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OLD WINE IN NEW SKINS: A COMMENT ON WARNER

Lynn D. Johnson, Ph.D.

I have often thought that in psychotherapy we tend to rediscover the wheel each generation. We never tire of declaring how far we have come. Considering Santayana’s dour prediction about the fate of those who ignore the past, it is useful for us to examine new developments in our field with an eye to history.

Warner (1982) conveys in his article this sense of discovery. Such a sense is exciting and, to the experienced psychotherapist, familiar. Warner postulates that he and his associates have developed a remarkable new approach to mental health which is based on eternal principles applied to everyday life. This application, they suggest, leads to a qualitatively different and better way of experiencing one’s self and the world.

Warner suggests persons experience emotions and feelings as things which occur spontaneously (at least those experienced subjectively as “genuine” and not contrived or exaggerated), over which they have no control. Therefore, changes in strong, deeply felt emotions are experienced as miraculous—perhaps due to divine intervention. People experience themselves as receiving, not initiating, emotions.

Warner then postulates that feelings are actually self-serving and determined more by the advantage they offer as a defense than by circumstances. He postulates that long-term, deeply held, unpleasant feelings experienced as “happening to” the person are a lie. The person actually has an active part in creating those feelings through choosing to perceive and construct reality in certain ways. A person is motivated to create this distortion because it helps shield him from the fact that he has been untrue to his own self, his own sense of right and wrong. Warner terms this process “self-betrayal.” Negative feelings, in summary, are caused by perceptual distortions rooted in our desire to justify ourselves for not doing what we ought.

Warner then outlines a “standard theory and treatment” which he claims represents “mainstream psychology.” This he describes as the therapist encouraging the acceptance of deeply held feelings, the congruent expression of those feelings, and the search for means of legitimately achieving the needs and wants expressed in those feelings. Warner suggests that “mainstream psychology” (more accurately, psychotherapy) fails to be helpful by failure to attend to the self-serving, self-justifying, defensive functions of emotions.

Obviously, what Warner has done is to take the contemporary Church doctrines about repentance and apply them to psychotherapy. The process of acknowledging the error of one’s behavior, the acceptance of responsibility, and the subsequent change of heart are clearly rooted in a model of the gospel. As LDS counselors read Warner’s theory and application, then, they will be impressed with these efforts.

In this article, I intend to question whether the gospel can be applied to mental health issues across the board. I do accept the concept that many people who are unhappy might well benefit greatly from Warner’s concepts. However, I intend to question whether those people are suffering from mental disorders in the sense of qualifying for a DSM III diagnosis.

I also intend to demonstrate that Warner’s portrayal of “standard theory and treatment” is a straw man, set up for the purpose of being knocked down. Warner’s idea that therapists are promoting acceptance of feelings rather than change of feelings is naive from a theoretical point of view. Many therapy systems do in fact promote actual changes in feelings and behavior, not merely acceptance and negotiation. While it may be true that many counselors practice what Warner has described, this is not an indictment of theory but of the practitioners.

As to the straw man point: Cognitive therapy (Beck, et al., 1979) is probably the most effective psychotherapeutic approach for depression which has been evaluated carefully. In therapy outcome trials, psychotherapy typically falls far behind psychotropic medications in effect. The Beck studies, reviewed in the volume cited above, suggest cognitive therapy has as much or more effect as medication (imipramine) and lower relapse rates. In the cognitive therapy model, feelings are viewed as outcomes of information processing, usually auditory. In other words, what I say to myself will determine my feelings, or more accurately, what I believe about myself and the world will determine my feelings. For example, if I believe I am bad and have no value as a person, I will naturally feel depressed. Beck and his associates postulate all feelings are understandable and reasonable, given the underlying assumptions and beliefs the person has about the world. However, these beliefs and assumptions are faulty, over-generalized, and not empirically tested. The standard technique in this system is to challenge feeling states through testing of underlying beliefs. The feelings are not “lies,” but they are mistaken.

Strategic therapy is a system of therapy which is rapidly growing in popularity (Smith, 1982). Milton H. Erickson, M.D. is considered the dean of strategic therapists. He was the father of the concept of strategic

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1 I would like to thank Addie Fuhriman for her constructive comments about this paper. All responsibility for the ideas in it, however, is mine alone.

