Zen and Psychotherapy

Integrating Traditional and Nontraditional Approaches

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CHAPTER 3

From Realism to Idealism: Traditional Therapies and Zen

There are probably more religions than cultures, and each age produces several philosophical systems. However, there are just a few major scientific approaches to understanding and changing human behavior and it is important to understand them for at least two good reasons. First, the biological, learning, cognitive, psychodynamic, and humanistic perspectives and the connections between them constitute the larger scientific background against which we need to consider a Zen approach. Second, the various clinical disciplines and techniques that characterize traditional mental health care are also grounded in the five perspectives, so understanding how each of them addresses clinical issues prepares the ground for a consideration of whether and how Zen techniques can be used at the practical level.

There are several ways to examine the basic approaches to theorizing, researching, and altering human behavior. The most widely adopted one usually begins with presenting a set of key ideas about what is most fundamental in determining human behavior from a particular point of view. That information is often followed by a discussion of major theories or schools of thought that represent a particular perspective on behavior. Typically, the investigation includes a look at how behavior can be changed according to each position and usually ends with some kind of evaluation that considers the strengths and weaknesses of each major theoretical position. One thing that most such examinations do not take the time to do, however, may actually be crucial in developing a comprehensive appreciation for the field as a whole.

This issue concerns the philosophical dualism we encountered earlier, only now we must consider what it means in regard to understanding human behavior scientifically. As a student of mine once said on an exam concerning the relationship between these two disciplines, "Psychology cannot escape philosophy." In other words, each of the five major perspectives in the behavioral sciences lie along a continuum of theoretical possibilities that spans the gap between realism and idealism. Starting with an emphasis on physical reality at the left, for instance, we find that the "hardest" or most scientifically rigorous perspective in terms of using observation, measurement, and experimentation, is the biological point of view. Learning theories come next, because of their classical emphasis on the same scientific paradigm. Cognitive psychology occupies the middle position because, although it is founded on neuroscience and therefore prefers more classical scientific methods, it also includes consciousness, which is very problematic for the other two naturalistic points of view just mentioned. The psychodynamic perspective is clearly moving toward the "soft" end of the continuum, because most of its notions are difficult to research or support in a way that is compatible with science practiced from a naturalistic paradigm. Finally, the emphasis on free will, the individual, and the commitment to understanding the farthest reaches of human nature clearly places the humanistic perspective in another paradigm often called the "human science" approach (Aanstoos, 1984; Giorgi, 1971).

A PHENOMENOLOGY OF TRADITIONAL PSYCHOTHERAPY

There are several ways to approach doing what amounts to a brief phenomenology of traditional psychotherapies. The one we will employ, which is presented in Figure 3.1, is based upon the continuum mentioned above, because that method will help us understand whether or not Zen can be seen as a complement or alternative to traditional practice. The heading of "paradigms" in the diagram, then, represents the chasm created by realism and idealism. The Aristotelian or hard end of the continuum that spans the two different paradigms is characterized by an emphasis on the physical world and the forms of the scientific method that are used to study it. As such, this side of the scientific picture prioritizes observable data, measurable findings, the experimental method, and "objective" knowledge. The primary value of investigating human phenomena from this natural science paradigm is that the knowledge it yields is more reliable and valid: Findings generated from this way of doing science are relatively easy to test, duplicate, and

I. SCIENTIFIC PARADIGMS IN THE SOCIAL AND BEHAVIORAL SCIENCES

"Hard" <——————————————————————> "Soft"
(Aristotelian, measurable) (Platonic, experiential)

II. PERSPECTIVES (Broad, long-standing, scientific approaches to understanding behavior)

Biological	Learning	Cognitive	Psychodynamic	Humanistic
-Evolution	-Conditioning	-Information	-Unconscious	-Free Will
-Brain	-Environment	-Representation	-Stages	-Self-fulfillment

III. MAJOR SCHOOLS (Major views or theories within a perspective)

-Sociobiology	-Behaviorism	-Cognitive	-Psychoanalytic	-Phenomenology
-Biological Psychiatry	-Social Learning Theory	-Constructivism	-Psychodynamic	-Transpersonal

IV. EXAMPLE: Depression

-Physiological Imbalance	-Negative Reward Ratio	-Thought Distortions	-Unconscious Conflicts	-Meaning Making
-Achieving Homeostasis	-Positive Reward Ratio	-Pattern Breaking	-Working Through	-Making Choices

V. EVALUATION

-Factual	-Factual	-Integrative	-Individual	-Individual
-Reductionistic	-Reductionistic	-Reductionistic	-Subjective	-Subjective

FIGURE 3.1 Information map of the five major scientific perspectives on human behavior.

verify. They also tend to be nomothetic in that they apply to behavior across the board for a particular species.

The other or "soft" end of continuum, by comparison, does not ignore naturalistic findings, but it also includes the data of human experience, which means that its methods are more descriptive and inferential or Platonic. Although less reliable and valid in the classical scientific sense, the value of this approach is that it is able to access dimensions of being human that are inaccessible to harder methods. Consequently, research and practice from this end of the continuum tend to emphasize the individual, which means that it is more ideographic. Gregory Kimble (1984) described the basic difference between these two paradigms as "psychology's two cultures," which I have always found an apt metaphor. He also found a number of

different scientific values that distinguish the two groups and these theoretical and research priorities parallel the hard-soft distinction mentioned above. Of course, lest one become too biased toward either direction or "culture" right from the beginning, it is important to realize that each end of the continuum has strengths and weaknesses in terms of understanding and treating behavior. For instance, one is more concrete or factual, but the other is more holistic or comprehensive.

The second level of the diagram illustrates the relationships that the perspectives have to one another as they span the scientific continuum. There are a number of ways to characterize each view, but the key question is how much detail to include while describing them, which is to ask how many of the more important ideas characteristic of each perspective should be considered in order to understand its uniqueness. If we were doing a history of psychology, for instance, then we would present each view in great detail, beginning a discussion of the philosophical foundations of each perspective, moving on to identifying its ideas and their founders, and then tracing development of important lines of thought up to the present. Since we are not doing such an investigation, we can take a lesser course as long as it is still descriptive. Therefore, this part of the process will be limited to identifying what might be considered the two most important ideas that give each perspective its distinguishing character.

The same situation applies to the next (third) level of the diagram, which concerns particular schools of thought within each major view. Because they are based on seminal ideas, each perspective gives rise to many theories over time. Some of them are powerful enough in their own right so that they become entire schools of thought within a perspective, although all such schools still embody the core ideas central to the perspective from which they emerge. Once again, since our aim is not to do a history of the field, this aspect of our investigation will only mention what might be considered as being the two most important theoretical positions within a perspective. When possible, I will select one school that is ideologically conservative in order to represent the ideas of a perspective in their "pure form," so that we can appreciate just how different these intellectual cultures can be. The other school will be one that is "mainstream" and much more representative of the perspective in terms of mental health research and care today. A complex problem for historians of social science is, of course, what to do with overlap between perspectives and schools, and I will make some comment in this regard at the end of our investigation.

The fourth level of detail in our information map attempts to show how these approaches help us to understand real people in real situations. Presenting a case study of a clinical problem, and then examining how different perspectives might understand its etiology and treatment, is an established way of doing that (Barton, 1974). Therefore, I will use a clinical vignette concerning an individual who suffers from depression to illustrate how each perspective moves from theory to practice. Depression is chosen for several reasons; it is a common mental health problem to which most people can relate and which most clinicians have seen frequently enough so that it is useful to us as an example; it is complex enough to have multiple dimensions, which is to say both biological and psychosocial components; and it has been studied enough for there to be a rather solid body of findings concerning which treatments are most effective. These characteristics should allow us to examine how the perspectives operate in theory and practice.

Finally, the fifth and last level of the map is an evaluative one: It focuses on the relative strengths and weaknesses of each point of view. The vertical columns on the diagram serve to identify how each perspective flows through the various dimensions we are considering (basic ideas, major schools, example, and evaluation, respectively), thereby creating a comprehensive view of behavior.

Let us move through the various levels of the diagram both in terms of theory and practice so that we can understand the scientific continuum of change in order to see if it is possible for Zen to have a place in it or not. In addition to discussing the major ideas, primary schools, and strengths and weaknesses of each major view, we will also see them in action through a case study. Our subject is a 26-year-old man who walks into the office. He is of typical height and build, possesses normal intelligence and appearance, has reasonably good health, and is from a blue-collar background. His parents wanted him to go to college because they did not have the opportunity and they knew that getting a good education would be helpful to him. This background makes him fairly representative of Americans in general. In addition, there is some history of mental illness in his family, but there has been no clinically significant indication of such a problem for him until now.

After putting himself through undergraduate school and working for a time, he and his wife decide that he should go back to school and pursue a graduate degree for their future. They met during college, found they had a mutual interest in metaphysical or "spiritual" values, and married on that basis, promising to be faithful to each other "forever." Together as a couple for two years now, they do not yet have children. He works the evening shift, meaning that they are separated much of the time. Seven months into the process of going back to school, his mother, who happened to suffer from schizophrenia, dies unexpectedly after a sudden brief illness. He manages to

get through the end of the academic year successfully, but has delayed mourning the loss until the end of that period. As soon as the semester ends, his wife tells him she wants a divorce, that she is involved with an older man who is very comfortable financially (which is something she always admired), and that she wants her husband to find another place to live as soon as possible so that she can get on with her life. At first she agrees to marriage counseling, but consistently fails to show up for the joint appointments. Instead, she goes off with her lover on an extended luxury trip while the husband struggles to make ends meet in a small attic apartment 300 miles away from home back at school.

The client is now feeling grief from the unresolved death, rejection from his wife, betrayal through her infidelity, and confusion as to how all this could be happening to him. In addition, he is unemployed, financially distressed, displaced, and just in the midst of his studies with the end being very far away. In a word, he is depressed. The fellow does, however, have some very good friends who care for him and who urge him to seek out help, which he does. Note that this kind of misfortune could fall on anyone: It has little to do with ethnicity, gender, or age. In fact, such a scenario may even be more likely to involve a woman, as they are probably subjected to this type of betrayal, abandonment, and financial hardship more often than men in our society, at least historically. In any case, such a situation could lead to mild, moderate, or, under certain conditions, even severe or suicidal depression, all of which are real possibilities under such circumstances, which makes the situation a good example for a clinical discussion. Let us call him John simply because we have all known someone with that name and see what each perspective is likely to offer him, including one that incorporates Zen.

THE BIOLOGICAL PERSPECTIVE

First, the biological approach to understanding human behavior is based on the principle of uniformitarianism, especially as it applies to evolution. Such a position assumes that nature (the physical world and all that is in it, including people) is governed by a set of fundamental physical, chemical, and biological laws. Above all, these laws are consistent, hence the phrase "uniform," and not capricious or vulnerable to manipulation by forces outside of the physical universe. When something occurs that is unexpected, for example, it only becomes a matter of trying to understand the phenomenon better, which is to say researching it further and in greater detail. Furthermore, because these laws are natural and consistent, they can be investigated through observation

and experimentation, or though the naturalistic paradigm of using the scientific method. Natural selection is one such principle that pertains to evolution, which is a central characteristic of a biological view of behavior, and this process plays a major role in determining behavior as a basic law of life. Therefore, understanding the rules that govern how organisms operate, the particular behavior of a species, and how these things change over time is an important part of this approach.

