PROPHETS OF PSYCHOHERESY I

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Chapter 21

CLAIMS, CURES AND QUESTIONS

Meier and Minirth's writing and speaking are periodically punctuated with claims for improvements and cures. Even beyond their Freudian bias is their confidence for cure and/or relief for a variety of problems. But, their claims are not supported by the literature and research. We shall discuss some of what they say, compare and contrast it with the literature, and then make some general comments.

Insight Therapy.

Meier and Minirth repeatedly proclaim that insight therapy is dramatically effective in treating all sorts of problems. When they discuss such problems as depression, fear of flying, multiple personalities, early life traumas, bulimia and phobias, they recommend insight therapy. They sometimes use extreme words such as *cures* and *you will get over it* through the use of insight therapy.[1]

Because of their repeated endorsement and use of insight therapy, as well as their claim for its effectiveness, it would be helpful to know what it is. Dr. Michael McGuire in the *Psychotherapy Handbook* says, "The history of Insight Psychotherapy can be traced to Freud."[2] Because insight therapy originated with Freud, it has to do with the activity of exposing the contents of the so-called unconscious. Therefore, Freud archivist Dr. Jeffrey Masson precedes his definition of *insight* with definitions of *repression* and *interpretation*:

> *Repression* is the activity that permits something to remain in the unconscious. It is one of the defense mechanisms; others are denial, undoing, reaction formation. It is not a willed activity. *Interpretation* is the activity the therapist engages in when something unconscious is made conscious to the patient or when a truth is declared. *Insight* refers to the intellectual and emotional recognition of the truth of an interpretation, whereby something that has been, until then, repressed is made conscious.[3]

Masson's definitions coincide very well with Meier and Minirth's statements about insight therapy.

From this and evidence stated earlier, we can conclude that Meier and Minirth recommend and utilize a therapeutic approach that is Freudian. Three examples of mental-emotional-behavioral problems and Meier and Minirth's claim for cures with insight therapy are those of bulimia, multiple personalities, and agoraphobia.

Bulimia.

The first example is that of bulimia. Bulimia is a food related problem of binge eating and vomiting, which is usually practiced by a female. In response to a caller, Meier tells her that if she is "not in danger of any kind of physical threat," she should see "a really good insight oriented counselor who can get in touch with those repressed emotions." He goes on to say, "You will get over that symptom of bulimia when you deal with the root problem." The root problem, of course, is repressed emotions; the treatment is insight therapy; and the result is she will get over it.[4]

In searching the literature on the eating disorders of anorexia and bulimia, we find that while much research is going on, there are no definite solutions to those problems. Direct or implied promises, such as the one above, are not given for any one particular therapeutic approach by people in touch with the research.[5] In her book on eating disorders, Dr. Hilde Bruch indicates that patients with eating disorders "appear singularly unresponsive to traditional psychoanalysis."[6] Psychoanalysis, of course, is Freudian insight therapy, which is fixated upon unconscious repressions, as in the case above.

Multiple Personalities.

A second example related to Meier and Minirth's claims for insight therapy is that of multiple personalities. The DSM-III describes the multiple personality this way: "The essential feature is the existence within the individual of two or more distinct personalities, each of which is dominant at a particular time."[7] Probably the best-known example is in the book *The Three Faces of Eve*.

On one of their programs Meier said, "**Only** insight oriented therapy" helps or cures multiple personalities.[8] (Emphasis added.) However, Dr. Richard Kluft, in his keynote address at the First International Conference on Multiple Personality/Dissociative States, says, "There is no real 'right' way to treat multiple personality."[9] Note the contrast between Meier's word *only* and Kluft's words *no real "right" way*. In a research volume on multiple personalities, Kluft says:

> The scientific study of the treatment of multiple personality disorder (MPD) has barely begun. Several treatment approaches have been described, but none has been assessed with rigorous methodologies or along objective dimensions. There are no studies comparing the efficacy of one approach with that of another. Furthermore, it is difficult to measure the impact of treatment against a cohort of untreated cases. There is no potential control population of treated or untreated cases in the literature. The follow-up of a limited number of cases and a small number of autobiographic accounts offer tantalizing clues but hardly constitute a data base.[10]