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therapy, and originated many of the concepts and techniques (Haley, 1973). Erickson was famous for appearing to totally accept the beliefs and feelings of his patients, only to cause profound changes to happen to those beliefs and feelings through the therapy process. In Smith's 1982 survey, Haley and Erickson figured among the top ten psychotherapists in terms of influence on the thinking of clinical psychologists, so we may assume this approach represents to some extent a “standard therapy.” Haley, Erickson’s main proponent, has consistently pointed out the interpersonal aspect of communication (Haley, 1963). Feelings, for example, are very powerful ways of communicating, and Haley has recommended therapists view feelings as attempts to communicate and influence others. The idea that feelings should be expressed in therapy is discouraged in Haley's work. He emphasizes the need for the therapist to have clear, understandable goals for the patient, and to give directives which accomplish those goals. Haley’s directives may be compliance-based, meaning that the patient should do them in order to benefit; or resistance-based, meaning that only through resisting the directive will the patient benefit. More commonly, Haley advocates the double-bind—in which, no matter what the patient does, he will benefit.

The interesting thing about the strategic therapy is the the “cures” tend to be dramatic and almost unbelievable. Haley (1973) describes Erickson's therapeutic strategies and results; Palazzoli, 1978: Palazzoli, et. al. 1978 describe the application of strategic psychotherapy to two extremely difficult populations, anorexia nervosa and schizophrenia, with similar dramatic results. Weeks and L'Abate (1982) describe paradoxical interventions and follow a case throughout a complete course of therapy. Fisch, Weakland, and Segal (1982) outline treatment within the Palo Alto brief therapy model of six sessions or less, and demonstrate impressive results. Haley (1980) details his work with heroin addicts and early-onset schizophrenics, and even gives a case-by-case outcome, a truly astonishing and moving work.

A third example of therapy which is certainly “mainstream” among graduates of the University of Utah psychology program is Ernst G. Beier’s communications-analytic therapy. Beier’s books (1966, 1975) detail his theory of behavior which claims that so-called involuntary behavior, such as symptoms and emotions, are actually in service of the strategic advantage those involuntary behaviors give, especially in interpersonal relations. Beier argues that the child learns very early that emotions of a certain class have great power in his particular environment, and these emotions will then be displayed whenever the child needs the unique advantage they confer. The emotions are subjectively felt as genuine. To the impartial observer, however, they seem to be useful ways of manipulating the self and others. This concept is close to Warner’s idea of the emotion as a “lie” although Beier would repudiate the use of such a word as “lie” or “sin” as unnecessary and judgmental. Beier believes the nonjudgmental stance the therapist takes gives him the power to make the changes in the neurotic character of the patient. If, however, the patient can find out what the therapist values and desires, the patient will begin to involuntarily manipulate the therapist as he manipulates everyone else around him.

Langs (1978) argues as a psychoanalyst that whenever the therapist accepts as genuine the feelings or perceptions of the patient, he excuses the therapeutic efforts of the analyst and patient. In other words, there is no need to analyze that material since it is genuine. Langs argues that this constitutes an unholy alliance, so to speak, in which the patient’s defenses are reinforced rather than worked through. Langs argues that when this happens, the patient, while consciously grateful, will unconsciously perceive the therapist as corrupt or incompetent, probably both. Langs postulates the proof of such unconscious perceptions will be always present in the verbal material the patient produces in therapy, in derivative (disguised and indirect) forms, and will form a continuous thread to meaning through the therapeutic relationship.

While the above weaken Warner’s bold assertion (“No one in mainstream psychology believes a feeling can be genuine, i.e., really felt, and at the same time dishonest, i.e., a lie about its own character.” p. 25), the most powerful example of the error of this position is taken from Transactional Analysis (TA). TA is certainly a popular approach to psychotherapy, at least from the point of view of the self-help books sold. Every well-stocked paperback bookstore will feature several TA books in its “psychology” section.

A standard work in TA is Berne’s 1966 volume, Principles of Group Treatment. Berne says, “Self indulgence in feelings of guilt, inadequacy, hurt, fear, and resentment are colloquially called “rackets.” ...The problem of legitimacy in connection with such feelings has not been completely solved by the transactional analyst...(but) the transactional analyst starts from the basic position that there is no such thing as Adult anger, that anger is a “racket” indulged in with Parental permission or encouragement. ...To the Adult, pain and frustration are problems to be solved; to the Child they are provocations to be taken advantage of. (Now I’m entitled to hit you,’ he says) ...The same applies to disappointment...” (pages 308-9) Berne was often scornful of therapists who advocated free expression of negative feelings, and would ask how throwing a typewriter out the window would improve your relationship with your boss.

