence between their values and their behaviors. This new program took advantage of an existing program but built on it for those who needed something along more traditional L.D.S. lines. The name of the program was Substance Abuse Volunteer Effort Incorporated. This became shortened to S.A.V.E. Inc. With permission from Alcoholics Anonymous and Al-Anon, the twelve steps and twelve traditions were modified to meet the needs of this part of the L.D.S. population. The basic concept was retained, but the "higher power" became Jesus Christ, and rather than merely working for sobriety, the aim of S.A.V.E. was also to return those who attended back into Church activity and participation. Programs were provided for both the adult and the youthful user and families were included. An educational offering was added to the program to round it out.

Although not endorsed by the L.D.S. Church, those who have been working with S.A.V.E. have worked closely with the leadership of the Church to make it compatible and effective with Church values and concepts. Even though the program was designed for the person with an L.D.S. orientation to God, values, and life in general, it is not limited to just L.D.S. people. Anyone who desires to participate is welcome to do so.

In contrast to the typical AA meeting, there is no smoking or coffee. In a S.A.V.E. meeting, participants are invited to speak of their God as a personal God and testimony can be borne if appropriate. Those interested in forming chapters are invited to do so under the guidelines established by the Central governing body, which includes priesthood representation.

The following services are provided by S.A.V.E. Inc.:

1. *Outreach:* S.A.V.E. provides educational seminars and speakers for L.D.S. groups on a variety of drug and alcohol related topics.

2. *Family Intervention:* S.A.V.E.'s family intervention services are adopted from the Alcohol Intervention manual of the L.D.S. Church and are developed to assist those surrounding the substance abuser.

3. *Support Groups:* S.A.V.E. has received permission from AA and Al-Anon to adapt the twelve steps and twelve traditions to an L.D.S. perspective. Support groups include S.A.V.E. Families, S.A.V.E. Abusers, S.A.V.E. Teens, and S.A.V.E. Youth.

4. *Educational Resource Center:* S.A.V.E. has developed a list of materials appropriate for use by L.D.S. people concerning habituating substances. These materials are available at minimal costs.

If a S.A.V.E. Chapter would be helpful for those you serve, more information can be obtained by contacting:

S.A.V.E.
2568 Washington Blvd.
Ogden, Utah 84401 or by calling
(801) 621-7283

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REPORTED CHILD SEXUAL ABUSE: SUBJECTIVE REALITIES

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Presented at the AMCAP Convention
4 April 1985

On occasion, a particular case is illustrative of a number of principles somewhat distinct from the core problem or presenting difficulty of the case itself. Studying the winding path of case development can prove to be a fruitful way to gather techniques, cautions, and hypotheses. This is our purpose here. While this article is not actually an in-depth case study, nor true research following experimental design, we trust you will find something of use or at least some stimulation from our journey.

We have chosen the particular case in question because of the category in which it falls, i.e., alleged sexual abuse. Arguably, this is the hottest topic currently in the therapy world, certainly in the media. This case, reviewed here in a step-by-step fashion, highlights some cautions that are often in danger of being overlooked in dealing with such cases, particularly during a near hysteria period of public attention.

Presenting Problem

Melody, about five and one-half years old, was brought to our office by a very concerned mother who had had an introductory contact with us via telephone. She is a product of the mother's first marriage, which ended in a divorce when Melody was two years old. The mother, Joanne, was given custody of the girl. Melody lives with her mother and Joanne's second husband Harry, of about three and one-half years, and their daughter (Dixie, about two years old). On a rather regular schedule Melody visited her natural father, Bill, two weekends per month. The natural father's household consisted of himself, his second wife (Sally, a young woman in her early 20's for whom this is her first marriage), and their daughter (Susie, aged nine months). All members of both families are LDS.

Joanne reported to us that Melody's 1st grade teacher had seen her "fondling" female members of her class in the school's bathroom. According to Joanne, Melody possessed sexual knowledge "beyond her years" and had demonstrated in neighborhood play situations, as well as at school, behaviors such as fondling of erotic body zones, open-mouth kissing, and oral stimulation of the genital area of other children of similar age.

Further, the mother was quite confident as to what had caused the behaviors. She explained that her marriage to the child's father had ended largely because of his demands for sexual activity—the amount and nature of which she found "disgusting." He had repeatedly wanted Joanne to engage in what she referred to as "oral sex" and often attempted to persuade Joanne to pose in the nude for photographs he wished to take of her.

Subsequently, he had allegedly been unfaithful to her, shortly after which they were divorced. The mother had strong suspicions that Melody's natural father had sexually abused her in the interval between the divorce and his remarriage. During this period he had roomed with several other men. From the mother's report, the father had repeatedly ignored requests that Melody not be taken to see "R"-rated movies with him and his new wife. Melody claimed, upon her mother's questioning, that she could watch anything she wanted on cable TV while visiting her father and that she had learned what she called her "techniques" from movies and TV. Similar requests for Melody's TV

watching to be more closely monitored had, in the mother's view, been likewise denied. Joanne expressed fear that her daughter had inherited her father's "preoccupation with sex" and felt that something must be done to curb this tendency. The implication was clear-Melody had been "tainted" by her father's "perverted" nature.

Joanne was also concerned about her daughter's poor conduct grades at school. At her school and grade level it was usual to provide conduct grades as well as academic grades. While Melody's mother claimed that she did not expect top academic grades from her daughter (stating that Melody was not as bright as she herself had been in school), she wished to see Melody exhibit a little more self-control. Academic grades tended toward a D, while conduct grades were somewhat lower. From the mother's perspective, Melody was rebellious. She seemed unwilling to obey household rules such as getting ready for school in a timely fashion and putting her toys away. On some occasions Melody pinched or scratched herself (leaving visible marks and bruises) after being reprimanded by her mother and sent to her room.

Lastly, because of observed incidents of Melody's inappropriate sexual behaviors, Joanne had told family members and parents of children that Melody might come into contact with to "keep an eye out" and thus help prevent recurrences of a like nature.

Alternative Generation

One of the essential skills of a proficient therapist is the ability to manipulate diverse pieces of information to generate significant questions for proceeding with treatment. Without any attempt to be exhaustive in our analysis, we have formulated a number of questions. Is sexual abuse currently occurring? Does Melody really engage regularly in the behaviors reported? If so, what do they mean to her? What is her natural father actually like? Was she, in fact, sexually abused? Are the spouses of Melody's parents nonentities, only bystanders, or do they have a role in this portrait of current circumstances? Is there more than one client here? Is sexual abuse even the central issue of the case?

