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Presidential Address

S. Brent Scharman, PhD
October, 1989

It's been fourteen years since I began working as a full-time counselor. I realize that time is brief compared to some of your professional experience. As I reflected on the many things I could discuss in this presidential address, I decided to use this as a time to reflect on the choice we have all made to pursue a helping profession as a career, and on the current state of the profession.

My earliest recollection about why I chose psychology as a career goes back to the time I was in the sixth or seventh grade. On the family bookshelf I found a paperback copy of Sigmund Freud's classic book, The Psychopathology of Everyday Life. I remember reading through the book and understanding very little of what was there. What I do still clearly remember, however, was the fantasy I had at the time about helping someone unravel some complicated aspect of their life by interpreting a puzzling dream or getting them to free associate and break through their defenses. At the time it felt exciting, fascinating, challenging and even romantic.

Through the years I considered other career choices, but the ultimate decision to pursue counseling felt comfortable and satisfying. In fourteen years I found that some of my fantasy was correct, it has been a challenging and fascinating career choice. Some of it was incorrect—the miracle cures are few and far
between and most progress in therapy comes from unromantic, hard work.

About nine months ago I had the experience of eating lunch with some of my colleagues in the Deseret Industries cafeteria, a true gastronomic experience. As I ate some jello with fingerprints on it, I observed the interaction of a young couple attempting to feed and supervise their young child who appeared to be about two years old. His frequent cries and uncontrolled behaviors led to repeated threats and occasional slaps from the obviously overwhelmed parents. Their unkempt appearance and lack of social skills and awareness only increased the feelings of frustration I felt as I observed the scene. Upon leaving the cafeteria, I remarked that in all likelihood that boy was going to be sitting in a counselor's office 20 years from then asking for help. The counselor would have the unenviable task of attempting to help undo the effects of 22 years of living, and, if he or she worked in an agency setting, they would probably have the added challenge of bringing about the changes in short-term therapy. I felt discouraged and eating a rubber cookie didn't help any.

When I got back to my office, I was quickly taken from the world of the theoretical to reality. I began an interview with a 38 year old compulsive male who was frustrating his family by his unreasonable needs for structure and control. The fellow could only be comfortable when the clothes hangers in his closet were all exactly the same distance apart so he would measure them to assure order. He measured the growth of the flowers in his front yard and attempted to keep them uniform by digging beneath the more quickly growing offenders which got too tall. His wife had to back their car into the driveway and park with the tires resting on previously assigned markers. This rigid behavior felt reasonable to the husband, but was driving his wife crazy. He eventually terminated therapy prematurely and little progress was made.

The evolution in my awareness from fantasy to harsh reality has frequently prompted me to ask myself the question, “What do we really have to offer as a profession?” I'm pleased that my honest answer to myself is, “We have a lot to offer and many satisfied clients who would testify to that effect.”
The profession is not without its frustrations, however. Prior to becoming a counselor, I spent ten years in retail sales for a large international company. During that time I dealt with all of the frustrations that go along with the competition of the free enterprise system, including having someone bring back a pair of shoes after 15 years of wear because the soles had worn out, and then demanding a new pair. During that time, however, I also had the very satisfying experience of being able to meet the needs of customers in very concrete ways, and having them leave the store with a tangible product in hand and a smile on their face. I had a lot of friends in those days because everyone hoped I might offer them a discount because they were in need.

Those experiences were very different from my experiences as a therapist. There is no tangible measure of change and the observable outcomes are frequently difficult to see. I not only don’t have more friends, but people I’ve seen in therapy will sometimes avoid me in public places for fear that someone will sense I’ve seen them professionally.

At this point I would like to share with you some of my current impressions, both positive and negative, about our profession. (I’m using the term “our profession” to signify the related work we do as social workers, psychologists, marriage and family therapists, psychiatrists, doctors and nurses).

As a group we may have the worst reputation, and receive the least respect, of all professions. The tendency is to think that we are all liberals and that anyone with common sense could do what we do. A recent letter to the Editor in the Deseret News characterized mental health care professionals as “charlatans” and described the profession as “idiotic and dangerous.” A local social worker and member of AMCAP, Dr. Kent Griffiths, made an eloquent response in a follow-up letter to the same newspaper.