It should be clear now that many therapists expect to change feelings in their patients. Acceptance of feelings may be present, but often as an intermediate step, with the goal of change in the mind to the therapist. Further, the strategic, Beierian, and TA therapists view repetitive, strongly held negative feelings as strategies of methods used by the patient to influence others. This, according to these thinkers, is especially effective, since the patient can disclaim responsibility for the feeling while using it to his advantage, (“I just can’t help being so difficult when I’m depressed.”)

While the reader at this point may appreciate that
Warner is misinformed about his concept of “standard theory and treatment”, he might ask, “But hasn’t Warner described a powerful approach to mental health, one which incorporates the gospel ideals of repentance of sins and a change of heart? And what about the idea that mental health services can be delivered to neurotic populations through the use of group seminars, conveying these ideas through examples and parables?”

The first point implies that bad feelings are sins. Some would argue that feelings are resources God gives us to help ourselves experience free agency. I have some reservation with such a view, as it ignores the points alluded to earlier—namely that feelings can be used manipulatively. I rather want to raise the question whether mental and spiritual health are the same. To believe they are the same implies all mentally healthy persons are living righteous lives. Some may not take that view, but would take the view that all spiritually healthy persons are mentally healthy.

I am not aware of any data which suggest all spiritually healthy persons are mentally healthy. How would we decide such a thing? I have seen persons in treatment for psychosomatic disorders who seem to be righteous. In the treatment of psychosomatic disorders, the problem is not the existence of unpleasant feelings; on the contrary, the problem is more often the absence of unpleasant feelings. Psychosomatic patients seem to lack the cognitive and conceptual tools necessary to experience unpleasant feelings. The term “alexithymia” has been coined to describe these patients, meaning “no words for feelings.” The patient has no idea there is a problem, although through counseling they can become aware of the underlying problems and address them. The process of helping a patient arrive at that point, however, is pure psychotherapy. I would guess that no amount of seminars could be helpful to that population, since it is through the interactive therapy process that the patient “gets in touch with” the feelings, to use a cliche. (We will not address the question of paradoxical or family therapy approaches to this disorder.)

Can it be possible to imagine a person living a life pleasing to God and not being mentally healthy? This seems unknowable, since we can’t make accurate judgements for one of the dimensions. Nevertheless, let us construct an hypothetical 2 x 3 table.

Since we cannot know how to classify persons along the dimension of whether God is pleased with their lives, let us instead substitute the judgment of such criteria as “active in Church affairs” and “appears to live a Christian life.”

As you can see from Table 1, my examples are somewhat simplistic. Nevertheless, I am sure we can think of people who fit into each of the six classifications. As workers in mental health, we tend to judge people along the dimension at the top of the table. God, on the other hand, being higher in his understandings and perceptions than we are, judges along the dimensions at the left of the table, or in eternal terms. Clearly the only dimension we can actually judge is high versus low mental health; the elaboration into a table of levels of righteousness is conjecture. Nevertheless, we can at least question whether mental and spiritual health might be orthogonal.

<table>
<thead>
<tr>
<th></th>
<th>High Mental Health</th>
<th>Low Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saints</td>
<td>Well-adjusted saints: active, faithful Christians, etc.</td>
<td>Active, faithful saints with psychosomatic disorders, depressions, etc.</td>
</tr>
<tr>
<td>Ministering Angels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Valiant</td>
<td>Inactive “saints” who are happy, successful in the world, etc.</td>
<td>Inactive “saints” with neuroses, drinking problems mild impulse disorders, etc.</td>
</tr>
<tr>
<td>“Good” Men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wicked, Liars</td>
<td>Well-adjusted persons who fight against God, Church; abortionists, etc., who are apparently happy</td>
<td>Psychopaths, severe impulse disorders, suicides, etc.</td>
</tr>
</tbody>
</table>

What about the second point, that teaching through example and metaphor is a more effective way of delivering mental health service? I believe this idea has much to commend it, not the least of which is the observation that Jesus did much of his teaching through parable. Actually, the telling of stories is one of the oldest ploys to bring about change, with roots in the Old and New Testaments. Zen Buddhists and Hassidic Jews are famous for their teaching through story. More currently, Milton Erickson was well-known for his use of stories and anecdotes, and his use of them has been analyzed from several perspectives. Haley (1973) used them to illustrate Erickson’s systems orientation to therapy, Bandler and Grinder (1975) looked at linguistic patterns, Gordon (1978) extended linguistic and matching operations analysis of metaphorical therapy, Zeig (1980) illustrated the interpersonal outcomes of Erickson’s metaphors, and Rosen (1982) catalogued the embedded messages in the metaphors into themes. Bandler and Grinder point out that the process of listening to a story creates an involuntary “transderivational search,” or in other words, a process of applying the story to the self. Haley (1982) tells humorously of this process.