The literature demonstrates that those who work with multiples disagree as to the desired end result of treatment. Some are in favor of a complete integration of the

multiples into a single self (fusion). Others work towards a "peaceful coexistence" of the parts. Some even question whether fusion is possible or even necessary.[11] Dr. David Caul says, "It seems to me that after treatment you want to end up with a functional unit, be it a corporation, a partnership, or a one-owner business."[12] One specialist claims that "what is needed for resolution is that the patient make clear-cut moral choices." This individual "considers it imperative that all multiple personalities and their equivalents make a moral choice of existential proportions between good and evil."[13]

A multiple personality disorder is a severe problem and is recognized as such by the various researchers and practitioners. We did not find the word *cure* in the numerous volumes we checked, except that once, out of the numerous volumes we checked, *cure* was used with quotation marks.[14] No one used the word *only* in relation to a single treatment methodology.

Agoraphobia.

The third example is a panic attack disorder. The anxiety that becomes a panic attack when people leave home is referred to as agoraphobia. According to one textbook:

> Agoraphobics are defined not only by fears of public places and conveyances but also by their fear of being away from home and familiarity—places and people that provide psychological security. Indeed, agoraphobics tend to fear any situation where an easy retreat to safe territory is not possible.[15]

Meier has some very definite opinions about agoraphobia. He says, "People that get it usually are the first born in their family."[16] Meier asserts that the reason is that parents "expect too much out of their first child."[17] In describing the type of counseling he does and recommends, Meier says that "they dig and probe and dig and probe and work your way through the childhood issues, adult issues and look at the repressed anger at/toward mom and dad, look at the obsessive compulsive thinking. . . ."[18] Meier speaks of either psychotherapy over a three-year period of time or hospitalization with psychotherapy for a considerably shorter period of time. He says,

> For agoraphobia we recommend hospitalization because it's so painful to go through for three years. Why stay locked up in your house three years? If you can check into a hospital unit where they do know what they're doing and where they can dig and probe, and almost all the cases we've treated, nearly all of them have gotten over their agoraphobia within about six to eight weeks in the hospital. So instead of two or three years of out-patient counseling by digging and probing, doing the same thing but doing it seven days a week, getting group therapy seven days a week, individual therapy four days a week, by digging and probing and looking at these insights daily, it usually takes longer than it does for depression. Depression usually takes one month to get over in the hospital but agoraphobia usually takes two months, sometimes even three months,

> once in a while even four months but usually about six weeks to sixteen weeks, somewhere in that period. And a lot of that depends on childhood factors, but by working on these things day by day a person can get totally over it for life in a couple of months in the hospital.[19]

There are several questions that need to be addressed. First, is agoraphobia associated with the first born in the family? Second, is insight therapy, the "dig and probe and dig and probe" type, usually a real deliverance from agoraphobia? And third, is it usual that "nearly all of them have gotten over their agoraphobia within six to eight weeks in the hospital"?

In all the literature we read, we found no one identifying the first born in the family as the most vulnerable to agoraphobia. Nor did we find any research which related agoraphobia to parents expecting "too much out of their first child." We did learn that "the tendency to have panic attacks runs in families."[20] We also learned about other theories that had been proposed and examined. [21, 22, 23] However, we found no pattern of the agoraphobic typically being the first born child nor any relationship to parental expectations.

We wrote to Dr. Dianne Chambless, a well-known researcher in the area of agoraphobia and asked:

1. Is the agoraphobic typically the first born in the family?

2. Is there any research to support the idea that agoraphobia is the result of parents who expect too much from their children?

She replied, "To my knowledge there are no studies of birth order or of parents' expectations."[24]

Related to birth order of children and later problems of living, Meier says:

> We're probably treating a thousand people for alcohol and drug addiction right now currently at our clinic. Nearly all of them come from families with certain dynamics that produce the alcoholism. Most of them are the youngest child in their family.[25]

Again we searched the research literature and found no support for Meier's statement. In addition, we called Dr. Herbert Fingarette, author of Heavy Drinking: *The Myth of Alcoholism as a Disease*, and asked if he was aware of such a relationship. He said, "No."