Assessment of Melody

The course of action chosen was to attempt a clinical investigation and assessment of Melody with regard to personality, and sexual knowledge and behavior. We treated the case as possibly one of sexual abuse and handled it accordingly. We made efforts to learn about her alleged fondling of others, just what sexual knowledge she possessed, and how likely it was that she had ever experienced sexual abuse. Asking such questions meant that the mother's perceptions were also under investigation as to their accuracy and validity. We employed several techniques.

Administration and scoring of a Peabody Picture Vocabulary Test revealed Melody to be significantly above average in intellectual functioning. Allowing for the Peabody's weakness in discriminating actual performance differences among children scoring over one standard deviation above the mean, Melody clearly was at least in the upper 10 to 15% of her age group on this measure of responses to visually encoded material. In interviews she exhibited a high level of curiosity, activity, quickness and flexibility; in sum, she is quite a bright child. Second, she was indeed strong-willed and persistent and a challenge for even a well-prepared and schooled parent. Melody did not take the agenda for socialization submissively. She could readily perceive the flagging energy and loss of patience in an adult working with her and use it to her own advantage. Rewards often came to her from seeing the impact she could have on the environment, irrespective of it being labeled as a negative impact.

Melody's self-esteem was poor and likely getting worse. She labeled herself as "bad" in a self-evaluation and exhibited considerable anger turned toward herself in her projective drawings (House-Tree-Person and Family Circle); she had been clearly spotlighted as a probable problem at school, church, and in the neighborhood by her mother's alerting of

significant people. It appeared to us that repetitive negative feedback from the environment was serving to reinforce a sagging view of self. Positive attention, praise and successful approval of accomplishment seemed to her virtually unattainable.

Using a variation of the House-Tree-Person suggested for use in sexual abuse cases (Holder, 1980), it was determined that Melody was strongly bonded to both her mother and father. While no evidence was found for sexual abuse having occurred, her feelings of closeness or alienation to others was significant information. Her most interesting and enlightening drawing was of herself within a circle surrounded by a refrigerator, chair, and pictures on the wall. She was set apart from her family consisting of Joanne, Harry, and Dixie, who were linked arm in arm on the same page indicating that she felt alienated from the family with whom she lived.

Three other methods were chosen to assess sexual knowledge and abuse: a play period with dolls, an indirect interview technique, and a play period with anatomically correct dolls. This latter technique is used frequently in child protective settings throughout the country and is accepted in numerous court proceedings. Evidence gained through this approach is asserted by its proponents to reduce to a minimum the doubt surrounding what kind of sexual abuse, if any, has been perpetrated upon the child and some of its effects. However, in our reviewing this intention with Child Protective Services personnel in Harris County, Texas, they expressed reticence regarding the appropriateness of its use with Melody. Apparently, the use of this technique has proved to be overstimulating sexually to some children with resultant negative effects upon subsequent therapy contact with the same practitioner. Accordingly, it is most effectively utilized as a quick measure of the extent of sexual abuse, when follow-up therapy is to be done by a different practitioner. For these reasons, play with anatomically correct dolls was abandoned in favor of play with family member dolls less anatomically correct. Again, these results indicated age appropriate sexual behavior and curiosity, but no overt signs of sexual exploitation.

An indirect interview technique was used as a second tool in ferreting out sexual knowledge and experiences. This device yields information about the subject's emotions toward parents and is often used in determining attachment in legal proceedings where child custody is being disputed (Lockwood and Roll, 1983). A series of eight guessing questions is used demonstrating four major aspects of attachment: responsiveness, confidence, hostility, and security. Although results indicated Melody held an equal sense of security toward both natural parents, stronger indications of responsiveness, confidence, and hostility were demonstrated toward the mother, Joanne.

Bonding with all four adults in Melody's life was tapped by a third approach, including a tongue depressor game developed by Jewett (1984). The child draws the features and clothing of family members (as she perceives them) onto tongue depressors. The child is then observed in her play with the figures. The manner in which the child has the figures communicate, the topics of discussion among the family members as well as the inclusion or exclusion of family members and/or topics of conversation can give clues to the feelings that the child has for the members of her family.

As a final step in assessing Melody, she and her mother were seen together in two successive counseling sessions with a view toward encouraging interaction between the two during these sessions and observing carefully the nature and processes prominent in that interaction. It is material to mention Ms. Taylor carried out this next step separate from any previous clinical contact between either the mother or Melody and with minimal knowledge of any conclusions and impressions resulting from the contacts.

It became clear during these sessions that Melody was an extremely "bright" child, probably more creative and inquisitive than the mother, and could be manipulative in getting what she wanted.

She was acutely aware of what to do to "trigger" her mother's negative response, and as we met it became obvious that Joanne's major area of vulnerability was in the area of sexual activity, based on her own fears and personal view, which appeared to us as overly rigid and negative. Melody had arrived at her own version of this perception and was using sexual misbehavior at least partly as an attention-getting device.

At this point, we drew a number of tentative conclusions from the assessment; we had assembled evidential support for explanations of the current behavior. Two consultations with Melody's natural father and his second wife provided clinical impressions of them as individuals and of the nature of their marital interaction and confirmed some factual matters related to Melody's exposure to sexual material, including "R"-rated movies and sexually explicit scenes on cable TV. That exposure combined with her brightness and curiosity had contributed in a major way to her "sexual" behavior with other children, both schoolmates and cousins. We think it unlikely that Melody had ever been sexually abused. Of great concern to Joanne, the continued visits with her father were judged to be "safe." Continued provocative behavior had brought substantial attention—very agitated responses from her mother—and hence considerable payoff to Melody. Melody's motives as she interacted with her mother might even be termed a form of retaliation or subtle hostility directed at the mother in response to Joanne's personal disapproval and the girl's inability to get things right in her mother's eyes. It is not an exaggeration to say that Joanne often simply did not like her own daughter.

Generating Alternatives

Who now should be treated first, mother or daughter? What were the characteristics of the natural father? Would he be willing to aid in restructuring his home environment to aid in Melody's behavior changes? What was the depth of Melody's hostile feelings for her mother? What was the depth of Joanne's feelings for Melody? What was the best intervention to use with Melody? What parenting skills would best serve Joanne?