Two weeks ago I received a referral on a woman sent home nine months early from her mission for depression. This depression had required a week of inpatient care before she was stable and not actually suicidal. I was to do the follow-up therapy, but the referral was accompanied by the opinion that all that was really
needed was self-reliance and some "talking to" by the person making the referral. Recently I was saddened to hear someone say, "It's too bad Dr. X chose to go into this field. He could have made a contribution in one of the real sciences." Another conversation I overheard conveyed this theme, "John is wasting his money going to counseling. All he really needs is a caring friend."

It's my current opinion that nothing could be further from the truth. A good therapist, one who really helps bring about change in the lives of people, is a unique and exceptional individual. They need to be extremely bright, insightful, able to form a positive relationship with a very diverse group of clients and need to be mentally healthy themselves. It also helps, when meeting with clients who are confused and hurting, to have a therapist who has clear values and is not confused about their own life. It's been my experience that most therapists I've associated with meet these criteria. They are very capable and their own lives are in order. It's the exception when they would meet the stereotype of the "liberal therapist." Certainly the therapists I've interacted with at AMCAP measure up very favorably on these positive criteria.

As Hans Strupp (1978) pointed out in his article on Specific and Non-specific Factors in Psychotherapy, the question can reasonably be asked, "If it takes such a capable person to be a good therapist, why is it that some of the literature shows little difference in the outcome of trained and lay therapists?"

- My opinion is that the answer is at least five-fold:

  - Change is difficult to measure.
  - Much of what therapists have been doing in the past 25 years has been Rogerian therapy. Many lay therapists are naturally good at this, and when they listen and show concern people feel better and may really improve.
  - Some trained therapists are not very good.
  - People are often looking for advice and quick solutions, and those are often given by lay therapists, so they are evaluated positively.
Those who are helped most by lay therapists may be those who need the least, in other words, they need support to get through a crisis, reassurance, praise, information, a listening ear or a boost to their self-esteem. In other words, they may be basically quite healthy to begin with and looking for something reasonably, easily given.

I am certainly not suggesting that it’s bad when a non-professional is able to help someone. The vast majority of help that has been given throughout history has been given by untrained friends, family, spiritual leaders, teachers, etc. What I am saying is that for the client who needs more than support, warmth and listening, it’s a complicated process and requires much more skill than most people think.

One of my strong current impressions concerns the value of diagnosis. Like most counselors who were trained in the 60’s and early 70’s, I received little training in diagnosis. Characteristic of the emphasis I received is a quote from one of the texts used in my master’s program. Brammer and Shostrom (1968) in *Therapeutic Psychology*, stated that “Roger’s seems particularly adamant on the question of diagnosis. He claims that diagnosis . . . is an actual detriment to the psychotherapeutic type of counseling.”

While I would hastily agree with the concerns we have all heard about labeling and judging, I would also affirm that much good can come from an accurate diagnostic impression which guides therapeutic intervention. I feel that the refinements that have been made in the Diagnostic and Statistical Manual in the past ten years have been revolutionary in helping us conceptualize mental, emotional and behavioral problems. It has led to clearer communication, tighter research designs and has forced us to make decisions about what will constitute a given psychological condition.

If I go to a medical doctor for pains in my stomach, I want to know whether he/she feels I have appendicitis, ulcers or cancer before treatment is begun. In similar fashion, a client coming for counseling has a right to know whether the therapist feels the client is not dating or going to work because of social phobia, avoidant personality disorder, or because they are depressed. How would
you feel if a family member was going to a therapist because of overwhelming fears which were incompassitating her? You’d be pleased if she came home after the first visit and reported that she had felt comfortable and had been understood. You’d probably feel even better if, in addition, she reported “the therapist feels that I am experiencing panic attacks which are common for about 5% of women my age. She is recommending anti-depressant medication, stress reduction techniques, and facing of my fears.”

