The Failure of the Therapeutic: A Latter-day Saint Christian Alternative

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Abstract

This article argues that secular psychology, insofar as it is grounded in naturalism, secular humanism, individualism, and therapeutic affirmation detached from transcendent truth, does not possess the conceptual, moral, or spiritual resources necessary to lead persons out of this malaise. Genuine healing requires more than mere symptom relief or self-affirmation; it requires a fuller account of the human person as a fundamentally moral, spiritual, relational agent oriented toward meanings, obligations, and truths that transcend the individual self. We argue that Latter-day Saint Christianity offers just such an account and possesses the resources necessary to ground theories that sufficiently address the issues that constitute the malaise of modernity. It does so by locating healing in Christlike compassion, understood as the inseparable union of love (or, charity) and truth-telling. We suggest that integrating the truth and love requires that faithful Latter-day Saint clinicians become disciple-clinicians who seek God's guidance, develop sensitivity to truth and love, tell patients the truth compassionately, and foster the moral and spiritual sensitivities of those they serve. Alterity Focused Therapy is presented as one possible clinical expression of this framework, organized around doing what is best for the other, gathering more information with curiosity rather than judgment, and living, sharing, and supporting others in living out these principles in relationships.

***Keywords*:** moral agency, Alterity Focused Therapy, Emmanuel Levinas, relational healing, Christian therapy.

For well-over a century now, the discipline of psychology has claimed to possess a privileged, scientific understanding of human moral, emotional, and interpersonal distress, as well as the origins of the social discord that inevitably accompanies such things (Fuller et al., 2013; Feest, 2022; Hughes, 2018; Kardas, 2023; Miller et al., 2013). Psychological theorists, researchers, and therapists alike have proclaimed that naturalistic psychological accounts of human behavior can provide a firm scientific basis for developing the interventions and techniques needed to overcome all manner of human social and emotional problems (Cacioppo et al., 2004; David et al., 2018;

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Hill and Dahlitz, 2022; Mahrer, 2000; Rieken and Gelo, 2015).

However, clear evidence for the sufficiency of such accounts and the validity of such claims is still very much in question given that over the decades we have seen not a decrease in, but rather an increase in rates of depression, anxiety, suicide, feelings of isolation, alienation, and hopelessness, the breakdown of the family and the collapse of the institution of marriage, and the erosion of sexual standards and moral sensibilities (Alicandro et al., 2019; Blue Cross Blue Shield Association, 2018; Curtin et al., 2016; Hillman and Ventura, 1993; Lebrun-Harris et al., 2022; Mojtabai et al., 2016; Stone et al., 2018; Trueman, 2020; Twenge et al., 2010). All of these reflect what philosopher Charles Taylor has called the malaise of modernity (Taylor, 1991). This malaise, or crisis in meaning, has brought about the rapid disintegration of our communities and our social, political, and moral order.

The malaise of modernity may be best understood as a precursor or catalyst to our present discordant society. When our moral, social, political, and religious lives are ungrounded, we find ourselves experiencing a pervasive sense of unease and discontent. Throughout our daily lives, this is manifest in feelings of alienation from our families and communities, existential questioning about one's identity and life's purpose, and strained relationships due to the pervasive cultural value and assumption of self-interest (Doherty, 2022; Gantt and Thayne, 2014; Gantt and Williams, 2021; Miller, 1999). Drawing on David Foster Wallace's work, Christian philosopher J. K. A. Smith (Smith, 2014) paints a picture of this world—what Taylor (Taylor, 2007) calls a Secular Age—in which many of us find ourselves. He describes a world of:

> almost suffocating immanence, a flattened human universe where the escapes are boredom and distraction, not ecstasy and rapture. Hell is self-consciousness, and our late modern, TV-ized (now Twitter-ized) world only ramps up our self-awareness to an almost paralyzing degree. God is dead, but he's replaced by everybody else. Everything is permitted, but everybody is watching. So most of the time the best "salvation" we can hope for is found in behaviors that numb us to this reality: drugs, sex, entertainments of various sorts. (p. 14)