Intervention

In this instance, a luxury sometimes not available was possible. We were able to implement therapy with both mother and daughter in weekly separate sessions. In our view, Melody needed individual counseling to modify the sexual behavior that had now become a habit and to help her deal with her feelings of low self-worth. Secondly, Joanne needed improved parenting skills to more effectively parent Melody and to decrease the payoff Melody received for inappropriate behavior. For the next four months, we held weekly sessions individually with Melody and Joanne.

Melody was open and frank but relatively ill-informed during the discussions about general sexual topics. She expressed considerable remorse and guilt concerning her fondling of other children. Particularly disconcerting to her was the possibility that she might not be able to stop this behavior, and this would prevent her baptism into the LDS church scheduled in eight months. Joanne had emphasized this point repeatedly and had Melody discuss her "transgressions" with their bishop prior to our meeting.

Several sessions were reserved for discussion about the mechanics of sexual intercourse (with Joanne's permission) as well as the process of birth, which was of particular interest to Melody. We emphasized the pleasurable feelings associated with manipulation of the genital area and the part that this played in the procreation process. She appeared greatly relieved to discuss the facts openly without moralizing. She was able to verbalize her fears and concerns as well as clear up many inconsistencies and falsehoods.

By talking with Melody we found that she could anticipate the episodes of sexual fondling of other children. The antecedent behavior included sexual fantasies about a female cousin, Margie (eight years old), who she said had introduced her to the sexual behavior. Indeed, she

reported that her fondling of other children always was accompanied by her fantasies of sexual activity with Margie. In order to extinguish this behavior, we replaced the sexual fantasies with fantasies that were pleasing and more appropriate. We devised a technique that included her favorite times of year: Christmas, Easter, her birthday, and Valentines Day. She decided that when she became aware of a sexual thought about Margie and the fantasies began (whether Margie were present or not) she would substitute these more appropriate fantasies in a very specific pattern; i.e., if she looked to the left, she thought about Christmas; if she looked to the right, she thought about Easter, etc.

We also spent a large part of a session role-playing [practicing] the application of this technique. We pretended that the therapist's notebook on a table was a "bad" thought that she wanted to get rid of, and with her coloring book (in which she had just colored a picture) she practiced knocking the notebook off the table, thus replacing the antecedent behavior that in the past led to the fondling of other children. Melody has had great success with this behavior modification technique and has not had an episode of sexual fondling for 10 months. Of importance to note is that she had had several social contacts with Margie which in the past would have triggered the inappropriate response. Meanwhile in individual sessions with Joanne, evidence quickly accumulated showing that she had an acquired negative view of all sexual matters. This attitude appeared to stem from parental attempts to teach, in perhaps overly rigid ways, LDS moral standards in relation to the nature of sexual experience with its joys and dangers. Joanne's personal perception about such matters were acquired subtly as she grew up. Attempts at explaining to her the scope of Melody's sexual fantasies or the effect of Joanne's parenting skills on Melody's behavior appeared to fall on deaf or ignorant ears. Joanne's preoccupation with the "moral" aspects of Melody's sexual encounters with both her cousin Margie and school playmates obscured Joanne's ability to understand the impact of this behavior on Melody's present functioning in her own family and at school.

Indeed, sex, as a topic of discussion, was a somewhat "taboo" subject both in her parental home as well as her present home. If sexual matters were discussed, they were spoken of in hushed tones with a heavy degree of moralizing thrown in. Humor was never associated with sexual topics. This presented an obstacle in our therapeutic sessions since Joanne could not or would not discuss sexual aspects of behavior without accompanying it with a heavy dose of moral imperatives.

Alternative Generation

This was clearly a crossroads in therapy since it was imperative for Joanne to understand how Melody viewed sexual matters and how she was using her superior intelligence and Joanne's aversion to sexual topics to manipulate her mother. How was the therapist to provide insight to Joanne so that she could parent adequately? Could Harry play a role here?

In a somewhat desperate move to enlist aid, we decided to add her husband, Harry, to the sessions with Joanne in hopes of getting his help in the use of proposed parenting skills. Interestingly, the introduction of Harry into a joint session with Joanne proved to be the turning point with Joanne, but for entirely different reasons than we had thought. It soon became obvious that Harry had a sort of catalytic effect on the whole therapeutic process. Often, it seemed, he was able to reframe or reinterpret the content of our sessions for Joanne at home after the sessions. After that, progress was more consistent and incremental. One of the factors that made this development such a surprise was the initial clinical impressions of Harry, indicating that he had less power and authority than Joanne in their relationship, with no indications that she would ever seek or yield to his counsel. It was through Harry that Joanne was finally able to perceive the depth of the turmoil her daughter was experiencing. She began to understand that Melody's fantasies which preceded her fondling behavior were rather

similar to those that precede masturbation in adolescents. Once that was clearly understood through Harry, she became an ally in Melody's attempts to modify her behavior. She could now appropriately encourage and express confidence. This opened up the communication between mother and daughter, and Melody was able to start discussing sexual topics with her mother. At about this time Joanne became pregnant after several years of unsuccessful attempts, and mother and daughter soon had ample opportunity to discuss the pregnancy and birth process.

Attention was then turned to more effective parenting skills that would build Melody's self-esteem. Joanne was encouraged to determine what areas of behavior were of utmost concern and to concentrate her efforts in these one or two areas. She was, up to this point, at a disadvantage in dealing with a child as bright, verbal, and manipulative as Melody. Joanne had functioned primarily as "reactor," outwitted by Melody's intelligence. Joanne complained that she was "simply unable" to control Melody's other [nonsexual] behavior.

Through a series of suggested readings about parenting processes and developmental phases of childhood, Joanne gleaned new insight into her daughter's state of developmental growth and some appropriate techniques for parenting her. We discussed Melody's lack of self-esteem and her outbursts of anger. We suggested substitute methods for Melody's displays of anger, and Melody practiced them: e.g., instead of throwing toys at the walls, she was instructed to jump rope a given number of times. This use of substitute behaviors intrigued Melody and served to extinguish over a few months the scratching and biting of herself that she had been doing when she first came to visit with us. One possibility is that the substitute procedures were more intriguing, more rewarding in and of themselves, and the procedures may have appealed to her intellectually.

