Techniques, Principles, and Persons

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Since almost a year ago when Brent Scharman announced to the Board his intent to have this convention focus on principles and techniques of the change process, I have been anxious to hear what some of my long-time colleagues would have to say. My respect for Bill Dyer, Richard Bednar and Allen Bergin led me to expect their high quality presentations. The nature of change is a topic that has interested me for many years. In my last several years of teaching, counseling and psychotherapy, I spent most of my time encouraging students to become careful observers of themselves as they engaged with clients who were making changes in their lives. My research those last years centered on teaching as an element of personal developmental change. I am happy now, in the spirit of this meeting, for an opportunity to share a few of my conclusions about the change process with you. Frankly, I'm glad to get my "two cents" in!

Recently a colleague asked me, "How do you treat child abuse?" My initial reaction was to be somewhat at a loss for words—something that rarely happens to me. After a second thought, I responded, "Why, I don't treat child abuse. I often treat persons who were abused as children, but I don't treat the abuse, per se. I only consider it as it appears significant to the concerns the person presents to me." I would like that to be a marker as I explain to you what I believe about psychotherapy and learning to become a psychotherapist.

Consider, for example, three persons who present themselves as "Depressed," each of whom meet the DSM III-R criteria for Major Depression. All three describe themselves as having a "dark feeling as if a dark cloud hangs over me," having reduced energy, are being lethargic and without motivation to "get going." Their
appetites have decreased, their sexual libido diminished and their regular sleep pattern interrupted. This much they have in common. They are also very different. Two are females, one is male. One is about 50 years of age, one forty-ish and one twenty-five. One has been married to the same man for more than twenty-five years, had three children and is determined never to divorce. One has married seven times, is now proceeding with a divorce, and is determined never to marry again. The other has never married, is dating for the first time in 3 years, and is extremely shy. Two respond to antidepressant medication. One of them has used medication successfully several times in the past but says medication alone is not enough to help. One has well-developed social skills and can move in and out of relationships easily, even if defensively. One is very comfortable with same sex peers and very uncomfortable with opposite sex peers. Two are deeply religious (though of very different faiths)—one LDS, one very anti-LDS—and one isn’t interested in religion at all. Two are “child-like” in their faith and dependence on the therapist. The other is an independent, adult-like patient, somewhat bewildered because something has happened to her “feelings” that she doesn’t understand. The parents of one divorced while the patient was a young child; two had alcoholic parents who never separated. I am confident the list could be expanded. I believe, however, that it is sufficiently complete to show that there is little that is common among the three patients other than their depressive symptoms. The question is, therefore, whether the treatments of the three can have much in common.

Consider the other side of the treatment equation, the therapist. I could choose from my staff of 12 therapists three who were similar on any one or two characteristics; non-LDS, female, male, Minnesota graduates, Utah graduates. All have professional training and hold a valid license to do psychotherapy. Yet, the list of their personal characteristics, which I believe affect therapy, would be as divergent as the three clients. Their personal histories, personal values, family status, and reaction to control are all different. Indeed, they are as unique in their individual therapy as are the clients they treat. I know, because I consult with them weekly. To be sure, they often do similar things, but they do therapy in a unique way that is a manifestation of their personalities, beliefs, values, childhood and adult experiences as well as their training and professional experiences.
Because I believe this in general to be as true of therapists as with clients, I would like to make four declarative statements about psychotherapy and the education of psychotherapists. I will preface these statements with four observations that I believe serve to justify these beliefs. I will finish with a statement about what these conclusions mean concerning the mission of AMCAP.

**General Observations About Psychotherapy**

1. After 40 or more years of research on the outcomes and process of psychotherapy there is still little evidence that any therapeutic approach is significantly more effective than any other. Many have attempted to show the efficacy of one approach over another for particular types of problems, but, with few exceptions, those attempts have failed.

2. The Analytic, client-centered, behaviorist, cognitive, and existential schools of therapy have grown up around very sensitive, capable, charismatic therapists—respectively, Carl Rogers, B. F. Skinner, Albert Ellis, Milton Erickson. At first, they were highly successful, then reflective and analytic, and, finally, theoretical in their work. Not the reverse. That is, theory followed practice, practice did not follow theory. Wolpe may be the only exception to this rule. Rather than it being a case that “Nothing is as practical as a good theory.” It has been the case that “Nothing is as theoretical as good practice” (Hunt, 1987).

3. Schemes of diagnostic categories (beginning with Kraelin and ending in DSM III-R) have been reasonably successful in describing symptom patterns and assigning labels with fair reliability. However, except for the symptom patterns that clearly suggest medical treatments (viz., major depressions, thought disorders, and bi-polar illnesses), treatment modalities have otherwise been inconsistent. The medical therapies have some consistent success with specific diagnoses, but this is not true of different psychotherapeutic modalities.

4. Perhaps the most cogent observation is that there is very little evidence that professionally trained therapists are more successful than carefully selected non-professional care givers. In a related way, the cumulative evidence that short-term therapy is just as effective as long-term therapy leads me to question the efficacy of “treatments” of any particular kind.
Psychotherapy and the Education of the Psychotherapist

1. Psychotherapy is an art, not a science or a technology. And like all good art, while fundamental principles and techniques contribute to a finished work, the artist and his or her material is the essence of a finished work. Therapy is a creative process and to be successful, a therapist uses his tools as creatively as an artist. The therapist as a person is more important than theories or treatments.