The world Smith is describing is all but unavoidable given that, as Ledewitz (2009) notes, "secularism has failed to establish a ground for human existence" (p. 36). That is, "secularism has not given us a way to orient ourselves to reality" because it "does not know how to answer questions like, what is the purpose of human life? or what may I hope for?" (p. 36). Indeed, Ledewitz (2009) argues that secularism "does not even like to think seriously about such questions" (p. 36). When our moral, social, political, and religious lives are ungrounded, we find ourselves experiencing a pervasive sense of unease and discontent. This instability and rootlessness lead to expressions of dissatisfaction, division, conflict, and the erosion of trust, we find ourselves surrounded by or even participating in a vicious cycle as the things that characterize our modern, secular age create even more intense malaise, which, in turn, furthers the discordance (Mohler, 2020).

Presently, psychology functions as one of the dominant interpretive frameworks for such human suffering. Where people once turned primarily to religious leaders, family systems, inherited moral traditions, and communities of faith to make sense of sorrow, guilt, grief, desire, marital conflict, moral obligation, and personal distress, many now turn to therapists, psychological concepts, diagnostic language, and therapeutic categories. This transition or shift is significant because psychology is no longer merely one profession among others. For many, it has become the language by which they understand what is wrong with themselves and others, what counts as harm, what love requires, what responsibility means, what obligation demands, and what healing consists of.

It is through psychology's interpretive lens that much of our culture has sought to remedy the malaise of modernity—our crisis of meaning—by articulating harm in terms of childhood wounds and neurological wiring, love in terms of attachment and oxytocin, responsibility as responsibility only for personal happiness, obligation as oppressive, and healing as a lifelong journey of cop-

ing with triggers. As such, psychology's attempts to address the malaise of modernity are more akin to sedatives and painkillers than a genuine healing balm, leaving the richness of human experience and relationships all the more hollow and ungrounded.

Many within contemporary psychology recognize the growing mental health and related challenges faced by many in the world today (see McPhillips, 2022). However, as Taylor (2007) notes, because almost all contemporary psychotherapies, and the theories on which they are founded, are based in "a humanism accepting no final goals beyond human flourishing, nor any allegiance to anything else beyond this flourishing" (p. 18, see, e.g., Ellis, 1992; Skinner, 1987; Rogers, 1951, 1965), they are singularly ill-equipped to address human moral and emotional problems at their deepest level or provide genuinely meaningful solutions to those problems. Because modern psychological approaches to human experience leave out such concerns as moral realism, transcendence and transcendent spirituality, and the meaningful possibility of non-contingent or divine truth, they do not and cannot fully account for the breadth and depth and inherent meaningful purposiveness of human experience. As Smith (2014), citing Taylor's analysis, points out:

> There is a specter haunting our secular age, "the spectre of meaninglessness" (p. 717)—which is, in a sense, a dispatch from fullness. And because this won't go away, but rather keeps pressing and pulling, it generates "unease" (p. 711) and "restlessness" (p. 726). (as cited in Smith, 2014, p. 129)

Indeed, as many have argued, this "spectre of meaninglessness," or spirit of nihilism, is a hallmark of our "Post-truth era" or "Post-Christian world" (see, e.g., Gantt and Williams, 2022; Hittinger, 2003; McIntyre, 2018; Poplin, 2014; Veith, 2020). And, while sole blame for such cannot be laid at the feet of the discipline of psychology, we will contend that the discipline, regardless of its well-meaning intentions, has nonetheless thus far failed to show that it possesses the conceptual and moral resources to adequately respond to the problems we face or provide for lasting healing of the human soul (Dalrymple, 2015; Doherty, 1995, 2022; Gantt and Thayne, 2017; Gantt and Williams, 2022; Williams et al., 2021).

We will argue that while psychology does not possess the necessary resources to provide the sort of intellectual foundation and moral sophistication we need to successfully bridge the social, political, and interpersonal divides we face in this Secular Age, Latter-day Saint Christianity does (Gantt et al., 2015). We will also argue that a psychology informed by the concept of Christ-like compassion is one that would be capable of providing a "peace-full" response to our tumultuous era, a response that offers a surer foundation for navigating the dangerous waters of human affairs in this challenging historical moment.