On a second front of the battle, to increase self-esteem, we pointed out to Joanne that Melody had little or no confidence in expressing her desires or preferences. For example, when choosing pictures to color in a coloring book, Melody wanted either Joanne or the therapist to pick out the picture for her to color, as well as the crayons to use. Joanne was instructed to devise opportunities to encourage Melody to make choices. She was instructed to pre-plan an opportunity, such as picking out vegetables for dinner or a particular dress to wear to church. Joanne was told to narrow the array to two choices that she herself could be comfortable with and then allow Melody to choose between these two. It was explained to Joanne that she must be able to accept either of the two alternatives since to subsequently persuade her to form a different opinion once Melody made the decision would undermine the entire process.

Joanne was simultaneously instructed to set aside some time each day for her and Melody to have private time together. Joanne worked both of these together nicely by encouraging Melody to help cook dinner when her other daughter was napping and Harry had not yet returned home from work. Melody was at first given the choice between two kinds of vegetables to accompany dinner and gradually increased her choosing to encompass the entire dinner menu within a few months. This evening ritual probably contributed more to a feeling of closeness between the two than any other single event. It was also during this dinner preparation time that mother and daughter began to share their feelings on a whole range of topics, including biology. Post-hoc observations suggest that Joanne had seen Melody as either competition or viewed her through an impersonal screen—never having learned to relate personally to a child. Perhaps there existed a similar formalism or lack of personal warmth as she herself was raised. With a close mother-daughter bond under construction and an increase in each party's self-confidence, the need for strong discipline decreased significantly. The adversary relationship and the games it spawned began to fade.

A final issue dealt with was fostering a more appropriate environment for Melody in her father's home, especially as it pertained to cable television and attendance at movies. Joanne was encouraged to discuss with Bill Melody's need to be restricted from watching "R"-rated movies. She was encouraged to use a minimum of moralizing, since this might trigger old memories for Bill and cut off communication. This action was delayed for two months because Joanne feared that her requests would be ignored. To the contrary, Bill's reaction was immediately positive and Melody's TV watching was restricted to more appropriate children's viewing. As an example of Bill's conscientious approach to his responsibility, Melody related an incident in which Bill walked out with her during a movie that had been rated "PG" because he felt it was too sexually stimulating for her to see.

Melody terminated therapy one month prior to her baptism and reported that her substitute fantasies were working very well. She had also made a number of new friends. Frequent opportunities had arisen for her to be alone with Margie in an extended family setting, and Melody had not experienced discomfort in those situations.

At school, the reports of Melody's sexual fondling of classmates have ceased for the past six months and her conduct grades as well as her academic grades have improved from D's and F's to B's and C's. She is now allowed to play with children in the neighborhood without excessive parental supervision. Melody has joined the ranks of the "normal" in her mother's eyes.

The case of Melody has provided an interesting opportunity for therapist creativity and flexibility. We see the possible outcomes as quite different from those anticipated when Joanne first contacted our office. Perhaps the greatest strides for these clients have come in a revision in the family's attitudes toward sex, increase in self-confidence for both mother and daughter, and enhanced communication between husband and wife. At least two of these outcomes had not been originally expected. Whatever the positive effects were, over the course of therapy they were partly the result of simply taking time to step back and generate alternative solutions and possible interventions. It was a matter of trying to assess what was known and juggle the several hypotheses that were present and to determine what approach to take and allow ourselves revision of the plan for treatment, rather than making arbitrary limitations as to client or problem.

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COMBATING CHILD SEXUAL ABUSE: A CAUTIONARY ESSAY

DENNIS E. NELSON, Ph.D.

Though seemingly diverse, hula-hoops, sensitivity training, pet rocks, tonsillectomies, and bustles all partake of a common element: to some extent each has been associated with the human proclivity to engage in fadism. To be sure, we usually associate fads with the more superficial aspects of life such as clothing, hobbies, leisure activities, or ancillary possessions, but students of historical bent can find passing fancies, phenomena we may refer to as being "in" or "out," within any area of knowledge or professional field as well. The health care professions evidence no immunity to this most "human" state of affairs. The aforementioned tonsillectomy, so familiar in the late 1940's and early 50's, and the recent reassessment of the commonplace Caesarean section deliveries of the 1970's provide two examples found in medicine. A similar long list of examples could be found in the Behavioral Sciences.

More than a few careers, some famous and others less well known, have been founded upon a topic, a research question, or point of view which happened to be popular, or was just beginning to emerge in the social fabric at the time. In some cases, progress has been retarded or delayed due to the vested interests of those involved in professional career building, or maintaining acquired position and power. Science is often no quicker than the masses in yielding up old truth for new. The words of Allen Bergin, spoken years ago as an aside during an AMCAP presentation, rather dogmatic in its behavior stance, seem appropriate. He remarked, "It's comforting to have the truth, even though you have it for only ten years."

Some twenty years ago, while working for a large private contract research firm in California while pursuing doctoral studies, it became a way of life and livelihood to become somewhat addicted to the Federal Register and similar publications, closely scrutinizing that key to continued income for both company and individual—the sacred RFP (Request for Proposal) from various government agencies. That period may have been the classic era of one form of fadism, at least in the behavioral sciences. It was, of course, during the tenure of Lyndon Johnson when the Great Society was trying desperately to flower, fertilized by bureaucrats with no end of ideas as to how to spend other people's money, and more than a few researchers willing to see each new RFP as touching some critical area of needed research, perhaps likely to lead to saving knowledge, or at least keep the project staff employed.

Adoption of such a view of the world was rather easy to acquire in the context of an academic community where research was religion and proposal writing a part of the liturgy. Though rarely admitted, often one's actual research interests gradually gave way to replacement by an acquired enthusiasm for the topics and issues of interest to contracting agencies, but with enough rationalization to preserve one's self-respect. Great time and effort was spent lobbying key people connected with the funding process at various agencies. Learning the emphases or elements in a proposal likely to catch the eyes of those decision makers who handed out the blessings was of vital importance. What slant should it have? What kind of approach to research was favored? What kinds of outcomes were hoped for? What was the power structure of the agency? Who was really going to select the proposals to be funded? What was the nature

of proposals funded by these individuals in the past? Grantsmanship was not to be taken lightly, and in the author's view, frequently caused the quality of research to suffer as well as defined with criteria of questionable relevancy that research which would be undertaken and how it was to be conducted.