Second, the biological perspective approaches understanding behavior on the basis of its physiology, especially that of the brain and its mechanisms. Thus, the biologically oriented theoretician, researcher, educator, or clinician will tend to focus on understanding how the brain works, especially at the neurological level, and particularly in terms of the biochemistry of synaptic transmission. Of course, the laws of uniformitarianism and evolution are still at work: For instance, the neurons of a simple worm work according to the same biochemical principles that ours do. The chief difference is, of course, in the number of neurons an organism possesses and how they are connected to each other, or their particular organizations, which means that the structures of the brain are important, too. Thus, the more complex the brain of a particular organism happens to be as we move up the evolutionary scale, the richer and more sophisticated its behavior will look. For example, the neurons and structures of primitive organisms produce basic behaviors like reflexes, as in a lizard. If an animal's brain is sufficiently complex to have a limbic system, then emotions may be present, as the case may be with a dog. Similarly, if the cerebral cortex is large and complex enough then consciousness also occurs. Of course, the building blocks of any brain are genes, which is precisely where the two principles of evolution and physiology come together, making this the "ultimate reality" of the biological perspective.

All biologically based theories of behavior are set upon these foundations and they all practice a clear preference for the naturalistic or hard scientific paradigm. But the most radical of these views goes one step further. In the case of sociobiology, which is "the systematic study of the biological basis of social behavior in all kinds of organisms, including humans" (Wilson, 1998, p. 150), for instance, biology *is* behavior, and it must be understood that way. According to this school, each species is concerned with only one thing—survival. To this end, behavior is primarily driven by and directed toward the future through reproduction, a process that is helped by natural selection or the survival of the "fittest," which is to say the most adaptive characteristic or behavior given a particular environment or change in it. The two forces of survival and adaptation give the species the opportunity to increase its number until it is maximized, which occurs when the organism

reaches the point where the environment can support no more creatures of this particular type. In theory, at this point a natural balance occurs that can be maintained more or less indefinitely, as long as nothing major changes in the environment. If change does occur, then the processes of adaptation begin again, which might lead to new characteristics becoming more fit and then being selected by nature until new possibilities prove more valuable, and so on. Of course, there are no guarantees in nature, which means that failures to adjust can occur, particularly in the form of extinction.

An interesting thing happens, however, when we take this approach to the level of human behavior, because then culture becomes involved. In this case, "the adaptiveness of the epigenetic rules of human behavior is not the exclusive result of either biology or culture. It arises from subtle manifestations of both" (Wilson, 1998, p. 150). The interplay of biology and culture as a combined evolutionary force allows evolutionary psychology to explain higher levels of human behavior, even those as complex as morality, in a completely naturalistic fashion.

Morality and other such types of high level human behavior provide a good example of how it is possible to say that "all" behavior is biological, even that which may appear otherwise at first glance. For instance, many social institutions, such as putting the welfare of the group ahead of the individual, marriage, developing and maintaining the concept of right and wrong, and so forth, are seen as having evolved in ways that increase the chances of children having the resources and stability required to reach adulthood so that they can reproduce and the species or culture can continue. Since reproduction is the primary business of any species, when children grow up, it behooves them to maintain the same general behaviors, customs, morals, and social structures, as long as they are "fit" enough to bring forth yet another generation successfully. In other words, they develop and are passed on from generation to generation, as a social equivalent of reproduction. Should these and related phenomena no longer have such an adaptive quality, then modification can occur through accident or experimentation and new ones may emerge or the group may vanish, just like the theory of evolution predicts. It must be said that sociobiologists and evolutionary psychologists are only one part of the biological perspective on human behavior and they are a minority that constitutes the extreme form of this type of thinking. However, they are an influential force and they do illustrate the power of a perspective to understand behavior comprehensively.

The rapidly emerging dominant school of this perspective, however, called "biological psychiatry," is more temperate in its philosophical claims and it is an extremely powerful force in the world of mental health research and

care. Biological psychiatry is "a distinct perspective claiming that psychopathology is a matter of biological malfunctions" (Fancher, 1995, p. 253) and offers at least two important contributions to the field in general. First, it defines mental illness as biological in nature, which means that it must be treated this way, too. Second, this name reflects a movement aimed at reestablishing psychiatry as a medical specialty, which distinguishes it from more psychosocial understandings of mental illness and those who approach it that way. Researchers, educators, and clinicians who work from this position, and they constitute the major force that drives modern psychiatry today, affirm the biological view concerning the importance of the brain, including its biochemical and genetic foundations, as well as the basic principles of evolution. Similarly, they advocate the hard, quantitative, natural science paradigm over any other. However, this school tends to suspend the ultimate implications of evolutionary thinking in terms of the philosophically larger questions, such as morality or the existence of God, and so forth, which separates them from the sociobiologists.

The key principle of biological psychiatry is homeostasis, or the idea that organisms seek out a state of balance between physiological systems and once it is achieved, strive to maintain this steady state. Behavior, then, is an attempt by an organism to reach and to maintain a balance between need and satisfaction. All the systems must work together to accomplish this fundamental biological goal, so disrupting one system causes imbalances elsewhere. For instance, homeostasis is disturbed when we are short of fluid levels in the body, resulting in a state of thirst, which, in turn, changes our behavior in the direction of seeking liquids. But after we have satisfied the need for water and restored homeostasis, it is disturbed once again when we need to eliminate wastes, thereby influencing behavior in yet another direction. Such a view of behavior is extraordinarily elegant: Normality occurs when biology functions as it should and abnormality results when it does not. The more serious the disturbance, such as in the case of physical or mental illness, the more severely our behavior is affected, too. Similarly, the more quickly homeostasis can be restored, the more rapidly behavior will take its normal course. Therefore, from this point of view, it makes good sense that we should concentrate our scientific and helping energies on understanding and using biological principles as the first priority.

Now let's look at how the biological perspective might typically go about understanding and helping John. First and foremost, of course, the individual presents various symptoms: His sleep is poor, his appetite is off, his energy is down, and most of all, his mood is melancholic. In order to understand these things, he must be examined, diagnosed, and, ultimately, treated. In

this case, of course, it will be found that, like all illness, the condition is a result of a disruption in otherwise normal homeostatic functioning. In the diagnostic process, various organic possibilities will be considered, because depression can result from many kinds of illnesses, which makes diagnosis and the language of diagnosis a key aspect of the helping process. Most likely, it will be hypothesized that John's brain is in a state of chemical imbalance. The focus of the clinician's attention (or what is "really" wrong with him) is probably going to be understood as involving synaptic transmission. Various neurotransmitters and their specific mechanisms of transaction such as reuptake will be regarded as the likely culprits. In keeping with the general principles of biology functioning, it will be understood that disruptions in these lower order systems lead to difficulties in higher ones, which means that eventually behavior and even cognition can become affected, as is occurring with John.

Typically, John will see a general practitioner for his condition, because they are more readily available than are psychiatrists and because many people still feel there is a negative connotation in seeing therapists. If so, his doctor would probably complete an evaluation of him in 15 or 20 minutes, a process which is often characterized by a series of directed questions to the patient and to which he usually gives relatively brief answers. More time will be spent in this intake process if he happens to see a psychiatrist first or is sent to one. Once the diagnosis of depression is made, he will probably be relieved to find that there is nothing wrong with him psychologically. Rather, it is only that his brain suffers from a "chemical imbalance." Instead of having to take a look at his role in the divorce, for instance, treatment consists of reestablishing synaptic balances, which is done through the judicious use of medications capable of passing through the blood-brain barrier. A follow-up appointment is set up to check on his progress and a suggestion may be made to "get some counseling."

Augmented by his chemical tune-up, John's neurons begin to resume more normal functioning, the symptoms begin to disappear, medications are terminated, and in a few weeks John is "cured": he no longer meets the criteria for depression, signaling that the illness is over. John may wish to get that counseling they talked about, but it is pretty expensive, very time consuming, and he no longer suffers so terribly much. In short, John becomes better able to function again and society gets its productive member back with a minimum of disruption: clearly, treatment has been successful in the terms specified by this traditional culture of healing. It is very important to appreciate that there is good evidence for using this perspective for treating depression: it usually helps. After all, the chief strength of the biological

perspective is that it is *factual*, or thoroughly grounded in the empirical, testable, and duplicable methods of hard science. In fact, the biological approach to mental illness is essential in dealing with more severe forms of mental illness. It is certainly a welcome advance over burning, confining, or warehousing people, all of which have been practiced by well-meaning "care givers" in the past.

Moreover, such a modern view fits very well with the Zeitgeist of our culture, particularly our respect for natural science and our positivistic view of the world. As Valenstein (1998, p. 1), says, American psychiatry is said to have changed from "blaming the mother to blaming the brain."

> The idea that mental disorders are physical diseases has been widely promoted and accepted for several reasons. It is known that people suffering from mental disorders and especially their families generally prefer a diagnosis of a "physical disease" because it does not convey the stigma and blame commonly associated with "psychological problems." Also, a "physical disease" often suggests a more optimistic prognosis and a briefer, less expensive course of treatment. (1998, p. 225)

In addition, major pharmaceutical companies play a key, sometimes hidden, role in advocating this perspective: They help train physicians through corporate sponsored continuing education programs; they fund much, if not the majority, of scientific research on severe mental illness; and these global powers are very active in terms of publishing findings or in making it difficult to publish them, depending on the degree of control the company exerts over a research or agency (Valenstein, 1998). Now, of course, they even advertise to the entire population on television. All of these things and more express and advance the biological perspective at the theoretical, research, and practical levels. Given the power of these forces, and the fact that they are part and parcel of major health care traditions of the West, it is no wonder that this particular culture of healing dominates mainstream mental health today (Fancher, 1995; Valenstein, 1998).

However, there are at least two serious limitations of such an approach to consider as well. The first one focuses on the science of the day. It turns out that although there is good evidence to indicate that biological psychiatry works, the same science tells us that there is no reason to believe that it works the way it is often presented as working, for example, in terms of neurotransmitters plugging into receptors like electrical sockets on walls. As one well-respected investigator who is largely sympathetic toward the biological perspective describes it:

> Understanding just why some drugs work and some do not is generally beyond the current capabilities of science. Even understanding how the ones that clearly

> work manage to accomplish their tasks is beyond current knowledge. Most of the original hypotheses about neurotransmitter deficiencies or excesses have not stood up especially well to testing; even where we do understand the effects on synaptic transmission, no one understands why that should translate into changes at the level of thought, feeling, and action. In the sixth edition of the highly esteemed text on neuropharmacology, Cooper, Bloom, and Roth say that " . . . at the molecular level, an explanation of the action of a drug is often possible; at the cellular level, an explanation is sometimes possible; but at the behavioral level, our ignorance is abysmal." (Fancher, 1995, p. 262)

He goes on to say that over 60 neurotransmitters have been identified so far, but that only a half dozen or so have been investigated. In addition, there are other complicating factors to consider, such as another group of molecules called neuromodulators, the fact that a single neurotransmitter may plug into a dozen or more receptor sites each of which has different functions, that neurons themselves can change in sensitivity, and that the brain makes new connections and sculpts itself in new ways all the time.