In their latest book, Meier and Minirth claim, "Research has proven that birth order has an impact on personality development. . . ."[26] Meier and Minirth are enamored with the idea of birth order and often see it related to certain mental disorders such as agoraphobia and alcoholism. However, contrary to what they say, the research has **not** "proven that birth order has an impact on personality development." *Science* magazine featured a special report by John Tierney on "The Myth of the Firstborn." Tierney says, "Birth order theory makes an appealing neat way to categorize human beings-----like astrology, but with scientific trappings." In reference to the research findings he says:

> After reviewing 35 years of research-----some 1,500 studies-----Cécile Ernst and Jules Angst of the University of Zurich reach a simple conclusion: On a scale of importance, the effects of birth order fall somewhere between negligible and nonexistent.[27]

The second question relates to Meier and Minirth's use of insight therapy, and especially their intense use of it. They recommend "six to eight weeks in the hospital" of "digging and probing." Because of Meier's reference to "repressed anger" and since repressed anger is their key dynamic of depression, one gets the distinct impression that Meier views agoraphobia as a form of depression. But, agoraphobia researcher Chambless says:

> Because agoraphobics begin to experience problems with their relationships and feel a general demoralization as the phobia progresses and endures, it is not surprising that most of them are also mildly to moderately depressed. For a time, this was confusing to mental health professionals, who thought that agoraphobia might be a special case of depression. Occasionally, agoraphobics are still told this. People who are severely depressed do sometimes become phobic for the duration of the depression and lose the phobias when the depression lifts. In the great majority of cases, however, agoraphobia is the primary problem, and the depression improves when the agoraphobia is successfully treated.[28]

In describing the treatment of agoraphobia, Dr. Andrew Mathews et al say:

> The central idea in the psychoanalytic view of phobias is that symptoms are the result of two processes: the repression of an emotionally charged idea and the displacement of this internal conflict to an object or situation in the outside world. . . . The repressed impulses presumably vary from patient to patient, but sexual and aggressive impulses are thought to be those most commonly involved . . . . The first requirement of analytic treatment is to uncover the repressed mental contents that account for the agoraphobia. The second is to enable the patient to deal with these directly so that the defenses of repression and displacement can be given up.[29]

In discussing the varieties of treatment for agoraphobia, Chambless says:

> Until the 1970s, agoraphobics were treated with standard (usually Freudian) psychotherapy. . . . The assumption was that with insight the phobias would improve. . . on the whole this approach did little for the phobias. . . unfortunately, most practitioners still use the ineffective method of "talk therapy."[30]

In discussing "Treatment for Fear," Chambless says:

> Considerable research has shown that a person who has a specific phobia is no more or less psychologically healthy than the average person. For this reason it is completely inappropriate for such people to be in talk therapies to overcome their problem.[31]

Thus according to the research, insight therapy, with its digging and probing, is not considered effective for either agoraphobia or specific phobias. Therefore, it seems that the issue of "six to eight weeks in the hospital" of "digging and probing" would be an overdose of what the research indicates to be the wrong treatment. It may be that "nearly all of them have gotten over their agoraphobia within about six to eight weeks in the hospital" at the Minirth-Meier Clinic. However, the research does not seem to support insight therapy with its "digging and probing" to be a primary effective method of treatment. In addition, Meier's statement that "nearly all of them have gotten over their agoraphobia within about six to eight weeks in the hospital" with "digging and probing" therapy seems enormously contrary to the usual success/ failure/relapse reported in the literature. But unless there are outside researchers examining their results, it is very difficult to obtain an objective view of their treatment.

Other Claims.

The following sections contain examples of other claims made by Meier and Minirth. The previous sections and the following contain neither unique or atypical examples of what they say. An exhaustive search of Meier and Minirth's writing and speaking for other such claims, which are not substantiated by research, would take much more space than this present section.

Schizophrenia.

On a radio broadcast, Meier said that schizophrenia comes "from severe inferiority feelings and genetic predisposition and a bunch of different factors and it's curable if you catch it early." Then he said, "If you don't get medical help for about six months it becomes incurable; the biochemical pathways become permanent." In reference to schizophrenia, he also said, "If they go six months without medication they're going to spend the rest of their lives that way and we see hundreds of them and if you catch them right away, within a week or two, they're totally curable."[32]

In *Introduction to Psychology and Counseling*, Meier and Minirth say, "Without proper management, a schizophrenic individual could be doomed to a life of insanity."[33] On the radio, Meier told of a young seminary student whom they were treating. In the course of the treatment the young man was checked out of their care. Meier said, "That was years ago and that guy is still insane today and will be the rest of his life. He would have been totally normal if he would have gotten a little bit of medication to restore him to normal."[34] In their tape series *Happiness Is a Choice* they make some of the same comments.[35]

