The Linacre Quarterly

Volume 41 | Number 3 Article 6

August 1974

Psychotherapy and the Problems of Values

John T. Dulin

Psychotherapy and the Problems of Values

John T. Dulin, Ph.D.

Whether one considers therapy as a healing process or as a learning process, the issue of values soon emerges as a significant factor in the therapeutic interaction. Prior to the last decade, however, little attention was given to the issue of values in any form of therapy. Charlotte Buhler was one of the few to focus on the problem and to acknowledge the fact of values in psychotherapy.[1] Although I will be discussing the issue in the context of psychotherapy, the general principles apply in other forms of therapy as well. The purpose of this paper is to explore, in a preliminary way, the values of the therapist insofar as they enter into the therapeutic process.

One might ask at the outset: If this issue of values is so important, how did it happen to be neglected for so long a period of time? I would suggest that the neglect of values in therapy has been due largely to Freud. His great influence on the development of psychotherapy and his lack of attention to his own value system seem to be the major factors in perpetuating the myth of a value-free psychotherapy, although one cannot overlook psychology's conscious attempt to align itself with the empirical sciences of the nineteenth century and reject any semblance of philosophy. In the area of psychotherapy, at least, the pendulum has swung to the opposite extreme, with a person like Breggin speaking of psychotherapy as "applied ethics."[2] This should not surprise us, however, when we look at the contributions of Erikson, Szasz, and others. Increasingly we are reminded of the fact

---

The author is an assistant professor in the Department of Psychiatry, School of Medicine, Case Western Reserve University, Cleveland and Director of Outpatient Psychiatry Day-Clinic, Cleveland Metropolitan General Hospital.

Dr. Dulin did his graduate studies at Loyola University, Chicago and was a post-doctoral fellow at Michael Reese Hospital, Chicago.

His article examines the absolutes and exceptions in the field of "normalcy" and reflects on the therapist's function in helping his patient achieve his own value system.

that the human encounter which we call psychotherapy involves not only the professional training of the therapist but also his personality, convictions, and values. What he thinks or feels about fundamental life values will inevitably be communicated to the patient, especially in view of the fact that psychotherapy often involves some modification of the patient's attitudes and value. In a recent presidential address to the Canadian Psychiatric Association, Dr. Malcolm Beck acknowledged his fundamental Christian orientation and stated that this was the only base from which he had license to speak. In a series of pointed questions he went on to ask:

> Can we, in fact, fully relate to man as he is, including ourselves, without accepting that man is as much a product of his personal value system as of his libidinal forces, and vice-versa; that he is free as well as bound, determining as well as determined, possessing free choice as well as conditioned; that he is responsible as well as responsive, a maker of history as well as being molded by history; and that he is a being whose moral and religious strivings are as real as his sexual and aggressive drives?[1]

Dr. Beck is obviously aware of the assumptive values operating in his therapeutic work, and yet he does not indicate how he arrived at this point of awareness. I would assume that he worked out his value frame of reference, in much the same way as the rest of us, on our own, independently of our professional training. It is true we were helped both through formal classes and through supervision to develop our diagnostic skills, treatment procedures and a frame of reference to interpret various kinds of behavior. But we were left largely to our own devices when it came to the issue of values.

Personal Values

We all tend to assume that reality is as we perceive it, that the values we choose are good, not only for us but for all men. Yet a therapist as a person has been influenced like every other person by his parents, his peer group, his church, and the society in which he lives. His attitudes and values have been developed over the years through interaction with these environmental forces. In the process of developing our personal value system we assess values proposed by others in terms of our own needs and goals and beliefs. We accept certain values and integrate them into our frame of reference. Others we reject as incompatible with our frame of reference, and still others we modify to fit into our system.

Psychotherapy, as I understand it, is essentially an interpersonal relationship involving mutual communication between therapist and patient with the purpose of helping the patient function more adequately. The therapist is one whose function is to help or heal on the basis of his professional training and skills. The patient is one who is hurting and comes to the therapist for help. We assume that pain whether physical or

psychological is a sign of malfunctioning. Psychological pain may be experienced in the form of anxiety, depression, or guilt. It may be experienced in the form of distorted perception, bizarre ideation, violent mood swings, or feelings of unreality.

The patient communicates to the therapist his experience of pain and the therapist draws upon his training and experience to diagnose the symptoms and to initiate curative measures. If the treatment plan is acceptable to the patient, the therapist and the patient formulate a mutually acceptable "contract," including not only the goals of therapy but also the means of reaching these goals. This is where the assumptive values of both patient and therapist come to the fore. If what the patient wants or expects is unrealistic or unacceptable to the therapist or vice-versa, and if the divergence cannot be resolved sufficiently to enable them to establish a contract, then they cannot work together.