Understanding the complexity of the biological picture is extremely important because it stands in stark contrast to how it is presented to the public, in undergraduate textbooks, via educational pamphlets in the physician's office (which, in the case of mental disorders, are often little more that glorified advertisements for drugs), and even in physician training provided by pharmaceutical companies (Valenstein, 1998). Indeed, I always find it striking that this literature, particularly that which is available to the lay public, often fails to point out (or simply minimizes) that, with the exception of bipolar disorder, cognitive and interpersonal therapy is at least as effective in treating most depressions as are medications. Similarly, most medication studies use placebos to give to control groups, but the placebos do not produce the same side effects the "real" medications do, which makes the research on the effectiveness of medication over therapy more questionable than people usually realize (Fisher & Greenberg, 1995; Valenstein, 1998).

The criticism here is that, although medications can and do often work, they do not do so for the reasons most people who advocate their use offer, which leads to the perpetuation of overly simplified ways of thinking about behavior and how to change it. In short, the fact of the matter is that we simply do not know what causes a "chemical imbalance" and how medications may affect them. Of course, there are several unfortunate consequences of maintaining a strong biological bias. For example, because biological research is the most expensive type, it consumes huge amounts of increasingly limited funds, some of which might be better spent on researching different approaches to helping and healing. Similarly, medications tend to become the

first line of treatment when a health care system adopts a strong biological bias, when it might be wiser in the long run to hold them in reserve for situations where less invasive forms of treatment do not work.

Another major criticism of the biological point of view concerns how it diminishes the importance of the person and the role that individuals play in determining the quality or direction of their lives. The tendency to ignore the significance of the person in these ways is reductionistic, a characteristic which,

> Refers to explanations of a phenomenon based on the properties of the constituent elements that compose it. Thus a reductionistic explanation of water would be based on the properties of hydrogen and oxygen. Molar explanations, on the other hand, are based on the properties of the whole, with the assumption that the "whole is more than (or different from) the sum of its parts". . . . While reductionism often provides insight into underlying mechanisms that may prove helpful in understanding some properties of more molar phenomena, it is an error to assume that the "bottom-up" approach is the only way, or even always the best way, for science to proceed. In pursuing the biochemical approach to mental disorders, an enormous amount has been learned about neurochemistry and drug action, but it is questionable how much has been learned about mental illness. (Valenstein, 1998, pp. 137–138)

The weakness here is not that the biological view is wrong or unimportant. Rather, it is that by focusing primarily on the substrata of human suffering, this approach is likely to miss other important, perhaps even more important, dimensions of behavior. For example, there is the classic chicken-and-egg problem to consider. Research shows that some mental disorders do have biological underpinnings that can be observed through brain scanning technologies, such as with some cases of obsessive-compulsive disorder. It can even be observed through the same technology that medications affect these areas and return them to "normal," suggesting that biology is the key to the development and treatment of these conditions. The problem is that cognitive therapy produces the same results as medication and these effects can also be observed, using the same scanning technology, as occurring in the same areas of the brain (Durand & Barlow, 1997)! Therefore, the question is not one of which perspective is "right," but which one is the best to use in any given instance. In other words, is it better to flood the brain with powerful chemicals the long-term effects of which we do not know in order to offer the possibility of a reasonably rapid intervention? Or is it best to respect the integrity of the brain, help the individual deal with his or her problems through some other form of therapy, but in doing so risk taking a longer time? The sad fact of the matter is that, all too often, it is only the bias of the therapist that propels the individual down one path or the other!

Similarly, biology won't tell us why John is depressed, how he should handle the losses he has suffered, what to do with his anger and humiliation, how it is that he always seems to be the one left when his relationships end, and what he can do about his own interpersonal style to help relationships in the future. These are not merely incidental or even just philosophical questions: If we really want to treat the depression effectively, they must be addressed because if they are not, then relapse is likely to occur. Indeed, even if relapse does not occur, getting into another unsatisfying relationship is still likely because medications don't help us learn how to do things differently. The absencé of disease may define health for the biological perspective, but a satisfying life involves much more than that. Reducing us to mere organisms, two-legged protean worms chasing other ones, if you will, fails to address the more meaningful aspects of being human.

Lest this presentation of the biological approach seems unduly harsh, I should point out that it is not intended that way. There can be no doubt about the facts that the biological approach has been extraordinarily helpful and that general practitioners and psychiatrists care greatly about their patients. Our goal, however, is to cover all the major perspectives in a way that gives equal weight to strengths and weaknesses so that we can understand the continuum of mental health care. It was necessary to spend more time on this one than we will on the others because it is first, which means setting up the discussion as well as engaging in it, and because this culture of healing dominates traditional mental health care today, which makes it the largest and perhaps most important part of the background for considering complementary and alternative views.

THE LEARNING THEORIES

The next perspective as we move from the left or "hard" side of the continuum toward the right or "softer" one is that of learning theory. The two most influential ideas of this approach to understanding human behavior are that all important behavior, for example, higher order behavior, is acquired, learned, or conditioned through natural, which is to say observable or measurable, principles of learning, and that the environment, particularly the cultural environment when it comes to human beings, is where most important learning occurs. It is not the case that learning theorists fail to appreciate the biology of the brain. Indeed, no learning could take place were it not for the capacities of this organ, especially in regard to memory. Rather, borrowing from the 18th century philosopher John Locke, the brain is seen as a *tabula rasa* or

blank slate upon which the lessons of living are written over time. Once again we see that science cannot avoid philosophy altogether, and it is important to appreciate just how powerful this idea was and is in our Western understandings of behavior.

For one thing, this position played a fundamental role in the development of democracy. If, for instance, all babies are born like blank slates, then the concepts of "royal" blood or "divine right," two principles that supported European political structures for centuries, are seriously undercut. Similarly, 100 years later, we see the same principle alive in the Civil War: If all men are created equal, then slavery cannot stand up to reason. Today the same principle of basic equality also undermines dictatorships or sexism. In addition, if it is also true that even though we all start out the same but always end up different as individuals, then there must be reasons for that to occur, too. The principles governing this phenomenon can also be studied, understood, and applied to all kinds of things. In fact, the groundbreaking work of such figures as Pavlov in Russia and Watson in the United States did just that, and in doing so created the first genuinely scientific psychology. Indeed, there are some who say that it was learning theory that legitimized psychology as a "real" (i.e., naturalistic) science, especially since the major alternatives to understanding human behavior at the time were religion, philosophy, and, of course, psychoanalysis, none of which could be proven in ways that are compatible with the hard end of the scientific spectrum. Moreover, just like any good scientific theory, this research led to practical applications in several areas of human life, most notably the educational and clinical settings, and with measurable results.

There are so many schools within the learning perspective that it might be more accurate to call it the learning *theories* perspective. However, two of them stand out to most authorities. Like before, one is very radical, which is to say it takes these ideas to their extreme, and the other is more moderate and widely used today. The radical behaviorists, such as Watson and Skinner, did not see a need to consider such notions as the mind in understanding human behavior. Since their influence in American academic psychology was so great, such topics as consciousness were virtually expelled from psychology and other social sciences from the 1930s to the 1960s or so. For a long time, the basic premise of learning theory was that behavior results from orderly processes, which can be observed, studied, and manipulated scientifically. So pervasive were these ideas, that just like Freud's, the learning view of behavior became a part of our everyday language and identity. Every time we say to parents, for instance, "Don't reinforce his behavior," we are speaking this language; each time a teacher "rewards" a student, the behaviorists are at work.

But modern learning theory has gone way beyond both Skinner and behaviorism. Now what is generally referred to as social learning theory dominates the perspective and this approach to learning is much more sophisticated than its behavioristic predecessors because it emphasizes the forces of culture. Of course, all social learning theories still reflect the basic orientation of the perspective: learning and environment determine behavior. But whereas earlier learning theories like classical or operant conditioning emphasized the learning part of the equation more than the environment, social learning theory focuses more on the latter. To be sure, social learning theory continues to affirm the basic principles of learning discovered through classical conditioning, such as repetition, generalization, extinction, and so forth. Similarly, social learning theory also affirms the basic findings of operant conditioning, especially, for instance, the process of shaping behavior. However, the addition of such cognitively oriented learning processes as imitation, modeling, or observational learning expands the ability of learning theory to account for human behavior by leaps and bounds.

The example I like to use for understanding the power of social learning theory concerns my wife, Marsha, and how we negotiated the household chore of determining who was going to be primarily responsible for cooking. In the "old days" (circa 1950s) the decision probably would not have been much of an issue: Everybody "knew" that cooking was "women's work." But like many modern dual career relationships, we married on the basis of mutual interest, mutual attraction, and mutual support for our professional interests. Cooking did not fit into this picture for either one of us, but it soon becomes an issue after the honeymoon, unless one is fortunate enough to be able to eat out all the time. To make a long story short, I do not like cooking because of family history and adamantly refuse to do it unless I absolutely must, which means that future meals are likely to be inconsistent in terms of meal times and quality if they are left up to me. Marsha, who never practiced cooking like girls growing up in traditional families might, at least was not adverse to it, so she chose to assume this duty as one that is primarily hers. The story is not a sexist one, because I got cleanup, including the bathrooms, which she, if not most people, considers a very fair trade! The point is one of how we are to understand the fact that she turns out to be an extraordinary cook and finds great pleasure in it today, even though she was neither trained nor rewarded for learning such a behavior in the past? So far, all we can say is that either the sociobiologists are right and women are better at such things because the biology prepares them for nurturing related activities, or that something very different than biology or simple conditioning is at work.

It turns out that although Marsha never did cooking in her home, it was a very traditional place where life centered on the kitchen. Even though her parents pushed education and not traditional female gender typed behaviors, it is no surprise where she did most of her homework night after night: in the kitchen! Although not practicing it herself, the social learning theorist might say that she was surrounded by a culture or environment of cooking. No doubt her mother, who was very traditional in these ways, exposed her daughter to much of the techniques and culture of cooking, albeit indirectly. Apparently, when it came time to cook, the observations Marsha could not have avoided as a child served her well as an adult: From the learning perspective she covertly acquired much more about the processes and behaviors of cooking than she had been conditioned to know overtly, or had even been aware of knowing. Thus, learning and culture are inseparable for human beings, and very sophisticated mental processes like those involved with observational learning must be involved for higher order learning to occur. In fact, the modern day version of social learning theory, which is usually identified with Alfred Bandura (1997), is now called social cognitive learning theory (Rathus, 1999) in order to better include these processes in its view of behavior. Of course, learning theorists also apply the same concepts and principles to modifying behavior in the clinical setting.