We will argue that Christianity entails that as psychologists (and other mental health professionals) we have an obligation to engage our patients in genuine, loving, Christ-like compassion—as opposed to its secular humanistic counterfeit (i.e., therapeutic empathy, unbounded affirmation, relativistic non-judgmentalism, etc.). Such compassion, we will argue, requires not only that we embrace and accept others in honest loving concern for them in their hour of suffering and need, but also that we stand firmly and openly in the cause of truth by inviting them to live according to the truth of who they really are and in accord with the kind of life we were all meant to live (Gantt and Thayne, 2017; Williams and Gantt, 2020). In other words, as Trueman (2023) recently argued, much of the world maintains:

> a commitment to the therapeutic anthropology that pervades modern Western society and the implicit assumption that any significant challenge to this from a traditional Christian perspective is unloving or bigoted. . . . The ethic of "love as feeling" rather than "love as directing to the truth" is strong. (para. 2)

Christianity, on the other hand, maintains that genuine love means directing others to truth; that is, to Christ. For the Christian psychologist, then, compassion and truth-telling are inextricably bound up with one another, and neither can be

neglected without emptying the other of its meaning. In what follows, we hope to show that only by compassionate truth-telling can contemporary psychology cease contributing to social and moral chaos of our time and instead begin to point the way toward mutual love and respect, personal and interpersonal wholeness, and a joyous and lasting healing that knits together souls, minds, and hearts.

Psychology and the Waning of Religion

In order to fully appreciate the argument we are making, it will first be important to review the cultural landscape in which we currently find ourselves. Where once we consulted with our religious leaders and family members on issues of morality and emotional, spiritual, and psychological well-being, many now consult mental health professionals. As King (2016), a commentator for Quartz magazine, noted: "it seems that many millennials grappling with the big questions in life want to work them out on a psychologist's couch instead of a church pew" (para. 5).

Conjointly, we have also seen the steady increase of the religiously unaffiliated—a group referred to as the "nones"—such that nearly 30% of U.S. adults claim no religious affiliation at all as of 2021, according to the Pew Research Center (2021). This is up nearly ten percentage points from 2011. While King framed our turn to psychologists and away from churches as a positive, critics (Browning and Cooper, 2004; Cummings et al., 2009; Nelson and Slife, 2024) have argued against this psychology and therapy's replacement of traditional religious, particularly Christian, worship.

For example, in *Psychology as Religion: The Cult of Self-Worship*, Paul Vitz (1977) argued that modern psychology and therapy have, for many individuals, come to replace traditional religion as a source of meaning and guidance in life. He contends that the focus on self-discovery and self-help within psychology has led individuals to elevate their own needs and desires above that of anyone else's such that they are given a quasi-religious status, effectively making psychology a new form of faith or belief system for some, or at the least leaving the patient as their own deity. Lasch (1978) similarly contended that American culture has become a culture of narcissism, eroding the traditional values of community, family, and civic engagement.

Vitz and other like-minded scholars (see, e.g., Entwistle, 2021; Fowers et al., 2024; Frie and Coburn, 2010; Snow, 2015; Vitz and Felch, 2006; Vitz et al., 2020) have continued to address these ideas in a variety of recent works, proposing non-reductionistic frameworks for understanding the human person that seek to combat the moral relativism and unbounded human autonomy proposed by postmodern thinkers. Although not writing from an explicitly religious perspective, Fowers (2010) has argued against one example of psychology's adoption of ego-centric and reductionistic paradigms: instrumentalism as a central ontological and ethical presumption. Fowers (2010) describes instrumentalism this way:

> [Instrumentalism] supports the central values of individual autonomy and satisfaction by promoting the effective pursuit of personal desires. In this way, instrumentalism is intertwined with individualism, which values the pursuit of personally chosen ends above all. Although instrumentalism is usually portrayed as ethically neutral, it is an ethical endeavor because it dictates that choices of values and goals should be left to individuals. The injunction to leave goals and values to individuals is at the core of the modern ethical project of increasing individual freedom of action and potential for success. Moreover, instrumentalism is an ethical perspective because it defines the nature of individuals' relationship with the world and with each other in means–ends terms, suggesting that strategically pursuing subjectively desired ends is the central business of life. (p. 105)