This slice of subjective history illustrates that rather strong, broad, social variables significantly effect even "science." The acquisition of knowledge, what problems will be given attention, which are ignored and the kind and amount of attention given are all subject to fluctuation. Thusly, the "fads" of Behavioral Science are made.

In the world of psychological services, life is no different. Reference is not made here to the historical shift in emphasis among various schools of thought or therapeutic approaches. The change in dominance through the decades from Psychoanalysis and dynamic explanations of behavior with recommended therapeutic interventions to somewhat different kinds of insight related and client-centered therapies, thence to the social learning and behavioral emphases of the 60's, followed by the cognitive and the later cognitive-behavioral alliance of the 70's to the biological revolution in the 80's is real and well-documented! These developments are not fads in and of themselves though they often reflect changes in social thought and the spirit of the times as much as they reflect clear advancement in knowledge. My focus is on a less macrocosmic phenomenon, more easily observable, much like the RFP experiences mentioned above.

While perhaps more numerous in the area of social work than in the office of the clinical psychologist, fadism is there none the less. Weight reduction, Type A behavior, run away children, adoption, and learning disabilities have all had their place in the sun during the last couple of decades along with teenage suicide, childhood alcoholism, and a score of other topics. Most problem areas follow a process of being "discovered," subsequently showered with media attention, suitable public awfulizing about the problem, a trunkful of solutions hastily offered, considerable funding graciously provided (often from private sector sources as well as public) and then after the parade has marched onto another area of concern, diminished public notice, little follow up funding and almost no evaluation of amelioration effectiveness. Like cocktail party small talk, a few topics are perennials, such as stress related difficulties and interventions. Very few seem to maintain their popularity for a considerable number of years running. It needs to be made clear that all work in the aforementioned list of problems is not being disparaged, nor is it being recommended that knowledge about these problems be suppressed or ignored.

Increasingly, however, it seems that the "discovery" of such issues or topics and the subsequent attention and approach to them is being too heavily influenced by factors unrelated to scientific inquiry or sincere human compassion. Millions of starving Ethiopians have taken world center stage since their "discovery" by the media. This rising trend toward "media event" therapy or what we might cynically call the "problem of the month club," has serious pitfalls and ramifications. Among these are the framing of the difficulty in sensationalistic terms, oversimplified proposed solutions to the current "problem," short term over-reactions followed by a business as usual attitude and a vulnerability of a problem so defined to being exploited for the gain of various interest groups. This possible outcome is seen as reality with regard to the black civil rights movement of the early 1960's by James Meredith, the famed civil rights activist, in a recent Ohio speech in which he asserted that that very thing had been done by white liberal politicians with the cause celebre of integration. They cared not, in Meredith's view, about civil rights at all, but rather about acquiring a segment of votes for their own political agenda. As important as it is to gain an understanding of what is causing this tendency to find and attend to social problems on an irrational basis and

explicating the pitfalls, this paper will confine itself to a moderately detailed analysis of the negative possible ramifications of one current example of the phenomenological class, child sexual abuse.

If there were a slick paper magazine equivalent to *Time* in the bailiwick of the helping professions, the Topic of the Year Cover (equivalent to Time's Man of the Year Cover) for 1984 would surely be Child Sexual Abuse. (*Psychology Today* doesn't fully fit the analogy since its coverage is somewhat broad in regard to human behavior and such bias as political idealogy and "selling" potential for advertisers' influence that selection as well as style.) The current year (1985) promises a renewal of the appropriateness of our hypothetical cover. Hardly a month goes by without a TV documentary related to the subject. Newspaper coverage of litigation on the matter (the McMartin case being the most prominent) is recurrent. Articles on the topic in the "Lifestyle" and "Family Living" sections of Metropolitan dailies abound. Programs to instruct children in avoiding or coping with potential, current or past sexual mistreatment are proliferating. Juvenile law related agencies are being presented with startling increases in allegations to investigate. Schools in some areas are rushing to implement classes, counseling groups, and other instructional programs on the topic. Printed material addressing the issue even includes a Spiderman Comic Book which has been distributed in the Sunday supplement of at least one metropolitan daily. A large department store chain in one major urban area is sponsoring an entire week of related activities for children and parents.

How can there possibly be any ill effects of such developments? One is tempted to give the whole movement an encouraging shout of blanket approval. Another national tragedy, an insidious injustice destructive to society has been disclosed and vigorous action taken to ameliorate the conditions. Through such efforts it can be argued that thousands of youthful lives will be saved from long term trauma, physical danger or perhaps worse.

Although risk to life and limb is recognized by stepping into the path of this instant social juggernaut, a few cautions and possible negative results of what is essentially a media based therapeutic model that has not been given adequate attention needs to be addressed. Such cautions are not suggested as being all inclusive, nor provided in order of priority. Some admittedly reflect the author's bias about what is healthy and desirable in people's lives:

1. An atmosphere may be created wherein authorities, whether child daycare center, juvenile protective personnel or others, make quick assumptions about the truthfulness of accusations when a topic is prominent irrespective of evidence discovered later to the contrary. Even intelligent professional people move quickly to conclusions about the truthfulness of an alleged event or its meaning, because of the repugnant nature of it, or current emphasis.

2. A significant number of falsely accused individuals are traumatized and marked for life, while in actuality being innocent. In a recent case that is not unique, the expenses to one so falsely accused included jail exposure to physical abuse from other prisoners, disruption to college education, a strong decline in college grades, an acquired fear of social gatherings (due to worry about who might have heard about his ordeal, and what parts they had heard), police rudeness—including the shouting of the charge throughout the jail so as to inform the other inmates, thousands of dollars in legal fees, and the closing of a family business due to adverse publicity and subsequent decrease in business revenue.