In John's case, for instance, a traditionally oriented behavioral therapist might begin by asking him to describe what he does during the day, especially when he is feeling depressed. He might tell her that most of the week he gets by with showing up to work or classes on time, getting most of his duties done, though not with the enthusiasm he used to feel, and that he then goes home and watches TV until he falls asleep, which is often late at night. As a result, he wakes up tired and repeats the process. "Weekends," he says, "are the worst, because my wife and I used to go out on Friday, spend Saturday with friends having fun, and then just hang out together on Sunday. Now all I do on the weekend is sit and watch TV." He wonders if there is anything more to life and is starting to feel like there is very little to justify going on with it much longer.

Where the biologists approach behavior at the physical level, learning theorists start with the behavior itself, or with what a person does. Put most simply, life consists of a series of negative and positive reinforcements: We have pleasant experiences and unpleasant ones, good days and poor ones. As long as the good outweighs the bad, one's "reward ratio" (Frey & Carlock, 1989) is positive and life is reasonably satisfying, if not enjoyable. Whether through the behavioral notion of "learned helplessness" or ordinary misfortune, depression occurs when the pendulum falls to the other side for an

extended period and creates a negative reward ratio. The lack of positive reinforcement causes depression, because it extinguishes the individual's attempt to obtain positive reinforcement, thereby setting up a vicious cycle of failure, avoidance, and, eventually, withdrawal, all of which decrease the chances of obtaining positive reward even further. John has clearly fallen victim to this negative behavioral cycle: The positive rewards he received from his mother are gone, as are those that came from his wife; he can no longer even count on the comforts of home because he is not living there; and the rewards that used to come from weekends filled with the anticipation of love, fun, and companionship have been completely destroyed and replaced with loneliness and other negative feelings.

Knowing that the situation is likely to only get worse, perhaps even to the point where brain chemistry changes, John's therapist devises a treatment plan that is designed to break this vicious behavioral cycle: He must reestablish a positive reward ratio and his current behaviors must be modified in order to do that. The key to the plan is, of course, to help him find new sources of positive reinforcement. Since the weekends are the most difficult period, she decides to concentrate her energies on that part of the cycle. Thus, she asks John to start asking people out for a date for Friday evening and to make plans to be out of the house most of the day on Saturday and Sunday. John resists the idea of asking anyone out because he is still "too hurt" to think about getting involved with anyone else. But he does understand the need to do something, so he agrees to make a list of possibilities for the other two days, such as going to the local museums, taking walks, calling up a friend, joining a new club, taking part in church activities, volunteering for some worthy group or cause, whatever he thinks he'd like to do. The therapist is also experienced enough to weigh the possibilities and assign "homework" that means actually trying some of them out for a while.

Much like the physician hoping that the right medication and dose will be found sooner rather than later in the process, the learning oriented therapist is relying on the possibility that John will eventually find activities rewarding enough to break the negative reward cycle or "learned helplessness" as many learning theorists prefer to call it. Hopefully, he will even find things that he looks forward to, things that bring him genuine excitement and real pleasure. John does seem to find some relief after a while, but not enough for the cloud of depression to disperse, so she asks him what is lacking. He responds that he feels lonely and "needs" someone. She then takes her techniques one step further and asks him to modify his Friday behavior by going on dates once more. This time he agrees to try that, only to report later that, "Nothing is happening, nobody wants to go out with me." She

asks him to describe how he goes about getting a date in considerable detail, and finds that his approach is to wait until Thursday night, call up a friend or acquaintance, and say something such as, "Hi, you wouldn't want to go out with me tomorrow night, would you?" to which the answer, of course, would usually be quite understandably, "No."

Since John's approach is not likely to be an effective one, his therapist begins to modify it, using the same social learning principles mentioned earlier. She might suggest, for instance, that he is to make a date at least one week in advance, pick out an exciting place he thinks he and the person might enjoy that is within his means, and ask her out in a pleasant, enthusiastic fashion. Then, she requires him to role-play and rehearse with her how he goes about asking someone for a date. With practice, he starts to become more successful in asking people out and, although he still "can't find anyone," at the very least, John's problem with isolation on Friday evenings is addressed. Eventually, it is very likely that he will date someone with whom he can develop a relationship, thereby restoring the reward ratio on the positive side of the scale and alleviating much of the depression. When ready, he may also be asked to share how he has gone about the grieving process to evaluate whether additional work needs to be done in that area. Either way, the therapy ends with John being able to move beyond depression into a life that at least brings some pleasure once again, tipping the reward scale to the positive side and avoiding a further slide toward despair.

The evaluation of this perspective is very straightforward because it is similar to the one we did for the biological point of view: After all, they are both on the "hard" side of the scientific coin. Thus, on the positive side, this approach to helping is very factual in that its findings are reliable, valid, and may be applied to behavioral challenges with a good degree of confidence. In a word, learning theory works: It offers a practical approach to understanding and changing behavior. In addition, the value system in which this perspective is grounded is much more optimistic than its biological companion. For example, happiness is not necessarily a part of the biological culture of healing, but learning theory legitimizes the "pursuit of happiness" in a way that is very consistent with the American dream. After all, what could be more rational than using scientific techniques to modify behavior and alter the environment in a way that optimizes positive reinforcement and minimizes negative reinforcement, as long as one does not run afoul of society's basic rules concerning social behavior? It is the "smart" (i.e., logical) thing to do, according to this perspective, and it is consistent with many traditional values in our culture. Indeed, in many ways, learning theory is particularly American: It is perfectly consistent with our concern with the pursuit of life and personal

happiness that is a part of so many of our institutions. It should be no surprise to see the same ideas embodied in the way we envision health and practice mental health care.

The downside, of course, is that learning theory, even social or social cognitive learning theory, is also largely reductionistic. This time, the reductionism occurs as a form of mechanistic thinking. Although the learning theorist may look at individual behavior, the look is a mechanical one that records actions, observes what they are contingent upon, determines what reinforces them, and uses the information to condition behavior in ways that adjust it in a socially acceptable fashion. Society itself, however, is seldom the question. Personal thoughts and feelings do not need to be addressed beyond the point of establishing and maintaining rapport, because they are epiphenomenal: Thoughts and feelings will spontaneously change once behavior does. Finally, there are no inherent values according to this perspective, only acquired ones, which can lead to a state of mere social relativism or even emptiness. This time our dehumanization does not take place in being seen as "large worms." Rather, it is as though we are simply very "smart rats" that can be conditioned into and out of all kinds of behaviors. Finally, the focus on adjustment and the lack of fundamental human values makes this approach to understanding and helping others potentially Orwellian in its application.

THE COGNITIVE APPROACH

In the broadest sense, the cognitive perspective "would appear to define psychology as the study of internal processes, conscious or not, which may be inferred by an outside observer on the basis of an organism's behavior" (Baars, 1986, p. 9). This perspective is uniquely situated in that it occupies the center of the continuum between the hard and soft general paradigms. Unlike their biological and behavioral brethren, however, cognitive psychology stresses the importance of mental processes, particularly those that are involved in determining how an organism perceives and organizes (understands) the world. Thus, this perspective focuses on two key phenomena: information and representation (Gardner, 1985). The former concerns how an organism gathers sensory data about the world based on its biology as a species, and the latter is concerned with how the organism uses such information to construct a working model of the world, the possibilities within it, and how to navigate them in a way that gets its needs met more times than not. Since human beings are aware of the world, self, and others, consciousness is

a key aspect of our behavior and, therefore, an important part of the cognitive approach (Baars, 1986; Gardner, 1985).

How organisms represent the world depends upon a number of key factors and processes. On the one hand, information includes data about the world, especially the surrounding environment, as well as internal feedback, including that which is based on current bodily sensations and on past experience. Mental representation involves the organism's nervous system, especially the brain's ability to recognize patterns, which is based on "schema" or basic ways of representing information characteristic of a particular species or individual. The process is quite complex even in lower organisms which are limited to fairly rudimentary concerns, such as where to find food, how to avoid becoming food, and reproduction, but matters quickly become exponential as we move up the neurological ladder.

One school of the cognitive perspective, often referred to as the information processing approach (Gardner, 1985), emphasizes understanding the mechanics of these processes in as great detail as is possible. Consider, for example, a possible cognitive understanding of the experience of going to the airport to pick up a loved one returning from a long trip. One stands in the waiting area and looks at the people getting off the plane. The retina is stimulated in a way that excites various "feature detectors" in the brain that are good at recognizing circular patterns (such as eyes and heads), horizontal patterns (such as mouths), and triangular patterns (such as noses). These neural excitations, in turn, are detected by other "agencies" (Minsky, 1986) that "bind" the data together in terms of higher order schemas, eventually reaching beyond simple gestalts like lines and circles to the mental representation or schema for human faces. Now that individuals are being perceived, higher levels of memory become involved, which allows us to sort through the dozens of faces getting off the plane in terms of a particular decision-making strategy, for example, curly hair, pretty smile, a certain walk, and so forth. When the pattern that is detected matches the one that is stored in memory, other processes may come into play more strongly, like emotion, consciousness, and behavior. Suddenly, for instance, we find ourselves directing our bodies toward the other whom we have just spotted, and moving toward them with open arms and smiles which clearly express our feelings and thoughts about being reunited. As soon as we hug the other, new sensations occur, different information is transmitted, other patterns are identified, and perhaps we even begin to anticipate a lovely evening together.

This process of information and mental processing is a dynamic one that goes on during all of our waking experience, and perhaps as we sleep as well. Of course, much of this processing is not done consciously, but automati-

cally, like a computer, which is a favored analogy for the information processing approach to behavior, albeit a very simple one in comparison to the wonder of the human brain. As we develop, the processes become more complex and mature: They have a cumulative effect so that over time the organism slowly constructs an adequate, which is to say reasonably accurate, model or map of the world in which it lives. In the case of human beings, of course, there are three kinds of maps to consider: One is a model of the physical world and the various laws that govern it, such as gravity which is a very important one for two-legged creatures; another is a map of the social world, which includes an understanding of how people behave in relation to one another and how behavior is regulated in a given culture; and the third one is a "self-theory" or a mental representation of ourselves, which includes a self-concept, or how we see ourselves, and our self-esteem, or how we feel about what we see in ourselves (Epstein, 1980). Of course, all of these maps and the relations between them develop over time, which means that new schema come and go in a relatively orderly fashion as we move through the life cycle, thereby making human behavior enormously complex.

The other school, which is generally known as cognitive therapy, is explicitly clinically oriented and gives particular emphasis to understanding how people construct knowledge about the world, self, and others, rather than to the biological processes involved in doing that. Depending upon how much detail the cognitive therapist and client want to develop, they aim at developing a reasonably accurate understanding of the client's cognitive maps, especially where it does not correspond well to reality. In this process, they take special care to identify what pre-reflective or "automatic" assumptions the client makes about these things. Of particular interest is how causality is understood, or who is responsible for what in life and when. Attention is also given to how clients envision the future, especially as to whether it is realistic or not. Assumptions clients make about others are also important. For instance, it is important to know whether they perceive people as being basically good willed, forbidding, or dangerous. Similarly, basic ideas concerning interpersonal communication may be examined. Last and perhaps the most important, it is necessary to understand how clients understand themselves, particularly in terms of whether or not the perceptions and self-evaluation are accurate. In all three dimensions of life, the therapist typically looks for what are called "irrational thoughts" (Ellis & Harper, 1977) or "cognitive distortions" (Burns, 1980), which is to say areas where these assumptions do not correspond to observable reality accurately, especially when the discrepancy contributes to unnecessary pain and suffering.