I have recently worked with a bishop who was helped by understanding that his ward member was experiencing schizophrenia, and not simply misunderstanding who had a right to receive revelation for the Church. It helped him understand why the previous three years of counsel given by a variety of helpers was going unheeded. I also think of how a life was changed when it was determined that a husband was experiencing adult attention deficit disorder, and that his inefficient performance on the job was not simply a matter of being stubborn and unwilling to try.

Diagnosis then, in my opinion, is not simply a luxury, something which you may use depending on theoretical approach to therapy, but is necessary as a way of conceptualizing behavior and determining intervention procedures.

Another one of my impressions is that we are getting better at finding techniques which help people. By techniques I am not simply referring to approaches based on different theoretical schools of thought. We’re all aware of the Bergin, Lambert (1978) research which showed little difference in outcome from one theoretical approach to another. These findings have been more recently confirmed in an article by Pilkonis (1984) entitled “A Comparative Outcome Study of Individual, Group, and Conjoint Psychotherapy.”

By techniques I am referring to the sorts of interaction cited by Arnold Lazarus at the Evolution of Psychotherapy Conference held in Phoenix, Arizona in 1985. Dr. Lazarus said, “There are specific techniques for specific syndromes. We’ve reached that level of development. Those clinicians who don’t know the specific techniques will find their clients non-responsive.”
I don’t think any of us would disagree with the idea that there is at least as much art as science in therapy. The role of relationship and use of self will probably always maintain their place as the essential foundation of effective intervention. However, just as a positive bedside manner may be necessary, but not sufficient for practicing good medicine, relationship may be inadequate in and of itself in bringing about therapeutic change with a client.

The idea that techniques can be valuable may seem like common sense to someone just entering the field of psychotherapy, but it is not at all noncontroversial. Again I go back to a quote from a counseling text. Blocher (1966) in Developmental Counseling, describing Rogerian Therapy said:

Since the client’s inner-growth force will enable him to make correct decisions once he is able to perceive his situation realistically, it is not necessary for the counselor to give information or assist in solving immediate problems. Since the establishment of the relationship is the primary role of the counselor in all cases, there is little need for differential diagnosis. The treatment is similar for all cases.

I am personally more in agreement with Richard Stuart, who said in Helping Couples Change (1980):

I was taught that every client gains more from the process of forming a therapeutic relationship with a caring professional than from any specific activities of the professional. I have since learned a counter truth that love is not enough. . . . A benevolent, caring therapist is needed to help each person learn to accept responsibility for change in the interaction, but this major shift in the perspective will come about only when the therapist bets more heavily on the deployment of technological skills than on being an accepting friend.

Let me clarify my point with a few examples. When I was first assigned to do treatment with sexual abuse, I thought, “what could be worse. It’s long-term and there’s little progress.” I have now come to think of abuse treatment as one of the areas where work is done that really makes a difference in the lives of people.

Regarding treatment of sexual offenders, Abel and Becken (1984) stated that 50% of untreated sex offenders reoffended within the first year after being apprehended whereas only 5% of treated offenders reoffended. Other intensive treatment programs
have shown significant success as exemplified by the Girretto (1978) study of the child sex abuse treatment program in Santa Clara, California which showed less than 1% recidivism within the first year following termination of therapy. The difference came about because of structured, standardized programs which provided individual, marriage, family and group therapy over an extended period of time, and which dealt with specific sexual issues. They also had the influence of the law increasing the motivation of perpetrators.

The National Institute of Mental Health Studies on Treatment of Depression (Elkins, 1985) pointed out that treatment helps people get better. In their studies it was shown that subjects receiving medication were helped in eight to twelve weeks while cognitive or interpersonal therapies took 16 weeks, but all three were generally more valuable than no treatment or placebo, especially for the most severe cases. Combining therapy and medication was most effective. I might editorialize here that it is my impression that cognitive therapy has become as popular as it has in the past ten years only partly because of the results it produces. I feel that many people have begun using cognitive therapy because it is very concrete and very teachable and therapists feel that they have something specific to offer the client.