Freud, for example, despite his neglect of the issue of values, is quite clear in specifying values when he describes the formation of the analytic pact or contract:

> Our plan of cure is based upon these views: The ego has been weakened by the internal conflict; we must come to its aid. The position is like a civil war which can only be decided with the help of an ally from without. The analytical physician and the weakened ego of the patient, basing themselves upon the real external world, are to combine against the enemies, the instinctual demands of the id and the moral demands of the super-ego. We form a pact with each other. The patient's sick ego promises us the most complete candor, promises that is, to put at our disposal all the material which his self perception provides; we on the other hand, assure him the strictest discretion and put at his service our experience in interpreting material that has been influenced by the unconscious. Our knowledge shall compensate for his ignorance and shall give his ego once more mastery over the lost province of his mental life. This pact constitutes the analytic situation.[4]

More briefly he says, "We conclude our pact then with the neurotics: complete candor on one side, strict discretion on the other."[5] The fundamental rule is the heart of analytic psychotherapy. The patient ought to say everything that occurs to him and the therapist ought not to take advantage of this candor. I am not necessarily disputing this rule, especially with regard to the neurotic population with whom Freud chose to work. What I am concerned about in Freud and in others is the lack of investigation of the values operative in a given therapeutic situation and the validity of these values. We know from experience in therapy that the patient very quickly picks up the therapist's unexplored bias toward one or the other issue, and this is certain in some way to influence the patient. The patient will soon pick up what the therapist holds on matters of sex, marriage, religion, divorce, work and general life style. In particular, he will pick up conflict or discrepancy between what the therapist

says and what he feels, between the conscious and the unconscious assumptive values. What the therapist feels is often conveyed by non-verbal cues, and what comes across to the patient is a double message. The therapist may encourage freedom of expression but at the same time transmit cues which contraindicate his statements.

Assumptive Values

Let us examine for a moment a basic value in therapy which has definite ethical implications, namely, *to live is better than to die.* This value has widespread acceptance by society and underlies all therapeutic work. But let us ask a few questions and pose a problem. Is this value absolute? Are there no exceptions? What is the basis in nature for such a proposition? For the human, is "to live" restricted to the life span of existence within the space-time categories known to us? And further, granted that the proposition is valid for us, do we have the right as therapists to impose this value on a patient who calmly and deliberately chooses to die? We have all had depressed patients who saw no purpose in continuing to live, who see no meaning in life. What did we do? Recommend or use electro-shock treatment? Confine the patient to the hospital until we have succeeded by whatever means in inducing a will to live? Do we have the right to impose this value on another human being who does not accept it? Szasz for one, opts for absolute autonomy, meaning man's right and capacity to take responsibility for himself. Consequently if a man chooses suicide, that is his right and the therapist must respect this choice.

In an address delivered last year, Dr. Viktor Frankl used an example of a woman who called at 3:00 in the morning to inform him of her intent to commit suicide. Frankl's reaction, which would be that of the majority of us, was to spend over a half hour trying to convince her by every argument at his disposal that she should not go through with her plan. After exhausting all of his arguments, he discovered that the woman was willing to change her plan and come into his office the next morning. Somewhat to his chagrin, he also discovered that it was not the arguments which convinced the woman to defer her suicidal plan, but rather the fact that he, as a fellow human being, was willing at that hour of the morning to spend more than a half hour of his time listening to her and trying to convince her to defer her plan.[6]

In a somewhat similar case, though using more devious means, I was contacted in the early hours of the morning by a patient who announced to me that he intended to commit suicide. I asked him how he planned to do it. He answered, "By jumping from the window of my apartment building." I paused and then responded, "Well, if you are going to commit suicide you should at least feel half way human when

you do it. So do this: make yourself a pot of coffee, have a cigarette, walk around the block and then jump." He agreed and proceeded to hang up. In analyzing my response to this patient, who was not only given to intense, severe periods of depression, but also was markedly impulsive, I realized that I was stalling for time. A pot of coffee and a cigarette or two would take at least 20 to 25 minutes. It would take him another five minutes to get out of his building, perhaps 10 or 15 minutes to walk around the block. It was a calculated risk, but I thought that the stall for time and the fact that he would be going outside would serve to change his mind. There seems to be something about being alone, in the silence of the early morning hours, inside, which serves to induce or intensify depression. There is something about the openness of the out-of-doors that seems to help in lifting the depression, in instilling new hope, a new desire to live. Two sleepless hours later the phone rang again. It was the patient thanking me for saving his life.

Another illustration of an assumptive value in therapy: *my perceptual reality is normal and any significant deviation is abnormal.* Consequently, a goal in therapy is to bring the patient to relinquish his abnormal reality and to accept mine. For example, a patient was referred in from the medical service because she insisted that a cure be provided for her companion. The difficulty was that the resident could not see this companion and could not appreciate the patient's upset when the companion's leg was caught in the elevator door. The companion was described by the patient as a lifesize monster covered by long glossy hair, a kind of "later day Harvey," although not a drinking companion. This companion appeared whenever the patient was under stress and was there to listen whenever the patient felt the need to talk to someone. My immediate task as I saw it was to determine whether this object was threatening or frightening in any way to the patient. Was this object a reification of the patient's unacceptable or uncontrollable impulses? Was it a companion in loneliness? Was it good or bad for the patient to have such a being? After careful examination I concluded that this being was in fact, a companion, that it was good for the patient, and even though its presence did not conform to my reality I felt that it would be bad for the patient to attempt to remove this being. I felt it would be bad for the patient to force her by whatever means to conform to my reality and so I decided to let her keep her monster. After all it was no problem to provide an extra chair for the interview.