Each particular version of cognitive therapy has its own method for developing an understanding of how the client constructs reality, and each one

will have a list of typical cognitive distortions people make that create or exacerbate pain. These lists are used to help identify and label problems in thinking that interfere with seeing the world, self, and others, realistically. This cognitive "diagnosis," is shared with the client and various techniques are then employed to help the individual identify these problematic thinking patterns when they actually occur in life. This process is accompanied by teaching ways of breaking these unrealistic, which is to say unhealthy, perceptual and thinking patterns in order to construct more accurate, and presumably healthier, maps instead. Clients are asked to practice these activities until they become reasonably skillful at them. Notice that all the steps in this process are consistent with the cognitive perspective in general: People, like organisms, are designed to construct cognitive maps that help them navigate their particular worlds effectively. Good, that is, detailed and accurate, maps make this process easier and even pleasurable: they help us to prioritize goals, to minimize difficulty attaining them, and to avoid unnecessary obstacles. Poor, that is, distorted or inaccurate, mental representations not only make satisfying needs more difficult, but they also create more problems, often painful ones. A more rational course is to develop a better map, which usually means modifying old ones though "reframing" or other reconstructive techniques. Sometimes, if the person's map is very distorted, it may even be necessary to construct a new one, which is a process that requires considerable time and work.

This time we find our client meeting with a cognitively oriented therapist. After hearing John's complaints about loss and depression, she begins to explore with him the kinds of assumptions he makes about relationships, the durability of relationships, and what he thinks it means to lose a relationship. John tells her that he understands that sometimes life is unfair and people die prematurely like his mother, but that he "can handle that kind of thing as everyone's parents die someday." Then he goes on to say, "It's the marriage that's got me down, I'm such a loser, no one will ever love me again," as he looks down despairingly. After a careful review of other areas of his life which seem to be fairly healthy, that is, realistic and functional, such as friendships and work (in this case school), the therapist identifies the problem for John: Although infidelity and divorce are painful realities that happen to people all too often in life, he is suffering more than he needs to suffer in comparison to others who have gone through such things. She goes on to explain to him how a person's thoughts can alter their perceptions, which in turn, can influence their feelings and even show up in their behavior, such as setting himself up for continuing rejection and loneliness. In short, the therapist shows John how certain negative thinking patterns can cause unnec-

essary suffering, including self-defeating behavior and even depression. She also offers him an implicit hope that is very much a part of the cognitive perspective: if he breaks these patterns, then there may be different and more satisfying possibilities to consider.

Being a fairly rational individual about many things in his life, John realizes that there is no point in suffering more than he must, so he agrees to try his best. Over the next few weeks, he and his therapist identify the particular type of cognitive distortions he is prone to making habitually, and they begin to correct them by substituting more realistic thoughts each time an unrealistic one occurs. When he laments that he is a "loser," for instance, she points out to him that such a thought is irrational, because he has won a lot of things in his life and still has the chance to do that in the future. The thought is labeled as involving a particular type so that they can identify it more easily in the future. Perhaps it is an example of "name calling" (Burns, 1980), which is a very common type of distortion. After having taken this step, they then rephrase the thought more realistically. He ends up saying to her, "I'm a reasonably competent person: I've won in the past and, just because I lost this time, doesn't mean I don't have a chance in the future. After all, there are more than one fish in the sea."

Later on while at home, he starts to feel that life is hopeless again because he "knows" that he will never experience love once more. This time, he remembers to take out his pen and paper and examine this kind of a thought. Getting better at this new skill, he quickly realizes that another kind of error in thinking is causing him to suffer in order for his thought to be true, he would have to be able to tell the future, and that if he could do that, he should play the lottery more often! Once again, he seeks to make a rational substitution and remarks to himself something such as, "This relationship was better than any other I've had; who knows how much better the next one will be. After all, I'm only 26 years old and who knows what will happen by the time I am 40." He notices that he feels a little better about the future, not great by any stretch of the imagination, but things do seem less gloomy now, just as his therapist said it would. Though still hurt and lonely for now, he begins to think about other women who may be interesting to know. John is intelligent enough to notice that this technique can be applied to other kinds of problems in life and the chances of his depression returning after therapy diminish considerably.

The chief theoretical advantage of the cognitive approach is probably its integrative capability. In addition to making mental processes most important to human beings, such as consciousness, the center of the stage, this perspective allows the researcher or therapist to work with more of the person. Since

maps and models can always be expanded or modified, the approach also enables its proponents to integrate ideas, research, and findings from other perspectives, especially those from biology and learning theory, in part because they all share a preference for the same hard or naturalistic paradigm. For example, a good map of behavior would include understanding the neurological structure of the organism, the characteristics of its particular environment (including family, society, and culture for human beings), and an individual's learning history, which is to say how the brain and environment interacted over time to produce individual response patterns, some of which are common to the species and some of which are more unique to the individual. Advances in any area, such as in neurobiology, understanding social processes, or new information concerning an individual's history or experience, do not threaten a cognitive view of behavior, because such developments can be used to improve the accuracy of the models and maps used to understand it.

The second major strength of a cognitive approach may be even more important in terms of health care. First, as Fancher (1995) puts it, cognitive therapy is very "practical." It identifies clear problems, offers a step-by-step approach to dealing with them, and is based on logical connections with reality, all of which correspond to many of our cultural preferences. Furthermore, there is a strong empirical case for a cognitive approach to helping behavior that makes it appealing. For example, cognitive therapy has been found to be just as effective for most depressions as the biological approach, and perhaps even more so since relapse rates seem to be lower with cognitive therapy (Clinician's Research Digest, 1999; Nathan & Gorman, 1998; Valenstein, 1998). Similarly, this approach is beginning to show itself as being reasonably effective for other important conditions, with or without biological therapies, such as some anxiety disorders. Finally, the clinical techniques of cognitive therapy are clear and logical enough for almost any therapist to follow, regardless of theoretical background. This characteristic makes the approach an almost ideal one for what is often referred to as manualized psychotherapy, which is favored by managed care. Indeed, with promising science and much academic support behind it, it is no wonder that this perspective is now part of traditional mental health care and is so popular among clinicians today.

Nevertheless, there are limits to cognitive psychology to consider, too. First, it is still reductionistic. It is true that seeing human beings as individually mobile packages of carbon-based hardware and reprogrammable software that is capable of transforming sensory inputs into behavioral outputs in ways that usually conform to socially perceived reality is a very elaborate view of

human behavior. However, although this perspective takes us beyond protean tubes and past the capabilities of well-trained animals, we are still reduced, this time to "wet computers." In other words, the problem is that the most fundamentally human characteristics of a human being, such as creativity and free will, become algorithmic "search spaces" and probability-based internal decision making trees, respectively (Dreyfus & Dreyfus, 1986). Second, as with learning theory, adjustment is the goal of treatment and mental health. Once again, the cognitive perspective tends to see the problem as being within the individual, not within society, and that we are supposed to respond to a realistic vision of the world. Such a view runs into interesting theoretical and practical difficulties, however, when it encounters socially constructed realities that are unhealthy or destructive to begin with. For example, a society that encourages people to embrace superficial materialistic and hedonistic values as does our own, rather than deeper but more satisfying ones, may even be a case in point!

THE PSYCHODYNAMIC PERSPECTIVE

The psychodynamic perspective is the first one we encounter on the right side of the continuum and, as such, it is more subjective and less concrete than the others. This view has become so much a part of modern Western culture that I do not need to spend much time explaining its basic orientation. In the interest of saving time, then, let me simply remind us that there are at least two basic ideas which all the schools of thought in this perspective assume, share, and build upon even today. One of them is that of the unconscious. Although there is some debate as to how much of this idea was Freud's and how much of it came from German philosophy just prior to his time, he was the one who presented it as a "dynamic unconscious" (Hunt, 1993, p. 167), meaning that it is characterized by powerful subterranean conflicts that drive human behavior without the benefit of conscious direction. Moreover, he did so at a time when the larger culture was extraordinarily receptive to such a view due to various social and intellectual changes.

Historically, Freud's ideas concerning the unconscious and how it drives behavior became a powerful source of new thoughts and possibilities. As Wolitzky and Eagle would have it, "To a significant extent, the history of theoretical developments in psychoanalysis can be understood as a series of successive reactions to Freudian drive theory, with its emphasis on libidinal and aggressive wishes as the primary motive for behavior" (1997, p. 39). Although there is less general agreement on the next point, Freud's second

major contribution involved showing how such drives were transformed by developmental processes, especially those associated with specific ages in a person's life. Once again, the idea of natural, unfolding stages can be traced further back in European philosophy, at least to Rousseau. But it was Freud who tied the two sets of ideas together in a way that explained both normal and abnormal behavior in a consistent fashion.

For a good while the psychoanalytic school was dominant in this perspective, in part, because Freud tolerated few deviations when he was alive. But eventually followers broke away and transformed his ideas into other schools, especially Jungian psychology, ego psychology, and object relations or self-psychology. Today there are relatively few pure psychoanalysts writing or practicing, but there is a large number of people who use modified versions of these ideas to do clinical work. We can collectively refer to them as being "neo-analytic." In this case, Freud's two foundational ideas remain the same, but they have been modified to include more contemporary understandings. For example, where Freud's view of psychological life sees it as involving primarily internal and psychosexual processes, more modern psychodynamic thinkers understand the mind and development as being much more interpersonal and psychosocial in nature. Where Freud envisioned only five stages of development, most of which stopped playing a crucial role by age six or so, Erikson (1985) saw eight (and later nine) occurring throughout the life cycle, with all of them being instrumental in shaping our lives. Similar changes have occurred concerning the way this perspective goes about changing behavior today. Where classical psychoanalysis involved a patient reclining on a couch several times a week, modern psychodynamically oriented therapists face their clients, typically only once a week. Similarly, where the analyst is usually silent and lets the past announce itself indirectly through free associations and dreams, today's psychodynamic psychotherapist is likely to ask questions about the client's history, to more readily invite the client to reflect on various interpretive possibilities, and to play a more active role in helping the person to "work through" the difficulties they find.