I recently had a client say that taking a class at the Primary Children’s Medical Center, about how to interact with his son who was experiencing attention deficit disorder and hyperactivity, had changed his life. He reported that after years of searching he finally felt that he had received some specific techniques that had already enabled him to help bring about some change with his son. His relief was accentuated by the fact that he had already spent several years in therapy of various kinds which had been rather general, and although it had frequently provided some good ideas, had never been put together in a way that had actually produced change.

Details of other improved interventions won’t be outlined because of time, but consider the improvements in treatment of alcoholism through family meetings which create a crisis and are followed by disengagement of the co-dependent spouse, successful
treatment of multiple personality disorder with hypnosis, treatment of PMS, overcoming of a multitude of sexual dysfunctions by specific sex therapy techniques, use of ECT for psychotic depression, use of Prozac and exposure techniques for obsessive disorder, use of stress reduction techniques with anxiety disorders of all kinds, etc. Great positive strides are being made and we should be proud of them as a profession.

Certainly there are not specific techniques, with documented results, for all troubling conditions. However, mental health consumers have a right to expect that this is one of the main areas where attention and money will be directed during the next decade. We would be appalled if all surgeons had their own unique ways of treating an inflamed appendix, and if they were offended at our asking them how they expected to proceed with treatment. We expect that there will be a general approach which has been proven effective which will include a given surgeons personal touches. While the comparison cannot be made directly between medical and psychological intervention, clients do have the right to know how they will be treated and to expect that there will be some correlation from one therapist to another. I fear that sometimes we use the excuse, when a client drops out of therapy or makes no progress, “He wanted me to solve his problems for him,” when in reality we really didn’t know what to do to help them.

I accept the fact that psychological diagnosis will probably always be less exact than medical diagnosis, and that treatments for psychological conditions will always be more variant from therapist to therapist than will medical treatments. It’s my bias, however, that increased knowledge will narrow the gaps and mildly increase standardization over time.

It is common complaint of graduate students, or even of those recently graduated, that they got all the way through school without really learning very much about treatment. It is also common to hear students lament, “I know how to form a relationship and gather the relevant historical information so the first few interviews I have with a client go very well, but then I don’t know what to do once they’ve told their story.” I have heard students and practitioners say they feel manipulative, dishonest, or
even like they are performing malpractice, when clients present particularly complex problems which don't remit quickly or at all in spite of their best efforts. Sometimes the oft repeated phrase, "keep the problem on the client's shoulders," is only partially used to prevent dependence. Sometimes it's used because we really don't know what to do.

Students, or recent graduates, have said, "I've learned a lot about statistics, research design, group dynamics, community relations, personality development, etc. but nothing about helping a family with an acting out teenager, nothing about how to get a silent husband who won't show feelings to open up, nothing about how to treat explosive personality, compulsive gambling or sexual addiction.

My comments about techniques, or treatment in general, may sound like complaints. They are actually more observations than complaints. I think we are getting better and better at discovering what helps people change and in teaching it to students. My bias is that we should make it a higher priority and that students should be able to take classes that produce confidence in this area.

Another one of my biases has to do with the issue of length of therapy. Brief, or short-term therapy, is receiving much attention and many journal articles and books are pointing out its benefits. I think there is a strong place for this therapy for those who need support through a crisis, information for decision making, help with a specific marital or family issue when there is overall strength in the relationship, etc. Even those with more severe problems can benefit from a short, intensive look at issues which may lead to a relatively minor immediate change which can become more significant as it continues over time.

My concerns arise from the fact that sometimes brief therapy is imposed more for the benefits of the provider than the client. It's more a matter of keeping costs down and being able to see more people than it is a matter of believing it's what people need. People terminating from brief therapy often have a multitude of unresolved issues and find themselves in another therapist's office in the near future.
The reality is that someone needs to spend enough time with the client to help them through their issues. When agencies terminate at ten interviews, clients are left with the option of finding another agency, going without, or beginning with a private practitioner, who, of course, will be happy to see them as long as they would like to come, at a significantly increased price.