3. With this current topic of focus, as with so many others, the common error may again be made that information and publicity solve the bulk of the problem. Associated with the notion of economic free enterprise is the myth that truth will come out victorious in a free marketplace of ideas. This is, to put it bluntly, false, unless certain assumptions are made about the people in a particular society and about the length of time needed for truth

to be vindicated. What kind of information is really helpful in combating sexual abuse? How much of that information should be given to a particular age group? These issues have not really been investigated. As in the case with Sex Education, the real issue is not whether or not a child needs to be "educated," but by whom, with what information, in what sequence, with what values and with what underlying view of reality. Should the data or "facts" be interpreted intellectually or emotionally? Rare is the case where a sheer glut of attention and information bring significant, sustained change in behavior, even in clearly self-destructive instances. Individuals dying from lung disease as they puff merrily away on the disease producing substance serve, along with scores of other examples, as evidence of this fallacy in thinking.

4. In providing such intense "help" to children and pre-teens, they are also being given tremendous power for good or ill. This is a prime example of the principle that "knowledge can be power." By teaching the mechanics of sexual abuse in some detail, how it is done, (how to interpret human touch, for example), by publicizing how common abuse supposedly is and the likely sources from where it comes, by showing non-verbally and verbally how alarmed we are—almost paranoid about the possibility in some cases, we as adults are in danger of providing a means for young people to misuse their new knowledge for personal gain or self-destruction. Those who desperately seek attention have an effective way of getting it. Some who are angry with a step parent or natural parent have a new way of getting even. Members of the bright but bored set have a new way of manipulating the environment and watching the reactions of and effects upon others with little understanding of the deeper, subtle or long-lasting consequences for others. It seems a lesson from the Salem, Massachusetts witch trials of so long ago has been forgotten.

5. Current interventions seem to emphasize independent control over one's body and resisting any and all touch deemed inappropriate by the child. Such emphasis brings the danger of blunting the positive effects of parent child physical affection by placing the seeds of alternative meanings on touching as a behavioral class, as well as fostering inner conflicts over physical closeness and warmth. In the minds of a generation of children who so deeply need more, not less, physical contact with adults, the desire for an evaluation of this aspect of life is clouded. Children are already too isolated from open, regular physical affection. Analytical recurrent interpretation might displace spontaneous physical affection, in the lives of both giver and receiver.

6. It is my view that initially all healthy children very early acquire, or perhaps blend neo-natal experience with something quasi-instinctual, a sensing of intent on the part of adults around them including the intent of the adult's touch. This may be a general feeling of discomfort, uneasiness, OK'ness or calmness, if you will. We spend considerable time as therapists attempting to get adults back in touch with their inward sensing mechanisms, to be in tune with their body, and to listen to what one might refer to as "the wise little person inside of them." It is possible that continued societal emphasis on protective training regarding sexual abuse may bring them to second guess those inward rules of discernment, heightened generalized anxiety and fear, and promote even further the tendency toward intellectualizing rather than feeling.

7. Certain concepts that seemingly are commonplace and desirable in therapeutic practice, virtual articles of faith, are on occasion with more reflection and study found to be destructive. Study is needed of just what concepts are useful to teach and what is incorporated mentally and emotionally by children as the result of the teaching of a particular concept. Two examples will suffice as representative. Is it necessary or desirable to give young children instruction in just what erogenous zones of the body are and where they are located? Do we know what is "learned" from such instructions? Controversies

already exist over "bright victims" having possibly picked up cues and being coached as the result of interviews conducted by agency employees in alleged child abuse cases.

Concerning the concept of body ownership, yes, my body is in at least one sense mine, and I have agency over it up to a point. Yes, if I don't wish to be touched, I have every social "right" to request that I not be touched. As is the case with manufactured legal "rights," once something attains that status it tends to dominate and sublimate behavior which has only the status of a choice. How is my right not to be touched reconciled and balanced with a mere choice to be touched. Is it preeminent, more important? Is receiving the comfort, warmth, and pleasure of physical touch and exploration from another, or the "right" to express myself with my body to give such benefits to another, an equal right? Is the body only a possession of mine, a machine, a stewardship, or more? What concept does the child have of his body after the intervention and instruction is given?

8. The philosophical questions raised above as well as other issues cannot be artificially separated from values. As is the case with any topic which impinges on the more personal, intimate aspects of life, and is complex in nature, and where "learnings" affect character, the teaching of values is implicit. That process is never absent, in spite of disclaimers to the contrary. The question is not whether or not values are taught, but which ones.

9. We may be projecting too many of our fears and personal agendas as adults onto our children. Though in some instances unconsciously done, and commonly carried on without malice, the effects of fear inculcation on children take their toll regardless. Already the "statistics" appear. One out of every 10 children suffer sexual abuse in some form. Can an article claiming 1 out of 8 be far behind. Does the danger lurk around every corner and just down the hall in our own home? By implanting so much fear about so many things, we pollute the new generation's ability to really take a fresh approach to resolving society's problems and remake their childhood, shortening it and ripping it out of context. Just as subtle, and more perverse, is the possibility of vested interest group fear projections, like the techniques used by many hard asset newsletters, or the factions of the political left uncovering or manufacturing evidence that the nation's school children are running around the playground traumatized by the fear of nuclear war. Recruitment for future struggles over men's minds is at issue. We are naive if we fail to see that whole industries can develop from such beginnings, and spring from such non-noble motives.

10. Potential litigation will govern even more of our life decisions. Protection, not service, becomes the motto under such circumstances. What is best for a child slips to second place behind what might be the possible negative consequences legally for the service provider.

We chuckle about court cases in Sweden wherein a child sues his parents for being spanked, yet do we forget that laws usually serve to document the deterioration of character among the populace. Law substitutes for the inability or unwillingness of people to govern themselves. Further it is the weapon for forging social and political policy to the liking of various special interest groups, some of whom desire not goodness, but power and control over others for their own ends.

Undoubtedly, the nature of the concerns raised above will seem to some as alarmist, simply pessimistic or even bizarre. However, the intent has been to stimulate thought and research relative to the assertion that even intimate human problems and their remediation have become media events and processes and have determined and defined interventions employed according to often extraneous variables. Second, it is suggested that much more attention be given to thoughtful remediation efforts which would entail some consideration of the type of potential negative conclusions which have been discussed herein. Third, evaluation of

intervention effects needs to be a high priority—a concern which appears to be virtually absent in current programs relating to prevention of sexual abuse.

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PSYCHOTHERAPY AND THE RELIGIOUSLY COMMITTED PATIENT: A BOOK REVIEW

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Historically, the western world has talked easily of religion but not about the psyche and its hidden parts and passions (sex was always involved somehow). Psychiatry and psychology have helped change all of that, but now the situation is almost reversed. Religion is the new taboo—especially among therapists.