This time we see John with a psychodynamic psychotherapist at a local community mental health agency: Fortunately for him, they are willing to accept a lower fee so that he can work on his issues for a longer time than he could otherwise afford. The therapist begins by letting him talk about what he has been through in whatever way is possible for him at the moment, knowing that she may be setting the foundations for a long-term relationship. She offers a judicious combination of support and gentle questioning and he feels that she is accepting of his confusion, pain, and shame. Over time, they begin to explore how this recent loss resembles other losses, and John begins

to realize that he is dealing with much more than his recent betrayal and abandonment. Not surprisingly to his therapist, there are certain similarities in the relationship John had with his mother with the one that he had with his wife. He remembers, for instance, when mother "betrayed" him when she began to develop her mental illness when he was a child. For the first time in many years, he recalls how it was to visit mom in the "state hospital," which he was told to never tell anyone about lest they "look down on the family," and then carrying this secret with him into adulthood. Soon, he begins to feel overwhelmed by the fact that the illness had changed her so much. For the first time in years, perhaps ever, John feels the emotional loss of his mother as she changed from the beautiful, intelligent, socially graceful person that a child sees in his or her parent into someone different who appeared confusing by contrast. "Where did she go?" he cries. And then John lets the feelings and questions he has kept bottled up for years flood their way out of his psyche in a torrent of tears. Finally, he also begins to understand how this tragic event affected his father who did his best to struggle with the situation, as well as his mother.

Over time, his therapist gently invites him to think about how this new loss in his life might be a hidden opportunity to deal with an old loss that he no longer has to "repress," because he is no longer as vulnerable as a child. As they talk about the relationship with his mother and with his wife, John begins to realize that he "picked" her for the "wrong" (i.e., neurotic) reasons. For example, where his mother was sensitive and weak, his wife was callous and strong; and where one was faithful to her husband, the other was not. It was as though the marital relationship was based on some form of reaction formation to the parental relationship. In making such insights, he also begins to appreciate that his chances of having a lasting relationship were fairly low until he worked through these issues; that he was doomed to repeat them otherwise. Over the period of a few months of therapy, he begins to accept the loss of the marriage because it makes sense now: Where confusion reigned, there emerges a sense of understanding; and where there was anger, he now feels sadness instead. Most of all, he sees himself as beginning to shed the relational baggage from the past that has limited his interpersonal development until today. Eventually, John begins to realize that his friends have always been a saving grace in his life, giving him some things he should have gotten elsewhere, so he turns to them in his time of grief. Freed of the past, he now notices how Mary always makes him feel good about himself. They always seem to laugh so much and have fun just going to museums. John realizes that he finds much more satisfaction in her sensitive approach to life than he did with the more hedonistic one of his former wife. He realizes that he is not ready for another relationship until he gets a better handle on what he does with them, but he also knows that there is no reason to sit around on the weekends now and thinks about asking her out for the next one.

Freud's contribution was so powerful that his thinking became embedded in the very fabric of the West. Even today, it is easy to find examples of this influence in popular culture, such as the frequent use of Freudian humor in television situation comedies with which most of us have grown up. However, the shine has worn off psychoanalysis, so it is important to focus on what the neo-analysts bring into the next century. Today, the chief strengths of this perspective actually seem to rise out of the limitations of the other perspectives. Instead of focusing on the observable realities of the body, behavior, or mind, for example, the psychodynamic therapist looks in a very different direction: toward the subject and his or her inner life and personal experience. In addition to attending to the subjective world of feelings, emotions, desires, this process of mutual exploration is done "with" the client instead of "to" them, which further differentiates the psychodynamic approach from the others we have seen so far. The process of helping this way is usually much more affective, more interpersonal, and more intimate, for instance, than the other approaches we covered tend to be. The idea is to identify conscious and unconscious conflicts, to understand how their histories may be alive today, and to help the individual wrestle with these slippery problems so that they can reduce the stress they create. Similarly, the psychodynamic perspective is often genuinely concerned with healing such things as the narcissistic wounds created by abandonment, abuse or trauma, and not just helping to solve problems of living (Levin, 1993).

Of course, the major weakness of even modern psychodynamic thinking is just as glaring as it has always been: It is highly subjective and difficult to validate, or as it is sometimes said, "psychodynamic theory explains everything and proves nothing." Indeed, except for a small body of work concerning the unconscious, there is very little empirical support for the major concepts of this approach, and even what evidence might be supportive in this regard can be accounted for just as well, or perhaps even better, by the cognitive notion of subconscious mental processes. Although interpersonal forms of therapy do have decent research support concerning their efficacy, there is no reason to believe that they are so for the reasons psychodynamic theory claims. Finally, the perspective is still reductionistic. Although we no longer resemble worms, rats, or even computers, we exist as some kind of a noble yet tragic beast: We struggle valiantly against our evolutionary animal past by trying to sublimate primitive instincts into meaningful alternatives.

As such, we are capable of creating great works of art or even great cultures—until the dark regions of our collective minds destroy what we've built, like a Greek play.

THE HUMANISTIC APPROACH

As mentioned in chapter 1, the humanistic perspective began as an alternative to the behavioral and psychodynamic views that dominated American social science and mental health care through the 1920s to 1960s or so (Misiak & Sexton, 1973). This "third force," as it became known, is different from all the others in several ways, but especially in terms of its radical insistence on free will as a fundamental and irreducible characteristic of what it is to be human. Such a stance, of course, is absolutely incompatible with the determinism that all the other perspectives have in common. Whether biological, learning, cognitive, or psychodynamic in orientation, the other four perspectives treat human behavior as though it is based entirely on natural laws that act to "produce" behavior in a deterministic fashion. According to these points of view, if we knew how these laws work and how they were active in a given individual's life, then we should be able to predict their behavior at any given point, at least in theory. However, the humanistic response to this type of thinking takes issue with determinism itself. The disagreement would not be based on a rejection of natural laws, because the world and all that is in it must be accountable to them. Rather, the objection is based on the position that the individual brings an additional principle into play when it comes to selecting behavioral outcomes which violates or transcends mere mechanical orderliness no matter how sophisticated it might be: free will.

Of course, humanistic psychology does not understand freedom in a simplistic fashion. We are not, for instance free to flap our arms fast enough to fly or free enough to go back into time and erase the past. Rather, our freedom is always *situated*, which is to say that it is set in a context that is defined by the realities that constitute our current circumstances, and what is possible within such constraints. Yet within this context, we are seen as being truly free to enact whichever possibility we decide upon, regardless of past behavior, thinking, or history. Although, for instance, the past cannot be changed, it is seen as a living history, which is to say that although its events cannot be altered, their meanings can be. It is this fact that allows one to transcend the past and act in new ways, providing one accepts the responsibility for taking an active role in the creation of the future. The humanistic position also acknowledges the fact that people seldom act authentically in regard to their

potential freedom, and that instead, they usually choose to simply continue to do what their biological predisposition, learning history, habits of thought, or early childhood experience prompts them to do. However, this tendency to act as though we are determined does not negate freedom in any way, because human freedom involves uncertainty and responsibility, both of which we seek to avoid due to the anxiety they create. Therefore, it is a lack of courage that makes us appear to operate by natural laws of cause and effect: inauthenticity, not our lack of freedom, keeps us prisoner to these masters of behavior.

Another distinguishing central ideal of the humanistic approach involves the ancient Greek axiom of being "true to the self," which takes us way back to the idealism of Socrates and Plato. In other words, we all have an inner self that motivates us to transcend our current realities no matter what they may be, in order to reach higher (i.e., more complex, integrated, and sophisticated) levels of consciousness and behavior. Carl Rogers called this essential aspect of being human the "growth tendency" and sometimes characterized it in terms of his "homely analogy" of a potato left in a basement with only one small window for light (1977, p. 8). Yet one day he came down to the cellar and saw that in spite of overwhelming odds, the plant sprouted toward the light in an attempt to reach for the sky. Maslow conceived of this fundamental human drive in terms of an orderly process called self-actualization that included a hierarchy of relatively clear stages of human development, with each one being freer than the previous one. Both of them understood the development of the self as a key psychological process that never stops; it is something that is rooted in the human spirit that is shared by us all. Consequently, humanistic social science believes that it is possible to use the methods of science to study the "farthest reaches of human nature" (Maslow, 1971). Indeed, they would maintain that any approach that does not investigate this aspect of human behavior could never hope to be comprehensive in its knowledge or application, because this part of being human is the most distinguishing and important one.

As before, there are many theoretical variations of these and related ideas in this perspective. One crucial issue in this perspective seems to be just how far psychology should go in terms of the mind-spirit dilemma we examined in chapter 1. On the one hand, there are those who focus on understanding traditional psychological phenomena such as emotional states, individual behavior, social interactions, and so forth. They may even be willing to accept the fact that people experience things that they describe and understand as transcendent. However, such humanistic social scientists usually suspend the question of whether or not such things "really exist." Instead, the focus is

on using scientific inquiry to understand the experience, how the experience is structured and what it means for the individual. Although Rogers and Maslow would likely be sympathetic to this position, phenomenological psychology is probably the most rigorous school of this kind of humanistic thought.

Phenomenological research, contrary to some opinion, is not "antiscientific" (Giorgi, 1971). Indeed, phenomenological social scientists investigate human behavior using the scientific method: This kind of research begins with data (in this case the data of human experience), requires a methodical or step-by-step analysis of that data, and involves clear documentation of those processes so that others can duplicate them and by doing so confirm or question the results. A key difference between phenomenological investigation and traditional social science does occur, however, in terms of their respective goals. As we have seen time and time again, traditional research seeks understanding by reducing a given human phenomenon to its components, which ultimately enables it to manipulate them in order to control behavior. However, the phenomenologist's goal is to let "that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1927/1962, p. 58), which is almost the opposite process. Here the research is on how a given experience or phenomenon is structured and lived out experientially. Understanding takes place through identifying the components of an experience, but does not stop there like an experiment does. Instead, the phenomenologist must also describe how the various components of a situation interact with each other to result in meaningful experience for the individual and for other people who have similar experiences. This level of understanding is often referred to as the "general" or "fundamental" structure of a human situation, experience, or phenomenon (Giorgi, 1971; Mruk, 1994). In other words while experimentation is the best way to break something down into its parts, meaning can only be understood through a more complete form of description (Jackson, 1984).

On the other hand, the school of transpersonal psychology goes a step further than phenomenologists are typically willing to take and in so doing distinguishes itself in two important ways. First, whereas phenomenological social science is interested in any type of human experience or behavior, transpersonal social scientists and practitioners are primarily concerned with one class of them: Those that transcend the individual person.

> The word *transpersonal* simply means "personal plus." That is, the transpersonal orientation explicitly and carefully includes all the facets of personal psychology and psychiatry, then *adds* those deeper or higher aspects of human experience that transcend the ordinary and the average—experiences that are, in other words, "transpersonal" or "more than personal," personal plus. Thus, in the attempt to more fully, accurately, and scientifically reflect the entire range of human experience, transpersonal psychiatry and psychology take as their starting point the entire spectrum of consciousness. (Wilber, 1996, p. xviii)

Next, by being open to the entire range of human experience, the transpersonal school also sees many aspects of behavior in different ways than do those who do not include a transpersonal dimension to behavior.