We raise the question whether or not it is appropriate to speak of either a cause or a cure for schizophrenia. Is it appropriate for them to say that schizophrenia results "from severe inferiority feelings and genetic predisposition and a bunch of different factors"? In addition, is it appropriate to say that "it's curable"? The first issue we will address is the involvement of "inferiority feelings" in the onset of schizophrenia. According to research psychiatrist E. Fuller Torrey, schizophrenia does **not** result "from severe inferiority feelings."[36] Related to the ideas of cause and cure, the Harvard Medical School reports: "One in a hundred persons will at some time suffer from schizophrenia. **Its causes are obscure, and no way is known to prevent or cure it**."[37] (Emphasis added.)

In his book *Surviving Schizophrenia*, Torrey says:

> Contrary to the popular stereotype, schizophrenia is an eminently treatable disease. That is not to say it is a curable disease, and the two should not be confused. Successful treatment means the control of symptoms, whereas cure means the permanent removal of their causes. Curing schizophrenia will not become possible until we understand its causes; in the meantime we must continue improving its treatment.[38]

In addition, he says:

> Drugs are the most important treatment for schizophrenia, just as they are the most important treatment for many physical diseases of the human body. Drugs do not *cure*, but rather *control*.[39] (Emphasis his.)

If, according to Harvard Medical School, "no way is known to prevent or cure" schizophrenia, then the statement by Meier that "it's curable if you catch it early" must be false. Repeatedly we see in the research literature that "not all cases of schizophrenia respond to drug therapy."[40] Furthermore, there is no early detection assuring early cure for schizophrenia. In addition, Meier's statement, "If you don't get medical help for about six months it becomes incurable," must be false. Even if they were referring to control rather than cure being limited to those diagnosed within six months, the evidence indicates that control is not limited to early diagnosis or early treatment.

Torrey mentions "twenty-five studies in which schizophrenic patients had all been followed for an average of at least ten years."[41] He says that "over 4,400 patients were followed up in these studies."[42] Then he summarizes:

> Based on the patients followed in the twenty-five studies, it seems reasonable to conclude that *one-third* of all patients hospitalized and diagnosed with schizophrenia will be found to be completely recovered when followed up ten years later.[43] (Emphasis his.)

At the "other end of the spectrum" are one-third of the patients who are unimproved. Torrey goes on to say, "This leaves the remaining one-third in the middle category of improved but not completely recovered."[44]

The Vermont Longitudinal Study would seem to contradict Meier's after "six months it becomes incurable" and "that guy is still insane today and will be the rest of his life" statements. This study of chronic schizophrenia revealed that one-half to two-thirds of former patients "had achieved considerable improvement or recovery."[45] The study showed that "forty-five percent of the sample displayed no psychiatric symptoms at all," and half of them used no medication.[46] This longitudinal, well-documented project certainly repudiates Meier's statement, "If they go six months without medication they're going to spend the rest of their lives that way."[47]

Meier refers to a six-month period of time to medicate and also refers to the pathology as schizophrenia. However, Torrey says:

> . . . schizophrenia is a serious diagnosis and should not be applied indiscriminately to anyone who has any schizophreniclike symptom, however, brief.[48]

Torrey recommends that for such individuals with schizophreniclike symptoms of less than six months duration, they should use schizophreniform disorder as the diagnosis rather than schizophrenia. Thus, according to Torrey, Meier's reference to someone with schizophreniclike symptoms prior to six months as having schizophrenia is inappropriate.

In *Happiness Is a Choice*, Meier and Minirth say that someone "might be predisposed toward schizophrenia under similar stresses because of an alteration of dopamine in the brain."[49] In *Introduction to Psychology and Counseling*, they say, "Schizophrenia is another mental illness in which inheritance may predispose toward a potential weakness."[50] They also say:

> The dopamine imbalance is possibly precipitated by too much acute stress in an individual with a genetic weakness with regard to neurotransmitters, after a difficult early environment.[51]

By *predisposed*, it seems they mean *genetically predisposed*. Torrey refers to this "genetic predisposition (diathesis) in addition to stress" as "the so-called diathesis-stress theory."[52] Torrey says:

> The main trouble with stress theories of schizophrenia is that there are no supporting data. When studies have been done ascertaining the stresses in patients' lives prior to their schizophrenic breakdown, the stresses are found to be no greater than those in a random sample of a general population.[53]

Torrey concludes that "stress theories leave many important questions unanswered."[54]

In addition to their implicating stress, Meier and Minirth also mention dopamine. Dopamine is a brain neurotransmitter. Note the following statement from Torrey:

> Finally, it is now known that drugs which are effective in schizophrenia block dopamine action. For all of these reasons many researchers **suspect**

> that an excess of dopamine is one of the causes of schizophrenia.[55] (Emphasis added.)