Take another basic value in therapy: *To be well is better than to be ill.* We assume that a patient coming to a therapist for alleviation of pain is necessarily subscribing to this value. Other-

wise he would not seek out a therapist. But the patient's definition of well-being may be divergent from the therapist's. For example, the experience of severe anxiety reactions may be painful enough to bring an individual to seek therapy. He wants relief from the symptom but he may not want to relinquish the apparent cause, which may be anything from unrealistic academic goals to a homosexual life pattern. I say "apparent cause," because what appears to be an immediate behavioral cause frequently is only another symptom of a deeper cause. The stand that the therapist takes depends basically on his assumptive values. An achievement oriented therapist may focus on the emotional conflicts which are interfering with academic goals, while at the same time supporting the academic goals, whereas one who places less value on academic achievement may support a modification of these goals. Similarly, the sexually-permissive therapist may tolerate or even encourage a homosexual life pattern and focus on other factors in an effort to alleviate the anxiety, whereas a sexually-restrictive therapist will more likely work toward control and/or sublimation of the homosexual impulses. Examples such as these point to and illustrate the fact that assumptive values are involved in every aspect of psychotherapeutic interaction.

Therapeutic Interaction

This brings us to the question: on what grounds does the therapist take his stand? Well-being implies a norm, a norm which is the basis for judgements of good and bad. To a certain extent that norm is formulated in terms of the therapist's professional training and experience but more basic, in my opinion, is the therapist's own value system. I see this as more basic because in time it comes before his professional training, and the experience intake during his years of training is both filtered and modified by his existing assumptive system. To an extent we all perceive what we expect or want or need to perceive. This holds for the broadest ranges of reality as well as for the therapeutic interaction. Our formulations of criteria in psychotherapy are inevitably subjective and we cannot divest them of their subjectivity, but we can clarify these criteria by making them explicit, by questioning them and by questioning ourselves with regards to them. For example, do we define well-being in terms of the absence of manifest pathology? If so, what is our criterion for pathology? Is it social consensus or is it the nature of the organism? Going back to Aristotle in his Nichomachaen Ethics, we find a definitely teleological frame of reference. An action is said to be good when it is in accord with right reason and conducive to man's end, which is defined as happiness. It may be my bias, but I find this concept somewhat too culture-bound as well as too vague for application in a clinical situation. Further, I

would agree with Frankl that happiness is not an end in itself but rather a by-product of living, of striving for goals, of searching for meaning and fulfillment in life.

I would propose that every organism, including the human, functions on the basis of a blueprint of natural law. This law dictates what the organism needs for optimal growth. A plant, for example, needs certain biochemical combinations supplied by earth, sun, air, and water. As we move up to the phylogenetic scale, the needs become more complex as the organism becomes more complex, but on each level we find an analagous blueprint or natural law. It is this law, ultimately, which provides the definition of well-being as the criteria for psychotherapy. Though the point is rarely made explicit, training in psychotherapy is intended to develop a deeper and more extensive knowledge of the natural law operative on the human level. Because of his professional training and experience, the therapist is presumed not only to understand the law better than the patient but also, with his understanding, to help the patient lead a healthier and more adaptive life, which results in a sense of happiness.

Consequently, the therapeutic process involves a modification of the patient's values in the direction of the therapists assumptive world. This fact places a responsibility on the therapist not only to clarify his own assumptive values but also to ground them in the nature of the organism. His own needs and beliefs and prejudices will inevitably enter to blur the picture but at least he will have a workable basis for evaluation. As Teilhard de Chardin has said, "man is that being who not only knows but knows that he knows."[7] Because man can ask: Who am I? Where am I going? Why?, he has the task, the responsibility of finding the answers to these questions. The therapist's function as I see it is to help the patient in a search for these answers and he will be effective in providing this help, in fulfilling his therapeutic responsibility, to the extent that he has in some way arrived at these answers himself.

In conclusion, I hope that this exploration of the problem of values in psychotherapy may serve to stimulate your thinking and provide you with further incentive not only to evaluate your assumptive system but to help resolve some of the illusive ethical problems in psychotherapy.

REFERENCES

1. Buhler, Charlotte, *Values in Psychotherapy*, 1962, 1.
2. Breggin, Peter R., "Psychotherapy as Applied Ethics," *Psychiatry*, 34, 1971, 59-74.
3. Beck, Malcolm N., in *Psychiatric News*, Vol. VIII, No. 15, August 1, 1973.
4. Freud, Sigmund, *An Outline of Psychoanalysis*, 1949, 62-63.
5. Ibid, 64.
6. Frankl, Viktor, address delivered at the 81st Annual APA Convention, Montreal.
7. de Chardin, Pierre Teilhard, *The Phenomenon of Man*, 1959.