Mormons have continued to talk about religion through all of this. Mormon therapists have also kept religion in the forefront of their minds—as have a minority of other therapists. But in the broader world of psychotherapy some changes have been occurring recently. Now a major social science book club features a book on the topic of integrating therapy and religion for religiously committed patients. It not only encourages therapists to heal the split between religion and therapy but states that incorporating religious thought is crucial to treating the whole person. The best statement is a quote by another author in this book of essays:

> "Our psychologizing may seem actually a theologizing, and this book is as much a work of theology as of psychology. In a way this is and must be so, since the merging of psychology and religion is less the confluence of two different streams than the result of their single source—the soul. The psyche itself keeps psychology and religion bound together" (Hellman, in Stern, p. 141-2).

But why review a book that acknowledges what Mormon therapists have believed all along? Because we need to go further in integrating the links between our professional and religious halves, and because we too often only look to each other for new material without searching the world of religion outside of Mormonism to help us find deeper therapeutic questions and answers. This book helps in both ways, although it is only a fledgling effort and in no way covers the broad field of therapy well.

The editor, Mark Stern, tries through the vehicle of 16 articles from a variety of psychotherapists to bring the religious issues a client might have into the mainstream of concern for professionals. The book runs only 158 pages, containing a collection of short pieces that are generally the reflections of each writer. There is no unifying theme to these pieces, nor is research in this area integrated into most essays (there may not be much research to integrate). Most of the articles lean heavily on the theoretical side; only two or three focus on the bridge between the theoretical and practical in therapy. But most have several excellent ideas, or contain an interesting clarification of a therapeutic issue such as guilt, perfectionism, or the challenge of the therapist to be clear about his/her religiosity while simultaneously affirming the client's religious growth. Others wed religion and therapy with fresh concepts such as "the art of discernment" or the positive nature of some countertransference. Consonant with many Mormon therapists, the articles clearly reflect the religious commitment of the author (although institutional affiliation is usually not mentioned).

This is not to say that I would recommend you run out and order the book. Although I now think it is worthwhile, it took me two readings to grasp some

important concepts in a few of the essays. Maybe it was the vernacular of mainstream Christianity that sounds foreign to a long time Mormon like myself. Maybe it was that some of the writers were obtuse or used convoluted language or wrote about topics that held no interest for me. Maybe it was that I have just started doing some serious thinking about this topic and needed to warm up. In any case, my appreciation was earned, not easily won.

Since there is little space for a review of each article, I have chosen a few favorites for discussion that may yield some insights for Mormon therapists. In a good beginning essay, the editor sets the tone of the book by defining spirituality, outlining the role of the therapist, and acknowledging the intense dilemmas—or "psychospiritual quests"—that religiously active patients encounter. A good sample of the language of the book as well as summary of his article is the last paragraph of his piece:

> Patients need to know that their respective quests are honored by the therapists they have chosen. As witnesses to psychological growth and expansiveness, psychotherapists take on the mantle of psychological as well as spiritual authority. Beholding their patients' lives as radically developmental leads to better understanding of a covenant with God's evolutional essence within personal experience. This process is sacred since any insights a patient receives are more than an elaboration of individual psychodynamics. These insights establish a basis for the appreciation of the whispering voice of revelation making each pilgrimage into patienthood a confirmation of the worthwhileness and sacredness of the community of all human life (p. 11).

Carol Rayburn, in her essay titled "The Religious Patient's Initial Encounter with Psychotherapy", discusses some of the vulnerabilities that religiously committed people have when coming into therapy. For example, she cites some research (a few cited are over 10 years old) in which religious students are characterized as feeling less adequate and being more anxious, defensive and dependent with accompanying lower self esteem than non-religious students. Essentially, religious involvement does not save you from problems, and when emotionally upset it may work against you at times. "Religious patients, more than any other kind of patients are apt to experience their problems as felt punishment for some sin and to sense varying degrees of guilt for the misdeed" (p. 38). With that base, she does not deny religion, but outlines several interventions. She advocates actively supporting the patient's value system—both to the patient and to his or her family. She also suggests refining some concepts, such as perfectionism, in a new way for the client so that psychological and religious growth can occur. Additionally, she addresses the topics of guilt, anger, fear, gaps in therapist-client beliefs, and clients who are dissatisfied with parts of their religion.

In a striking essay, "The Spiritual Emergency Patient: Concept and Example," Steven J. Hendlin discusses the need for understanding what is truly happening when spiritually active people experience psychological symptoms of distress. Most psychiatrists encourage such people to cease religious practice or at least decrease it. He does not, but suggests that emotional crises can come as the result of unmasking unresolved issues while working to achieve a personality transformation or greater level of maturity through spiritual means. "The term 'spiritual emergency' suggests a crisis but also the potential for rising to a higher state of being" (p. 79). He suggests methods for affirming and continuing the religious practices while dealing with the emotional and practical problems. His is the only article to include concepts and techniques from transpersonal psychology, a branch of psychology that seeks to incorporate spiritual thought and practice from Eastern religions into western schools of therapy. His is also one of the few articles to provide an effective integration of theory and practice. He gives criteria for differentiating spiritual emergencies from usual psychotic or affective breakdowns, and

also provides a treatment plan, techniques and a treatment example.

More briefly, other essays have interesting ideas that invite the reader to grapple with both spirituality and therapeutic skill. Albert S. Rossi in "Change in the Client and in the Client's God" describes how a persons' concept of God gradually changes from a childhood image to a more adult image through the process of therapy. Raymond J. Stovich in "Metaphor and Therapy: Theory, Technique and Practice of the Use of Religious Imagery in Therapy" defines the nature of religious language as symbolic as well as literal and gives helpful techniques for weaving such language into therapy as stimulants for both emotional and religious growth.