Notice the word *suspect*. In this very complex, rapidly changing field of the brain and its neurotransmitters, it is better to use moderate language. It is better to use such phrases as "it seems as if," "it appears to be," and "it may be." And yet, Meier and Minirth make definitive statements that are questionable at the very least.

Insomnia.

Meier and Minirth were being interviewed on a radio program and Meier said, "Insomnia is a one-hundred percent curable problem."[56] We have researched the literature and contacted two well-known researcher/practitioners. The two individuals are Dr. F. Grant Buckle, Medical Director, Sleep Disorders Center, The Hospital of the Good Samaritan, and Dr. German Nino-Murcia, Stanford Sleep Disorders Clinic. Based upon what we have learned, it seems obvious that Meier and Minirth's promise is another claim completely without support in the sleep disorder literature or from information received from the two sleep disorder centers contacted.

Depression.

In *Happiness Is a Choice* Meier and Minirth say, "Scientific research indicates that 85 percent of significant depressions are precipitated by life stresses."[57] Again the use of a percent such as 85 communicates a simplicity that is difficult to support from the research. The studies that do take the simplistic approach and report a percentage generally report a significantly lower one than Meier and Minirth report. However, any percentage associated with the expression "precipitated by life stresses" is too simple to be acceptable. Dr. E. S. Paykel, whom they quote, says, ". . . there is often an amalgam of recent life stresses, chronic stressful social situations and absence of social support, genetic elements suggested by a family history, and probable biochemical factors."[58] These factors create a complexity that a simple numeral followed by a percent sign will obscure. In addition, it is obvious from the research that no single factor such as "life stresses" is generally enough to explain the depression.

In her book *The Broken Brain*, Dr. Nancy Andreasen says:

> We do not fully understand how depressions are triggered. Sometimes they have obvious precipitants, as was the case with Conrad Jarrett in *Ordinary People*, who became depressed when his brother, Buck, died in a boating accident that he survived. Other depressions appear out of the blue, as did Sylvia Plath's first episode, which began after her sophomore year at Smith while she was in New York on a coveted *Mademoiselle* guest editorship. Some patients have clear precipitants for some episodes, but not for others. . . . Sometimes depressions begin after a physical stress. . . but sometimes they begin when the patient has not experienced any kind of unusual event.[59]

She goes on to explain "endogenous" depression and then says:

> Depressions occurring after a stress were called "reactive" and considered to be purely psychological. More-recent research suggests that this view is an oversimplification.[60]

Drs. Ted and Renate Rosenthal speak of "Depression as a 'Final Common Pathway.'" They say:

> . . . such affective illnesses as pronounced, melancholic depressions are assumed to occur when a threshold is crossed by a combination of biological, psychological, and situational strains acting conjointly.[61]

Dr. Myrna Weissman, in discussing depression, presents evidence that "the reasons are biologic as well as psychosocial."[62]

The following quotes will illustrate the extent of the promise for cure for depression that Meier and Minirth offer. They say:

> Depression is one-hundred percent curable.[63]

> We have treated over two thousand patients for depression, both Christians and non-Christians, and *all* of them get over their depression.[64] (Emphasis theirs.)

> But even now, by applying the contents of this book [*Happiness Is a Choice*], depression is 100 percent treatable. In fact, depression (over a period of weeks or months) is 100 percent curable.[65]

Even the subtitle of *Happiness Is a Choice* implies the promise for cure. It is: *A Manual on the Symptoms, Causes and Cures of Depression*. Note the word *cures*.

