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Beliefs of a Mormon Clinical Psychologist

Robert J. Howell

Beliefs of a Mormon Clinical Psychologist

Robert J. Howell, PhD

In addressing the issue of developing my own identity as a therapist, my vantage point is that of a clinical psychologist. To narrow this field a bit, it should be noted that most of my work has been in the field of psychopathology and forensic psychology. Because of this orientation, I like to view the mental health field as one which deals with various types of mental illnesses. And psychotherapy as one of the modes of treatment for some mental disorders.

Ideally it would be helpful to have a broad overarching theory which would guide the whole field of mental illness. This was the attempt of Freud's psychoanalytic theory and some of the offshoots and variants of Freud's theory. To reiterate what is likely so well known it need not be restated, a theory should never be judged by its ultimate truth or falsity. Rather, it should be judged by its utility or usefulness. Thus, psychoanalytic theory has shown to be very useful in conversion disorders and in many of the dissociative disorders. It is of no value to organic-mental disorders or substance-use disorders and of little value to schizophrenic disorders or mood disorders.

Unfortunately, it seems to be the lot of the behavior sciences not to have any theories in the classical use of the term theory. The best the behavior sciences seem to be able to do are to utilize specific models for specific areas of study. But there has been little success in bridging any model, or combination of models into an

overarching theory. Indeed, the only conceptualizations in the biological and behavior sciences field that reaches the status of a theory, as I am using the term, is that of the theory of evolution. As indicated, a theory should not be judged by its ultimate truth or falsity but rather by its usefulness. The usefulness of evolution is beyond debate. All plants and animals are classified following the phylogenetic scale, hence the result of the theory of evolution. In the health field, one notes the development, first on lower animals, of the polio vaccine. The Rh blood typing was first done on lower animals. Many practice surgeries have been and continue to be performed on lower animals because of the similarities between lower animals and humans. Finally, in psychology, and specifically the field of learning, drug dependency, and brain damage, many findings have first been demonstrated in lower animals. All this points to the utility of the theory of evolution in the biological and behavioral sciences. Interestingly, the steps from subhumans to Homo sapiens is in trouble. There doesn't seem to be the smooth continuity, but this doesn't detract appreciably from the usefulness of the theory of evolution.

But, as indicated, in psychology the best that we have been able to do is to construct small models for specific ideas. This is also true of the field of mental health and mental illness. As previously stated, psychoanalytic theory is very useful in some mental disorders but of little value in others.

Over the years, I have come to an increasingly firm conviction that the only way progress is going to be made in dealing with the mental disorders is to consider mental disorders as discrete and specific illnesses with a different cause for each disorder. Some of the causes will be biological in nature. Some causes will be psychological in nature and some will have their roots in the family and other social entities.

It seems to me that the proper approach in treating a mental illness is very much analogous to that of any other kind of illness. That is, first a diagnosis should be made. The diagnosis hopefully will lead to the cause or the etiology of the illness. Then treatment should be based on this diagnosis and etiology. Thus, I believe, as indicated by Bergin and Strupp (1972, p. 8), that there should be

specific therapeutic interventions which produce specific changes in specific patients under specific conditions. The specific treatments should be based on the specific cause of the illness and this treatment should produce specific outcomes. Obviously, these outcomes should be measurable.

While such a model may seem best suited for biological treatments, I state again that just as I believe in biological germs so I believe in psychological germs and family and social germs as well. The treatment of choice for conversion disorders and dissociative disorders is psychodynamic therapy. In contrast the treatment of choice for bipolar mood disorders is chemotherapy and the treatment of choice for schizophrenic disorders is chemotherapy plus family therapy.

Much has been written about values in psychotherapy and whether values should be expressed by the therapist or not. Psychoanalytic therapy would have the therapist be as an opaque screen upon which the patient can impute his or her thoughts and feelings as contrasted to reality therapy where the beliefs and values of the therapist become quickly apparent. Whatever the therapist's belief happens to be on this question of values, it is certain that the therapist should be sensitive to the values of the patient. As long as the values of the patient do not contain germs of psychopathology, the therapist should cherish the patient's values and try not to disturb them.

In contrast, however, if pathology is enmeshed in values, then it is the obligation of the therapist to determine if potential costs or hurt to the patient is outweighed by the potential benefit to the patient by the therapist delving into these pathological patterns. If it seems that there is little chance of altering the pathological attitudes or behavior, or if it seems that the costs will outweigh the benefits of trying to modify these psychological behaviors, then it should be the obligation of the therapist to leave these behavior patterns or beliefs alone.

It is not likely that a therapist will alter the compulsive and meticulous behavior of an obsessive compulsive personality disorder (as opposed to an obsessive compulsive neurosis). If this is so, the

therapist would do well to leave such meticulous behaviors of the patient alone, or at very most, only try to make the behaviors a bit more tolerable for people around the patient.

It also follows that if there is pathology in a person's religious beliefs, it may be important to try to delicately undo this pathology and help the person have healthier attitudes and beliefs. Again, this should be attempted only so long as the potential benefits to be gained by trying to intervene, outweigh the possible damage or cost to the patient. If, for example, a patient's evangelical religious beliefs and behaviors serve an important need in that person's life, it would likely be damaging to the individual to try to get him or her to give up such beliefs and attitudes.

Therapists should always be sensitive to their role as a therapist and the limits of their role. It is important to realize that potential harm can come when a therapist crosses the line and attempts to become a personal friend, a religious counselor, or attempts to assume other roles which are beyond the realm of the therapist. It is almost axiomatic today that a grieving widow can be helped in many ways a therapist can never help, by another widow, or a group of widows, who have already experienced this tragic event. Similarly, a bishop or a minister can do things with and for a person that a therapist can never do. Conversely, there are things that a therapist can do which would be inappropriate for a minister or a bishop to attempt to do.

It is good practice for a therapist to involve the patient's church leader at the proper time, if this a relevant issue. In a similar manner it is important to involve self-help groups for the person or other community support systems. One patient who had experienced a very tragic event in her life, perhaps received more help from her LDS friends who included her in all their church and social activities—more help than any medication or therapists could have hoped to have done.

In conclusion, the role of the therapist should be contained within well-defined boundaries. The therapist should use the kind of therapy and make interventions which have good empirical support for the kind of disorder which the patient manifests.

Finally, the therapist should stay within the recognized bounds of his or her profession and not intrude into other areas.

Robert J. Howell is professor of Psychology at Brigham Young University

References

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