Kenneth Howard’s article on the Dose-Effect Relationship in Psychotherapy printed in the February 1986 issue of the American Psychologist pointed out some valuable information. He and his colleagues provided data, based on meta analysis of studies on 2,400 patients covering a thirty-year period of research, showing the following:

1. There is positive correlation between the amount of treatment and the amount of patient benefit.
2. Fifteen percent of patients feel better after only one interview or even after scheduling the first interview.
3. By eight sessions 50% of patients are measurably improved.
4. By twenty-six sessions 75% are measurably improved.
5. For the average patient sample, the maximum percentage improved would be reached in approximately 52 once-a-week sessions.

It’s not practical or necessary for many people to attend 52 once-weekly sessions. In fact, when this type of long-term therapy is undertaken, there are obvious abuses which can take place in terms of creating dependencies or making decisions simply to produce income for the practitioner.

Perhaps we shouldn’t really take a stand that we will do brief therapy or long-term therapy, but rather that we will meet the individualized needs of each patient as they come for services.

The Bergin, Lambert (1978) research points out that psychotherapeutic treatment is consistently shown as being generally beneficial to patients.
It has a significant role in their lives. I can confirm this from my own personal experience. When I went to marriage counseling seven years ago, those interviews became the most important hour of my week. I looked forward to them and rehearsed over and over again in my mind what had been said as the week progressed. The hour was too short and seemed to fly by. I noticed when we started and ended and even a few minutes missed was significant to me.

Because what we do is important to people, it's easy to get overly caught up in the importance of our role as a therapist. It's equally as easy to take it too much for granted so that it becomes routine.

There is a Buddhist legend which tells of the future Buddha incarnated as a hare, jumping into the fire to cook himself as a meal for a beggar after shaking himself three times, so that none of the insects in his fur should perish with him.

People don't expect that kind of sacrifice from us and we shouldn't expect it of ourselves. We needn't sacrifice our time or energies to our clients to the degree that our own lives or families are harmed. To quote Ed Tucker, we are not society's guardians who can stamp out mental illness. However, if we just spend enough time at it, we do play a significant role in people's lives and ought to act accordingly both professionally and personally.

The final comments I would like to make are directed toward the role of religion in therapy. The world has probably always been confused about the purpose of life and the importance of values, but it is certainly easily noticeable today. James Kirkwood, the Pulitzer Prize winning author of "A Chorus Line," was speaking for many when he said, "Life has got to be one huge joke. To my knowledge, nobody has ever come up with a logical explanation that fits any other alternative. But as long as we have been placed on the 'joke-board' there is nothing to do but play along with as much humor as possible."

I would agree with Mr. Kirkwood that the world does feel out of control and without meaning at times. It is when I feel that way the most, that I am most grateful for my understanding about
the purpose of life, and the role of Christ in it, that comes from my membership in the Church.

As a therapist for LDS Social Services, most of the clients I see are active members of the Church. Some I see are actively engaged in sinful behavior which is directly related to the negative feeling they have or the difficult life situations they have gotten themselves into. More frequently they are living rather traditional lives, following an LDS lifestyle, and there is no obvious relationship to any sinful behavior and their feelings.

LDS Social Services has the reputation in Utah of being a place where clients are told to live the gospel, pray and study the scriptures and their problems will go away. At the risk of sounding too defensive, I won’t list all of the reasons why I know clients are not dealt with that way, but I will mention one. Our clients are, for the most part, already living the gospel, praying and reading the scriptures, and they’re still hurting.

One of the advantages of working for LDS Social Services is that the door is open to appropriately make reference to a scripture, a religious concept or a talk from a general authority. For example, I have frequently made reference to Neal Maxwell’s talk on Irony, Marvin J. Ashton’s talk on Perfectionism, and Ronald Poelman’s talk on Adversity from this year’s April General Conference.

I don’t want to use my time today to give my side of the debate about the question of whether we should be pursuing the discovery of a method of conducting gospel therapy. I do want to go on record as saying that I think issues related to religion are just as important as any others that can be raised in therapy. The solutions to problems are often rooted in clarifying answers to spiritual questions, and in putting one’s life in harmony with those answers. When clients raise these issues, they have a right to have a therapist who is not confused him or herself. They also have a right to a therapist who doesn’t think that they have the correct answer to all spiritual questions and the right to impose those biases on the client.