“When some of my trainees visited Phoenix and met with Erickson as a group, ...(he told them stories). When they returned, one of them mentioned a story Erickson had told about him. One of the others said, no, the story was actually about her; ...(another of them said the story applied to his particular experience) I turned out that all of the group thought they had received a personal metaphor from Erickson designed just for them. ... Yet...(the metaphors were stories and cases that Erickson had told many times before...Some of the stories were ones I had heard many years before and I knew they applied personally to me.” (p. 6)

Warner and his associates tell seminar participants they are not being asked to identify with the stories. I believe this to be an excellent way of achieving a more profound identification with the story; so did Erickson. He would never admit a story was aimed at anyone in
poor method of actualizing them in the lives of clients. Where may these techniques be applied safely? Few counselors, in my experience, have the integrity needed to impose values successfully, and a therapist with a good system of values (espoused) and a more potent tools. I recall, for example, a story Ernst Beier once told about a woman who seemed clinically paranoid. She claimed her co-workers were watching her all the time. Rather than debate, the therapist agreed, and convinced the woman it was because she did a much better job than anyone else, and they were trying to learn from her how they could do better. Her symptoms then began to resolve.

Warner's reframing of feelings from inevitable and justified ("Well, doc, wouldn't you feel the same way?") to lies about their own nature and coverings for self-betrayals accomplishes the requirements for the definition above. He has certainly proposed a set of concepts which also fit the situation, and by doing so has changed the meaning of the situation for the person being reframed.

My fear about these techniques is that counselors will read or hear about them and proceed to try them out on their clients. What Warner and his group can do, others may not be able to do. Certainly much harm has come from therapists trying to be Milton Erickson when they are not. A similar problem can arise from Warner's work. For example, it would be easy to try to reframe a clinical depression with Warner's techniques, and I predict the results could be disastrous. The depressive person is clever at twisting things into statements of self-blame, and could reply that now he feels guilty about feeling depressed. Where may these techniques be applied safely?

Herein lies the major problem with Warner's presentation. While his stories are inspiring and enlivening, they fail to provide scientific proof of efficacy. In a field like psychotherapy, where everything from Reality Therapy to Primal Scream can legitimately be practiced by professionals, a basic problem is to find out what works. My professional experience makes me leary of people who want to impose any value system on others, even the true one--not because the values are not true, but because of the methods usually used to impose them. Few counselors, in my experience, have the integrity needed to impose values successfully, and tend to use guilt and pressure in place of love. A therapist with a good system of values (espoused) and a poor method of actualizing them in the lives of clients becomes a noxious counselor.

We are unable to evaluate the present techniques. It is irresponsible and lazy of us to believe in a method which offers only testimonials. Such proof is the mark of the quack, and in medicine we would properly shy away from it. How can we accept it in psychotherapy? Warner has apparently done no follow-up to his seminars, or at least he hasn't reported any. We do not know whether 5% or 95% of the people attending his seminars experience significant personal gain. We do not know whether 5% of those who do gain maintain that gain once home. A useful contrast is found in Watzlawick, Weakland, and Fisch (1974) where they report the percent of persons who resolved the presenting complaint after six sessions of strategic therapy. They also discuss their failures and possible reasons for them.

A second problem is in the lack of impartial observation of the seminars. Argyris (1978), in his work with organizations, has come to the hypothesis that people cannot adequately verbally model their own behavior. Argyris has observed a striking difference between how people describe their behavior and what they actually do. The first he calls the espoused theory and the second the theory of action. Argyris argues we are always blind to our own theory of action; thus we profit from feedback from others. Similarly, a talented psychotherapist can gain much from others observing his work.

A third problem lies in the choice of population to serve. Persons who seek help from seminars may be very different from people who seek help from psychologists or psychiatrists. Personally, I am sure they are, since I have conducted numerous marriage communication skills seminars. I find the people who attend these seminars are much less disturbed than couples I see in my practice. I find that with the former group it is easy to significantly help them, while with the clinical group much more energy is needed. If the people who attend Warner's seminars are good, cooperative, bright people, it may be quite easy to achieve significant gains.