2. Therapy—particularly good therapy—is the result of a unique interaction between two or more persons. It is not the application of anything. It is the result of one person (the therapist) sensitively responding to the pull of the other so that person can change, grow, develop, or heal. In the case of the three depressed patients described above, the minute-by-minute, hour-by-hour interaction had little in common across the three patients unless the units of analysis are so large as to offer very little useful direction. At times the therapist responds with great warmth, at times with inspired insight, at times with strong confrontation, and at times with cold indifference. At one time the therapist might be very supportive and directive, at another quietly evasive, at another provocative, and still at another interpretive. He might be very experiential or he might be very analytical. The response is most often pre-logical, intuitive, and non-conscious and is always in tune with the expressed (verbal and non-verbal) and unexpressed (though unconsciously communicated) need, hurt, or joy of the patient.

3. Therapy, because it is so personal, must then begin with the person of the therapist, not with some pre-determined school, theory, modality or technique of therapy. It must even begin with the person of the therapist before the person of the patient.

Largely, the professional psychotherapy education programs are upside down and backwards. They begin with science (abstractions), then techniques (applications), and then practice (experience). They should begin by doing therapy (experience), while consulting with a good therapist who can encourage sensitive reflection. Then through analysis and abstraction, the therapist finds compatible theoretical constructs. At that point a consultant or teacher can help a beginning therapist to get connected and stay in touch with the huge body of knowledge compatible with his
personal style. In this way a teacher can support and strengthen
the new therapist’s already partially developed abilities to help
others.

I believe, for example, that Richard Bednar’s therapy, a
procedure based on coping with rather than avoiding dysfunctional
behaviors or conflicts, is not coincidental. I know enough of his
history and patterns of coping to believe that his therapy is a
natural consequence of his life achievement translated through
years of careful observation of what works for him. Likewise, I
believe the same for Carl Rogers’ formulation of client-centered
therapy: that it was the result of developing a therapy that worked
best for him— one which grew from his life experiences. Thus, the
practice of therapy must be learned from the “inside out,” not from
the “outside in” (Hunt, 1987).

4. Therapy as a practice and the practice of therapy as a
profession must be strengthened and supported by continued
research and theoretical formulations. We become better artists as
we learn more about our materials and their use. The more an
artist knows about how other artists work, the more an artist sees
what other artists do, the greater his works become, so long as
they continue to be an expression of himself and not copies of
someone else, even copies of a master.

I want to be clear about this. Twenty five years ago I had the
good fortune to work with Jack Gibbs, a brother of Bill Dyer. Jack
was an expert small group leader. He had done much of the early
work with leaderless groups at the University of Colorado and was
a part of the “Bethel, Maine” group. In our discussions about his
“method,” “style,” or “technique” he protested strongly that he had
no “method” nor “style” nor “technique.” He was just a person.
Yet it was clear to those of us who worked with him and observed
him carefully that he was not an unskilled person-at-random. He
was a person who had highly developed sensitivity and skill
derived from thousands of hours of research, reading, writing and
practice, finely honed into an expertise that could not be abstracted
from his person.

Unfortunately, many young, inexperienced, group leaders
during that period heard only that one should be his own person
however clumsy or destructive that might be. Too often, profound
damage to group members was the result.

It is the larger body of knowledge that is the source material for
individual growth as a therapist. Always it is the integration of that
material within the person of the therapist that leads to truly good
therapy. It is just that we have things backwards—the person must come first, then theory, research, and practice. Nothing frightens me more than religious adherence to or evangelical proclamation of a given theory, modality or school or therapy. These schools of therapy are source materials for the therapist to use in refining his sensitivity to patients.

A few years ago, when I returned to Utah and rejoined AMCAP, there was much excitement about the need, the desire, even the will or mission to find The True gospel approach to therapy. It should be obvious from what I have said above that I am not supportive of such a venture. Not because I am not in favor of the gospel nor that I am not supportive of the church. Rather, I don’t believe it is the nature of good therapy or of good care giving.

I believe we are obligated to conduct therapy in a way not only expressive of ourselves, but also consistent with gospel principles. When patients make choices—or even if they are about to choose actions inconsistent with the essentials of Christ’s teachings—we would be inconsistent with our belief in free agency and individual responsibility to prevent them from doing so. On the other hand, it would be irresponsible of us as committed Latter-day Saints not to confront them. Our effort to have them give full consideration to alternatives should not, however, be at the expense of interfering with their right to make a choice free of defensive action.

One illustration may help. A woman is attempting to stabilize herself through a painful and bitter divorce. She was shaken because her husband wasn’t excommunicated by a church court when she was sure he should have been. She is very angry with the “other woman.” Though the “facts” of the case (as she presented them) certainly seemed to justify her expectations, I quietly explained to her, “I have sat through many high council courts. I often expected that my psychological knowledge might conflict with the proceedings and final judgment. Yet, not once have I left a court with the belief that an improper judgment had taken place.” My assurance seemed to give her strength to accept what had hitherto been unacceptable.

As she worked on her anger toward the “other woman,” she devised a clever metaphorical “trick” that would help her discharge a heavy reservoir of anger. I thought it was an excellent and creative catharsis. However, if it had been carried out in full, it would embarrass and humiliate the “other woman” in front of people she would associate with for years to come. I merely called the patient’s attention to the inconsistency between her deep
religious commitments and her plan to embarrass her rival. Serious reflection by the patient led to an alternate act that served the need as well.

Thus, I believe the mission of AMCAP is to strengthen our awareness of good professional practice, our knowledge of a wide array of human problems, and our commitment to gospel principles in our practice. I further believe we can do this best through supportive and open dialogue with each other, especially about those things which concern and affect us most deeply—our patients, our beliefs and values, and our testimonies. I pray that we will continue to have the courage to do so.

References