In "Forgiveness: A Spiritual Psychotherapy," Kenneth Wapnick illustrates a primarily cognitive approach to understanding how and why forgiveness is helpful in working through issues in therapy. He also supplies an interesting redefinition of transference and countertransference. He says, "we all project, and all of the time. In this sense, transference and countertransference are one and the same." He continues:

> Rather than seeing their reactions to the patient—annoyance, fear, guilt, concern, sexuality, discomfort, and so forth—as negative, as the term countertransference is usually understood, therapists would recognize that their patient was sent to them so that these very reactions would occur, bringing to the surface what has been repressed. When therapists' 'buttons are pushed,' the patient is no longer seen as the *cause* of these reactions, but rather as the means of bringing them to the surface. Thus therapists too are patients. Both people have been brought together to accept the opportunity offered by the Holy Spirit to join together and be healed by Him, seeing in each other the mirror of the self they would rather deny and avoid." (p. 52)

He concludes by observing that as therapists we need to be in the role of therapists, but not of it, willing to grow and be healed ourselves.

Some of the articles were just not interesting. Two on reinterpreting Freud's "The Future of an Illusion" from a religious standpoint and one on the difficulties of priests in therapy were of little concern to me. Another on "Formation Counseling," which I interpret to mean counseling a person to form his or her own meaning of life and how to live with it, was long and could have been easily condensed.

So the sum is that I have mixed feelings about this book. It has intriguing ideas, but many are not well stated. The book's stated purpose is crucial to Mormon therapists, I believe. However, much of the material may not hit close enough to the mark for many LDS practitioners, and although the book contains some helpful ideas, there are not nearly enough. In all, the most valuable help the book might give is to stimulate other thinking, on these and other topics, within our sphere of influence. And I believe books such as this, from outside of the Mormon world can help us ask broader questions, and find more avenues to the collective spiritual growth of clients and therapists.

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References

Psychotherapy and the Religiously Committed Patient, E. Mark Stern, ed., New York: The Haworth Press, 1985.

Also printed as *The Psychotherapy Patient*, Vol. 1, No. 3, Spring 1985.

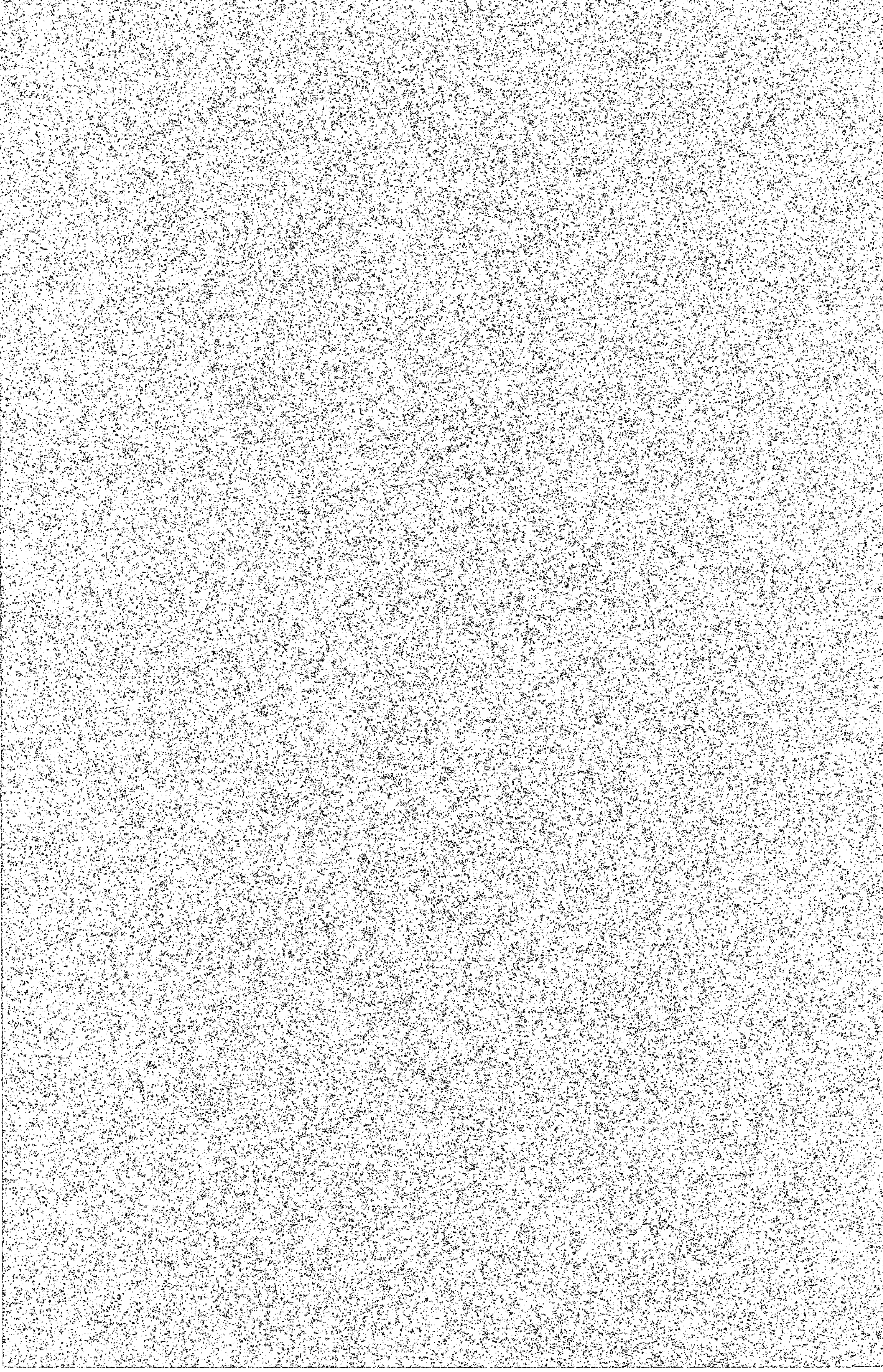
IN FUTURE ISSUES

It is planned that at least the next several issues of the Journal will be theme-focused with the majority of each issue being devoted to a specific theme. There will be some articles on other topics in each issue, however, to accommodate other writer contributions and reader interests.

The theme for the next issue, May 1986, will be ethical-legal concerns in the helping professions such as privileged communication, confidentiality, malpractice, etc. The deadline date for receiving manuscripts for this issue is 15 March. As usual, it is very helpful to receive them earlier.

The theme for the November 1986 issue will be vulnerable populations within the Church with concern for both identifying and helping them. The deadline date for manuscripts is 1 September 1986.

Themes currently planned for 1987-88 issues are principles of therapeutic change, cultural pressures—identifying and dealing with, and bases of psychopathology. If you have a recommendation for a theme, please submit it. Thank you.



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