LDS doctrine includes the idea that all truth is contained within the framework of the gospel. We can be certain that as research
and practice continue to bring new information and procedures to
our awareness, those that stand the test of time will be compatible
with the principles of the gospel of Jesus Christ. Those that do not
will ultimately fail.

One of my concerns about counseling when religious issues
become the topic of conversation is the belief we sometimes have
that religion should provide clear, easy answers to any question that
arises. I like Bruce Hafen's comments reported in the August 1979
Ensign magazine. He said, "If we are not willing to grapple with
the frustration that comes from facing bravely the uncertainties we
encounter, we may never develop the kind of spiritual maturity that
is necessary for our ultimate preparations." In the talk he also
pointed out that often there are not Church approved answers to
various questions concerning doctrine, policies or behaviors.

In my own practice, I probably see as many questions or
difficulties that arise from overzealousness or misinterpretation of
some spiritual matter as I do from under use or rejection of
religious principles. I recently heard a classic example in a staff
meeting. A man gave a priesthood blessing to his wife telling her
to have an affair with another man because it would improve their
own relationship. She did and ended up being excommunicated.
I call this a classic example because the individuals involved
probably had some measure of sincerity and had convinced
themselves that they were doing the Lord's will. In reality they
were mixing up their human feelings with what they wanted to
interpret as spiritual promptings.

Other examples from this past week's therapy include a convert
of 26 who was taught in a lesson she attended during the week that
she was born into the home she was because of her degree of
righteousness in the preexistence. The speaker didn't realize that
the listener had been born into a home where she was sexually and
physically abused. Or a couple married very unhappily for 15 years
who have done some destructive things to one another and to their
children but who have stayed together because they were told in a
priesthood blessing they were promised to each other before coming
to this life, a man with a narcissistic personality who said, "I really
ought to trash my wife right now, but I know she needs an
opportunity to grow spiritually to my standard. She is a returned missionary and he’s an exhibitionist. Or a woman who marries a man having obvious major problems which will significantly affect their marriage, but marries him only because she feels that her recently deceased husband is prompting her to do so.

Daily I deal with questions, as you do, about why a patriarchal blessing doesn’t seem to be fulfilled, why a blessing for health wasn’t realized, why sincere prayer and fasting on a relevant topic seemed to go unanswered, why devoted Church-service produced a strong quorum or ward but was destructive to one’s own family, etc. It’s probably not by coincidence that my talks in sacrament meeting nowadays are more inclined to stress patience and endurance than they did prior to getting into this profession. There aren’t very many easy answers.

The fact that religion doesn’t resolve all our questions should not be unduly surprising or disappointing to us. What’s important is that it does provide a framework that gives adequate direction, when common sense, personal revelation, and patience are used. The Book of Mormon analogy of the gospel as a rod of iron is certainly an apt one. One of my favorite scriptures is Galatians 5:22 which states, “The fruit of the spirit is joy, peace and love.” I believe that this is true though one will not always feel these, or only these, feelings. I’m frequently asked, as you probably are, “How can you stand to do this kind of work everyday? Isn’t it depressing?” I regularly respond that of course it’s depressing at times, but I stay in the field because I believe that change is possible and I’m optimistic about people. For every client who is just starting out, and is hurting, there is another one moving along in a healthy way who is beginning to feel better.

I’m proud of our profession and believe we really do have a lot to offer. It’s been a good career choice for me and I hope it has been for you. I’m pleased with the strides that are being made in theoretical, practical and research-oriented aspects of the work. Our tasks are difficult and there will always be failures. Those failures may get more attention than the successes because people who have been helped tend not to talk about their therapy. I do think, however, there is much we can do to improve our image,
our training, our methods of merchandizing, our discovery of specific procedures which will predictably help people and, as Mormon therapists, our ways of being helpful within the Church setting.

I'm grateful to be a member of AMCAP and have found it helpful to me in my attempts to become more professional and clarify and resolve the occasional struggles I have had in the profession. I consider my relationship with each of you one of the most pleasurable aspects of my career choice. Thank you.

S. Brent Scharman, AMCAP President, is a psychologist with LDS Social Services, Murray, Utah.

References