> *Transpersonal psychiatry*, therefore, is psychiatry that seeks to foster development, correct developmental arrests, and heal trauma at all levels of development, including transpersonal levels. It extends the standard biopsychosocial model of psychiatry to a biopsychosocial-spiritual one in which the later stages of human development are concerned with development beyond, or transcendence of, the individual. . . . *Transpersonal experience*, in addressing all human experience beyond the ego level, includes spiritual experiences but also includes embodied human experience of higher levels. (Scotten, 1996, p. 4)

Traditional approaches do not give such transcendental matters the same degree of concern, let alone validity. For instance, it is possible to understand this class of experience from the other perspectives, but in so doing the meaning of the experience is always reduced to basic components, such as brain chemistry gone awry, socially prescribed trance states, perceptual oddities, unconscious longings for a Freudian "oceanic feeling," and so forth. Even the phenomenological school is only willing to go as far as saying that such phenomena have important personal meanings for the individual or social meanings for the group. Transpersonal social science, by contrast, is very much interested in such possibilities, especially at the highest levels. Unfortunately, however, this openness comes at a certain cost: it is the "softest of the soft" in terms of both data and conclusions.

Now, we find John talking with a humanistic therapist. Although she is not sure whether she is phenomenologically or transpersonally oriented in her own thinking about human behavior and how to change it, she always is "client-centered" in her approach. This means that more subtle scientific and philosophical questions are suspended in the service of being fully present to her client and learning about him, particularly how he experiences the world and life from his frame of reference as a unique individual. Always addressing him in a mode of compassion, but not necessarily always agreeing with him even in the sessions, they talk about his pain and how he understands what he is going through in the "here and now." Together, they both come to understand that what John is experiencing at the deepest, most intensely personal level is a loss of meaning. His basic view of reality, which seems

to have been based on such ideas as fairness, hard work, getting ahead, and loyalty have been shattered, first by the way that life treated his mother (becoming chronically ill, dying early, and so forth) and then by his wife (her betrayal of him and the spiritual ideals they both professed). He now realizes that he doesn't understand very much at all about how life works, how to see others, or even how to live his own life: "It wasn't supposed to be this way," he laments, "I tried to do everything right, it's all so unfair." For a moment, client and therapist share this pain and at least John feels that he is no longer alone.

Slowly, practicing all the regular therapeutic principles of building rapport, timing, and confrontation, the therapist invites John to consider other possibilities, too. "Yes," she says, "life is unfair to people sometimes, what do you think that means when negative events happen to decent people?" Together, they begin to explore his understandings of the world, what it means to believe in happy endings and simple truths, and how he may not have been so innocent in the decline of the marital relationship, although he cannot be responsible for the actions of another. Now that the theme of responsibility has emerged in a nonthreatening way, client and therapist begin to look at his life as a series of choices, actions, and consequences leading to more choices and so on. John begins to see that, since he never really learned much about himself, he couldn't make very good decisions about with whom to get involved or whom to avoid. He now begins to understand that certain values, like fidelity, are important to him, which means that a more responsible way of selecting potential partners might be to look for such values in them before considering other, less important characteristics. He also comes to realize that he does not do well with responsibility and seeks to blame things on others, which probably makes him difficult to stay in a relationship with for most people.

Eventually, John realizes he has a choice to make: He can either do something about knowing himself better and about accepting more responsibility for his life—or not. He knows that the latter position seems to have led to a dead end, but does not know what the former will bring except that it offers new possibilities. He is cautious, but as a result of his being accepted so unconditionally by the therapist, he knows that he is not a "bad" person, a "reject" or "a loser," as he once felt. Their mutual journey has also shown him that there are other things in life that he values: For instance, his work gives him meaning. Thus, he decides to enhance it by doing some volunteer activities with people who need some help, some of whom are also women near his age. "It won't be easy," he says, "but I do feel more in touch with myself now and maybe that means I can make better choices in the future." Even though he is lonely, he knows that life is what we make of it, today and tomorrow.

Like the psychodynamic point of view, the chief strength of the humanistic perspective is that it focuses on the individual. But this time, there is absolutely nothing reductionistic about it. The humanistic psychologist recognizes the unique characteristics of any particular person, accepts them, and embraces the other's essential humanity, the humanity we all share and can cherish regardless of how different people may appear to us in other ways. Thus, the humanistic therapist engages the other in the mode of authentic encounter that creates a relationship based on meaning, not technique. Neither one is concerned with eradicating an illness, fixing a problem, creating a more rational view of the world, or mucking through the past. Instead, they focus on discovering value, perceiving possibilities, making better choices, and taking responsibility for the direction of one's life. From this point of view, we are never only large worms, smart rats, wet computers, or noble beasts: instead, we are human beings, first, foremost, and always.

Unfortunately, there are two major problems with this perspective, too. First, it suffers the same difficulties with empirical support as psychoanalysis does: It is very hard to prove much about these ideas, and the transpersonal possibilities might even be out of the realm of a scientific view by definition, making it the most extreme theoretical position on the continuum. Second, in taking that final step, the transpersonal position actually moves us back to the beginning in a certain important way. For once again, we encounter the paradox found in chapter 1. Even within the humanistic perspective, which lies at the farthest ends of the scientific continuum, the problem is curiously familiar: The school of phenomenological psychology embraces consciousness or "mind" as being essential to a real, complete, or holistic understanding of the person, but does not need to deal with "higher levels" of transcendence other than to acknowledge that people describe such experiences and sometimes find them meaningful. However, the transpersonal school is holistic in the fullest sense possible, which means that it might be able to consider more possibilities of perception, experience, and behavior. Yet the evidence for such reified phenomenon is always very questionable to the scientific method, even as it is used by most phenomenologists. Apparently it is true that, as was said at the beginning of this chapter, psychology cannot escape philosophy and the paradox is still with us even here.

ZEN AND THE TRADITIONAL PERSPECTIVES

Those of us who were trained only in the methods of the traditional psychotherapies often have a difficult time accepting Zen as a legitimate approach to helping and healing others, or at least may feel put off by it upon first

encounter. There are many reasons for such a reaction, most of which I have experienced myself: Zen can seem too different, too foreign, too religious, too philosophical, or, most of all, too unscientific to merit serious research, academic, or clinical attention. One of the main reasons for conducting the investigation of the therapeutic continuum we just completed is to address these concerns. For as surprising as it may have seemed initially, we now see that there actually seems to be a legitimate theoretical context for Zen in traditional mental health care. Providing that we keep the idea of Zen as a middle path clearly in mind, it is compatible with the humanistic perspective in at least six important ways.

First, like the humanistic perspective, Zen's search for truth is more Socratic or Platonic than Aristotelian, more ideal than real, more mind than matter centered. In other words, both approaches are oriented more toward a search for higher personal "truth" than objective facts or socially constructed realities, which places them at the soft end of the continuum. Second, both disciplines are insight oriented and make use of the here and now instead of just the past. For example, where humanistic therapy helps individuals "get in touch with themselves" through exploring the richness of immediate experience, Zen encourages people to do that through meditation and personal reflection. Third, both orientations aim at personal liberation. On the one hand, for instance, humanistic therapy frees the person from being a prisoner to the past or to inauthentic decision-making by encouraging him or her to exercise their free will through taking responsibility for their decisions. On the other, Zen masters help to liberate their students from the suffering caused by attachment to seductive or deceptive illusions by accepting pain instead of avoiding it. Similarly, both pathways to freedom require the individual to grow by increasing personal awareness, facing inner fears, and transcending challenges whenever they emerge.

Fourth, both humanistic psychotherapy and the practice of Zen are intensely interpersonal processes. Where the former emphasized honest and open communication in a client-centered fashion, for instance, the latter often occurs between student and teacher, which can be described as being "learner-centered." In each case, attending to the other, listening to them empathically, and engaging upon honest dialogue or occasional instruction are all exchanged in a mode of nonattached caring. Fifth, personal growth is a teleological process in either framework, which is to say that it is directional, not random: Development tends to go somewhere over time. More specifically, there is an "upward" direction to this movement in that growth is seen as a never-ending process that steadily moves toward higher, more integrated levels of experience, understanding, and behavior. Sixth, these two approaches are

concerned with some form of transcendence in that both the humanistic psychotherapist and the Zen master believe that it is always possible for persons to rise above themselves at any moment. This process is also seen as being absolutely essential to physical, psychological, social, and spiritual (however one defines that term) health.

In addition to this basic compatibility of frameworks, there are many more similarities between Zen and the humanistic perspective if we would compare it to the transpersonal school. In this case, for instance, we might look at the openness to different modes of consciousness that can be of interest to both. However, there is no need to go that far because we are simply trying to determine whether there is a place for Zen in traditional approaches to helping and healing, or not. For it is very clear that we have an answer to our question of whether or not there is a place for Zen in the traditional continuum of scientific approaches: It is "Yes," there is. Not only is the Middle Path compatible with several basic humanistic concepts, but it also does not have to be off the traditional therapeutic chart, so to speak, providing we do not stray too far from the balance this form of Zen offers.

To finish our case study, which actually turns out to be a real person Joan or I know, we now find that things have not gone well for some time now. Both John and his traditionally trained therapist feel that their work together is not progressing satisfactorily no matter what they try. John continues to be depressed about his losses, worries that he cannot afford the sessions much longer, thinks that he is a loser even in a therapeutic relationship, and even seems to be beginning to become visibly angry. In fact, his daily experience now includes feelings of worthlessness and obsessive ruminations. For example, he often remembers one of the last conversations he had with his wife, where he told her that he had thoughts about suicide and how she said, "Well, that's one solution!" His anger knots up his stomach and spills over into his relationships with others in the form of constant complaints about this, that, and other things, too. The therapist is becoming frustrated, and worried, as well.

She could move on to medications or, if she has been using them as an adjunct to treatment, to a higher dose. However, that might either interfere with John's academic performance or create a greater sense of hopelessness and low self-esteem, because he might interpret medication as signifying that he is "defective," just as his ex-wife often implied, so his therapist does not pursue this path. Further, his constant comparison between new relational possibilities and what he thinks he had before makes his attempt to modify dating behavior a continual disaster. Although he sees the logical faults in these ruminations, he seems to engage in the kind of "emotional reasoning"

(Burns, 1980) that renders cognitive therapy less effective, because his feelings keep starting up the negative cycles faster than he can break them. And whenever she interprets the loss of his wife in regard to his earlier losses, he seems to become even more depressed, so she is reluctant to allow him to regress further. In other words, John and his therapist reach one of the issues we talked about in chapter 1: a classical therapeutic impasse.

Now it is time to see what, if anything, Zen has to offer. Since Joan actually practices this approach, we can depart from the format I have used so far with John and ask her what she might do in such a situation.

Joan: If someone came in talking about losses and such, I would have the person talk with me, and I would really want to *hear* him. I see him as a person who is suffering. I could not tell him that "I am listening," but I think that in my sorrow for him, I would grasp the pain and the loss so that as I listen to him, something would come up. I don't know what it would be before it happens, but I trust that something would come up so that a connection would be there and then the person would know he was not alone, that his words are more than words; that his story is a story, but more than a story: It is his heart being cracked open, or being closed up as the case may really be, because he is closing himself off to the future by staying attached to the past and to his pain.