In reviewing Meier and Minirth's book *Introduction to Psychology and Counseling* in the *Journal of Psychology and Theology,* Stanton Jones notes that "this book contains many factual errors" and then gives examples. Jones also says:

> An area of grave concern for this volume is the tendency of the authors to use empirical research to illustrate points they are advocating rather than seriously struggling with the frequently contradictory evidence of our field. Their assertions are presented as unequivocal, with evidence contradicting their positions rarely cited.[66]

The strongest point that Jones makes is that they make several "poorly qualified clinical assertions which are quite misleading, the most obvious of which was that in the treatment of the clinically depressed person."[67] Jones discusses the claim and then says, "Such claims are overstated and have no place in professional publications." In

conclusion Jones says, “Overall, I cannot recommend this book as an introduction to psychology, nor as an introduction to counseling, nor as an introduction to Christian counseling.”[68]

And Still Other Claims.

In their publication *Christian Psychology for Today*, Meier and Minirth list a number of problems: “panic attacks, agoraphobia (fear of open places—they can’t leave their home), multiple personalities, psychoses, bedwetting and hyperactivity (in children), or sexual dysfunctions.” They go on to say: “If people with such problems are to be helped, they will probably need the assistance of a trained psychologist or psychiatrist. These problems are curable. . . .”[69] There is no qualifier used. They declare very simply and very directly, “These problems are curable.”

On one of their radio broadcasts Meier mentioned almost the same list and said, “They’re easily curable.”[70] If taken literally, this is a fantastic claim! It is a claim we have not seen supported in any of the literature; a claim we have not seen supported in any of the research; a claim which no other clinic we are aware of has made or would probably dare to make; and a claim that requires substantiation because it is in such contrast to what is known about those individual problems. We have never read nor heard of such an extreme claim in all the years we have been reading the professional journals, books, and research in these various fields.

Any statement to the effect that depression or any other such broad category of problems is one-hundred percent curable is likely to be spurious and promote false hope and grave disappointment. In *The Broken Brain*, Andreasen cautions:

> The word *cure* is used much too liberally today. We need to learn to distinguish between cure and care. People have been too often taught by both physicians and journalists to hope for “a cure” when in fact they should be hoping for care instead.[71]

We believe that by any reasonable standard, Meier and Minirth’s comments made about schizophrenia, “panic attacks, agoraphobia. . . multiple personalities, psychoses, bed wetting and hyperactivity. . . sexual dysfunctions,” and depression are overstatements, to say the least. The word *cure* is rarely, if ever, used for extreme disorders and we find no one who uses it as glibly as Meier and Minirth.

It is unfortunate that the major Freudian ideas that have not withstood the test of research are staunchly held and promoted by Meier and Minirth. Their continued use of the Freudian fallacies of the past, repression, the unconscious, defense mechanisms, the early psychosexual stages of development, and so on are startling in light of the current indictments against Freudian mythologies. More and more researchers and scholars are criticizing Freudian theories and presuppositions, and secular theorists are using them less and less. But Meier and Minirth continue to treat Freud’s unfounded opinions as facts.

NOTES:

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29. Mathews, *op. cit*., pp. 63-64.
30. Chambless, "Fears and Anxiety," *op. cit.*, p. 425.
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52. Torrey, *op. cit*., p. 96.
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57. Minirth and Meier, *Happiness Is a Choice, op. cit*., p. 98.
58. Letter on file.
59. Nancy Andreasen. *The Broken Brain*. New York: Harper and Row, 1984, p. 40
60. *Ibid*.
61. Ted L. Rosenthal and Renate H. Rosenthal, "Clinical Stress Management." *Clinical Handbook of Psychological Disorders*. New York: The Guilford Press, 1985, pp. 149-150.
62. Myrna Weissman, "Depression." *Women and Psychotherapy*. Annette M. Brodsky and Rachel Hare-Mustin, eds. New York: The Guilford Press, 1980, p. 97.
63. Meier on "Issues of the '80's," *op. cit*.
64. Minirth and Meier, *Happiness Is a Choice, op. cit*., p. 133.
65. *Ibid*., p. 195.
66. Stanton Jones, "The first Christian 'Introduction to Psychology and Counseling' Text?" *Journal of Psychology and Theology*, Spring 1983, Vol. 11, No. 1, p. 60.
67. *Ibid*.
68. *Ibid*.
69. Frank Minirth and Paul Meier, "How To Seek a Counselor." *Christian Psychology for Today*, Vol. 3, No. 2, Spring 1987, p. 12.
70. "The Minirth-Meier Clinic," *op. cit*., December 16, 1986.
71. Andreasen, *op. cit*., p. 257.