A fourth problem is with diagnosis. Warner claims his approach is useful for the neuroses, but as pointed out above, we do not know that his population would satisfy diagnostic criteria for neuroses. If neurotics benefit, which type of neurotic in particular? A bright obsessional might accept this model, a depressive might be worsened, and an hysterical might not understand a word of it. The model may fit the person who blames others for his feelings; what about the person who blames himself?

A fifth problem is parsimony. William of Occam, I believe, forbade the unnecessary multiplication of entities. This article has suggested that remarkable success in changing behavior and feelings is available from other therapeutic interventions. Many of these models do not accept the concept of the defensive and/or intrapsychic role of feelings. Palazzoli (1978) detailed her unsuccessful work with anorexics in which she used
the model of character defenses. She then shifted to a strategic model of family therapy, in which she utilized the idea that all anorexic behavior was really an attempt to help the family. Oppositional, self-destructive behavior was defined in the family therapy sessions as not only helpful, but positively necessary for the family to survive as a unit. This technique of positive connotation is used to change feelings in the family in an indirect, paradoxical way. In fact, the technique might be termed a restraint from change technique, since the positive connotation suggests the family cannot get along without the problem.

Now if such paradoxical and strategic methods work powerfully in family therapy, and with difficult problems without using interventions based on moral choice or renunciation of defenses, why are the latter methods necessary? I believe such methods most often simply produce resistance and resentment in many clients. We needed up asking our clients to learn our language. Erickson, in contrast, always instructed his students to speak the language of the patient. With Joe, the florist suffering unbearable pain from terminal cancer, Erickson never mentioned pain relief or relaxation or acceptance. Instead he spoke to Joe about the growth of plants, tomato plants, and the comfort and satisfaction a tomato plant might feel in growth, in rest, in the cycles of living. Joe achieved the results of pain relief, acceptance, and the giving up of his bitterness and fear without having to learn any new concepts or language. Erickson instead taught Joe's language, and used it to help Joe very economically.

Warner's program involves people learning new language and concepts. Again, this may not be necessary from a pragmatic perspective. Warner is locked into this position, however, by his assumption that mental and spiritual health are the same, and that mental suffering is caused by a variety of other factors, including inadequate utilization of personal resources, genetic factors, physical diseases, the interaction of physical and mental processes, and so on. If we can cure many of the patients we see without attending to supposed spiritual causes, have we performed a valuable function? Or could it be we are merely making well-adjusted sinners? In that case we are doing great harm.

But let us pursue this farther. If we admit that we have cured a person and made a well-adjusted sinner, we are admitting that sin and suffering are independent. Once we admit that, we must also admit that this notion that feelings are sins must be rejected. If individuals, families, and groups can be happy and well-adjusted without accepting the sinful nature of bad feelings, then Warner is in the uncomfortable position of Pope Urban, who insisted Galileo recant his idea that the earth moved. ("Nevertheless," he muttered, "it does move.") Scientific ideas must be tested against scientific criteria, not religious ones.

Warner has performed a valuable service by expressing these ideas. I enjoyed the article and am grateful for the incentive it has given me to think about these issues. My intention has been to challenge and propose, not to attack, and I hope this dialogue may continue.

Postscript: Just before this article was to be mailed to the editor of this journal, Warner was kind enough to send me a copy of his talk given to the BYU Alumni College on January 24, 1979. (Warner, 1979) The material in this talk answers some of the points I have raised. For example, he has begun to do follow-up, and estimates that 40% of those attending his seminars are benefiting. He also suggests others may benefit slowly.

In this paper he also makes the point that many psychotherapists do not consider their patients responsible for what they feel and do. Again, I believe from my experience with Beier and Erickson, that this position does not fairly represent the strategic therapy model. In psychotherapy supervision, I have heard Beier respond to a husband who feels his wife is unfreeing, "And what do you do to deserve an unfreeing wife?" The principle of shifting responsibility back to the patient underlies all of his work, although it is often more subtle and at times understated than in Warner's work.

Perhaps the reason Warner hasn't been challenged on his assertions about psychotherapy relieving the individual of responsibility is that, sadly enough, so much therapy is done precisely the way Warner describes. Of the theories of psychotherapy now around, aside from the strategic therapy model (more precisely, models), I have the idea I would be most comfortable with Warner's. Like strategic therapy, it involves a genuine (second-order) change; that is, a change in the way of being, and explicitly states that class of change as a purpose. I continue to assert that the strategic model is more parsimonious, and hope, again, this dialogue my continue.

REFERENCES


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