I would have a very deep connection with this person so that he would know that I am there with him, suffering with him, though not in a neurotic or unhealthy way. I would realize that he would have to go through what he would have to go through to be healed from this pain. He has reason to cry and I would help him find a way to not be afraid of being a human being with his sorrow, with his suffering. There is no one way to suffer, so I would honor him in his suffering in any form that it may take, because he is conveying something from his heart. I would honor not just his loss, but what took place prior to that loss, too, such as the relationship he had with his wife and mother. It is almost like painting a picture of the significance of this relationship for the person and the sorrow connected with the loss of not being able to go back and redo something. I would try to provide an environment that is totally filled with compassion, with love, with understanding.

It is hard for me to say what I would do without being there because I wouldn't know what I was going to do until I was there, but I would want to know about some things, such as what happened and the extent of the sorrow. I want to know about these things to give him the opportunity to open his heart up all the way, to crack it wide open, to let all of the sorrow

come out, to not be afraid to experience all of the feelings in their richness and depth, so that he can learn about life from them. That is what I have learned to do: provide a circumstance where people who are overwhelmed by their feelings are not afraid to have them. Something happens in that moment, they are no longer afraid when that happens. I think a lot of the problem he is having is connected with fear, with a fear of being exposed to himself that comes with such questions as what has this loss meant to him, whether it means he is weak, whether he should cry, whether he deserved it, and so forth.

I would also want to know about the fear that is connected to the sorrow, so that it could be accepted. When a person really opens up their heart, they open up to the rest of their life. Maybe the fear is about losing a part of the self that is not even connected with the mom, or wife. But loss can be a catalyst that brings the fear to the surface. I have often thought about that in relation to trauma: It is a catalyst that can become a blessing, even though the loss is severe. It could be an opportunity for someone to open up to themselves and to all their pain. Being open to such suffering, in turn, can lead to cessation. It is not a technique that allows this to happen, but the truth. I hope when I talk with people, fearlessness is a part of the process; that we both open more to *life*. That is my hope, but not an expectation, that no matter what it is, whether it is loss, an addiction, whatever, that the person will see that through that suffering something wonderful has taken place, that life is more open because of it. Sometimes I have even said to people who have been severely hurt by others, "You should write them a 'Thank-You' note!" Of course, I only do that when they come to realize that the event can, is beginning to, or has changed their whole life for the better!

At first John feels put off by this suggestion, but it is *Joan* saying it, not some "therapist." For a moment or two, he wonders if there might be another way of looking at his pain and the recent events that caused it. In his connection with Joan, it occurs to him that feelings come and go, and that the going of feelings can be just as important as their coming, providing one does not interfere with that process. He sees that there is a "lesson" here and shares this understanding with Joan. Sensing that they have reached an important junction in their work, she begins to explore the themes of suffering, attachment, and acceptance with him more fully by simply asking him about them like she would anyone for whom she cares. She notices that by the end of the session he seems more relaxed than usual, not happy by any stretch of the imagination, but more at ease in his body and voice.

Although nothing dramatic seems to occur on the outside, both individuals are aware that something important has occurred. As they say good-bye that

day, Joan finds herself looking forward to the next session, feeling more confident in her sense of who John is and what is going on in him. John begins to think about endings and beginnings and finds that in doing so he is able to let images of his ex-wife come into his mind and pass out with greater ease than before, not much to be sure, but at least he does not dwell on the pain they generate as much as usual. Experiencing on his own that this or that image or thought will "pass" if it is not fought against so hard gives him a new tool to cope with his suffering. He begins to look forward to sharing this insight at his next session, now seeing Joan as a fellow traveler as well as a mental health professional.

Of course, we will have to wait until chapter 4 to see how Joan actually brings Zen to her work through various clinical examples, but even here we can see some differences between Zen and the traditional approaches, even the humanistic one. Perhaps the most important one is that the Middle Path does not lock us into the paradox between idealism and realism that the others do. The question of whether Zen is to be used to help us transcend life's difficulties and grow in meaningful ways or whether it should be seen as a genuinely transpersonal pathway to transcend difficulty based on a metaphysical understanding of spirituality is meaningless here. As we will see with a story of the student asking the master whether there is a "real" self or not, the Middle Path allows us to accept either possibility without, as it were, worrying about it in theory or in practice.

But there is a more subtle issue to consider. Those who practice Zen as more than a complementary approach may become more committed to it over time, perhaps even to the extent that, like Joan, it becomes more of an alternative than complementary approach. For instance, the practice of meditation may start out simply as a way of helping to relieve stress or assisting in reflection. But, like regular physical exercise, prolonged practice seems to take the individual to quantitatively and qualitatively higher levels of ability and performance. Sometimes the process of meditation becomes increasingly more important and more central to an individual's life in a way so that it generates changes in values, attitudes, and life-style. Eventually, the individual may even become more Zen-like over time and adopt this orientation as his or her primary one, instead of just using it in a complementary fashion. We will return to these possibilities in chapter 5 when we try to integrate the two approaches and discuss how that can be done in traditional academic and training programs as well as clinically.

A WORD ABOUT THEORETICAL AND INTERDISCIPLINARY OVERLAP

Most behavioral scientists and practitioners are familiar with the five perspectives in one way or another, and many will notice that I left out a discussion

of at least two important technical points. One concerns the fact that some very important therapeutic modalities were not mentioned. Family therapy and narrative therapy are probably the two major ones, but there are others. The reason for this omission is twofold. First, the goal in presenting the major perspectives was to provide a context for Zen as a complementary therapy, not to offer a comprehensive review of the entire mental health spectrum. For those who are interested in greater details about the development of the major perspectives and how they relate to each other, I strongly recommend the works by Fancher (1995), Hunt (1993), and Wachtel and Messer (1997) that I have cited frequently. Second, certain important therapeutic approaches, including the two just mentioned, can be used by different perspectives in different ways. For instance, family therapy can be done from a social learning, cognitive, or psychodynamic perspective, depending on whether one emphasizes focusing on systems of interpersonal interaction, information processing and communication patterns, or unconscious conflicts, respectively (Wachtel & Messer, 1997). Similarly, both psychodynamic and cognitive therapists can use narrative techniques, such as is the case with Lacanian analysis or constructionist therapies. In other words, it is how a particular therapy or technique is used that counts, not its name, and identifying all of them are not central to our work.

Another kind of overlap that needs to be briefly addressed concerns the fact that there are a number of theoretical positions which "blend" perspectives together. Probably the most common example of this phenomenon is what is usually called "cognitive-behavioral therapy," where acquired patterns of behavior (learning theory) and acquired patterns of thinking (cognitive theory) are both addressed in order to understand or change behavior. But other combinations occur, too, such as the one we briefly encountered concerning Bandura's Social Learning Theory, which was originally very much a part of the learning perspective and is now called Social Cognitive Learning Theory, because of a new emphasis he places on cognitive processes. A similar issue can occur when a new school emerges in an old perspective. The so-called sociocultural position (Rathus, 1999) is a good example to illustrate this variation of the theme. Should this new point of view in social science be seen largely as an extension of learning theory that simply emphasizes the role of culture? Or is it a genuinely different new perspective on human behavior as several undergraduate textbooks present it? Clearly, one could argue a reasonable case for either position in regard to all three cases just described. However, it is necessary to remember that, although these are fascinating questions to those of us who are concerned with theory, they are not particularly relevant for our purposes: For we are concerned with how Zen stands in relation to the traditional mental health care picture in general, which means dealing with the perspectives and not all their

particular variants or combinations. After all, they are just smaller manifestations of the larger views.

Before moving on to asking Joan questions about applying Zen in the clinical setting, a final issue inevitably occurs as we move from theory to practice. In exploring the major theoretical perspectives that dominate traditional mental health care, we sometimes referred to them as cultures of helping or healing. As such, each traditional approach gives rise to various mental health professions and relatively distinct disciplines within them, each of which offers a way of understanding, diagnosing, and treating mental disorders and other problems of living. Like societies, each approach has its own core set of values as to what constitutes the "good" life, or a particular version of mental health as well as illness. Like cultures, each one also possesses a particular technical language that divides people into in-groups and out-groups depending on whether they have been trained in it or not. Similarly, each of them sanctions or licenses some behaviors in the form of acceptable practices and offers this "product" to the larger academic, social, and professional marketplace, which includes patients, students, administrators, and funding sources, too.

To continue Fancher's metaphor, we can also see that, like cultures, becoming a member of a mental health profession or particular discipline within one involves processes of socialization: We enter our particular perspective or professional group with the naiveté of a novice; we learn what our elders pass on to us as worthy; we practice sacred rituals until we do them automatically; we undergo various rites of passage certifying us as citizens of this or that particular community; and finally, we proselytize our values and views to anyone who wishes to consider them, especially those who are in our offices or classrooms. These individuals, in turn, are sometimes socialized into the culture as new citizens and the cycle begins once again.

Sometimes the lengthy process of professional socialization begins in very elaborate, well structured, and heavily supported programs, such as medical school. At other times the path is much less formal, as in the case of a substance abuse counselor who has "been there" and dealt with the issue of addiction through personal experience before helping others. But each culture of healing has its own "high priests" (e.g., leading biologists or Big Books), sacred values (e.g., homeostasis or abstinence), exclusive initiation processes (e.g., medical school or personal recovery) and privileged practices (e.g., medications or 12-steps). Although we may not become completely socialized, all of us go through the process and most of us begin our work as representing, if not defending, one culture of healing or another. Finally, each society of like-minded researchers, educators, and clinicians continues

to expand until it meets resistance from competing groups, at which point conflict invariably occurs.

In researching this chapter, I was disappointed to find that, as a field, we have a very good sense of our theoretical preferences and technical orientations, but that we generally fail to address the more competitive interdisciplinary issues outside of trade newspapers, closed meeting doors, or, upon occasion, court rooms. There simply does not seem to be much open discussion about the conflicts between the traditional cultures of healing in professional journals or in clinical training texts. Yet, such conflict occurs in spite of the well-known facts that most research on the topic of the effectiveness of the various mental health professionals clearly indicates that the particular discipline of a given clinician does not seem to matter greatly in terms of client satisfaction (Consumer Reports, 1995), or that the major traditional approaches to therapy often appear to be relatively equal in terms of their general effectiveness for most types of disorders, as I mentioned with depression in chapter 1. Indeed, even the more biologically based conditions fare better in their treatment when medications are combined with other kinds of support.

Fortunately, except for the "true believers" of a given culture of healing, most of us who practice probably end up being much more eclectic in our orientation than we were at the beginning of our careers. Time and experience soon show us that, in our work, whatever we were taught in school was inadequate to the tasks that face us in the "real world." The simple facts of the matter are that human life is simply too complex for one perspective or discipline to grasp and that our work often requires us to find ways of getting along with others who hold views different from our own so that we may be more helpful to our clients. As we shall see, just as we found that there is room for Zen at the theoretical context of our field, we may also find that the 10 concepts and principles may be helpful in terms of the interdisciplinary aspects of our work. If so, then we might want to rethink some of our academic, clinical training, and supervision practices, which is an important topic both Joan and I will address together in the last chapter of this book.