With their conceptual grounding in naturalism, radical individualism, psychological egoism, and instrumentalism many of the prominent therapeutic approaches in psychology ultimately encourage and sustain the idolizing worship of the

individual self as the most viable way to escape emotional and relational pain and suffering. This grounding serves to replace the previously transcendent—religion, God, family, community, and inherited moral order—with the merely immanent self.

The Failure of the Therapeutic

The modern, Western world's turning to psychology as a kind of new religion would not be a concern if the framework of psychology could handle and fruitfully address the issues that have long plagued humanity. However, therapy often lacks the vital resources—transcendence, a grand cosmic order, a framework that dictates what a good life entails, etc.—that have long allowed religion, specifically Christianity, to provide the healing balm that many have sought and have experienced. Indeed, recent decades have even witnessed secular psychologists seeking out and implementing—albeit typically in an instrumental fashion consonant with their naturalistic presuppositions—various traditionally religious or Christian practices because such approaches seem better equipped to facilitate the forms of healing they hope to bring about, as well as seeming to resonate more deeply with their clients (see, e.g., Plante, 2008; Ross et al., 2015; Vieten and Lukoff, 2022).

The kind of concerns that psychology (inadequately) seeks to remedy are often commensurate with the malaise of modernity. This malaise encompasses a pervasive sense of unease, disconnection, and discontent in response to the rapid changes and uncertainties of our modern and postmodern culture (Taylor, 2007). Throughout our daily lives, this manifests in feelings of alienation from our families and communities, existential questioning about life's purpose, and strained relationships shaped by the pervasive cultural value of self-interest. Individuals may also grapple with their identity; worry about who they are and their place in the world; question the constant and ultimately unsatisfying pursuit of material wealth, possessions, and power; and experience intense anxiety about the moral impact of varying kinds of technology on human relationships, the environment, and their own engagement in the world.

Taylor (2007) describes our situation as one in which we continually have a vague sense of loss, one in which "our actions, goals, achievements, and the like, have a lack of weight, gravity, thickness, substance. There is a deeper resonance which they lack, which we feel should be there" (p. 307). The world, and ourselves in it, manifest as a sort of existential and moral "flatland," one where we find ourselves, in the memorable words of Philip Rieff (1966), continuously confronted by the "absurdity of being free to choose and then having no choice worth making" (p. 93). The pervasiveness of this "malaise of immanence" (Smith, 2014) often results in profound experiences of anxiety, boredom, alienation from self and others, and depression, all of which reflect a broader existential, and we contend fundamentally spiritual, struggle for meaning.

Ultimately, we believe that contemporary, secular psychology cannot provide lasting and profound healing for two primary reasons. First, contemporary psychological theories and subsequent interventions are insufficient to address the malaise of our modern, secular world because our psychological theory and practice is too superficial in the way it frames and addresses patient concerns (see, e.g., Watts, 2019). For example, by focusing primarily on efficient symptom relief within a naturalistic and egoistic ontology (see Gantt, 2000, 2005). Second, psychology ignores essential and significant facets of human existence and experience such as transcendence, spirituality, morality, and truth.

Success as Symptom Reduction

One very common way in which psychological researchers define healing and therapeutic success is by measuring degrees of symptom relief. As the historian of psychotherapy and psychiatry Edward Shorter (1997) has noted, "lifting symptoms rather than cultivating a sympathetic rapport in the office [has] remained the ultimate therapeutic objective" (p. 314). Indeed, for most researchers and practitioners, at least those in the mainstream of the discipline, symptom reduction has been and remains the primary (if not the only) standard for judging the efficacy or success of any given therapeutic intervention (see, e.g., Becker et al., 2011; Cuijpers, 2019; van Os et al., 2019). In other words, researchers and therapists alike

tend to understand a therapy to be "working" if a patient reports a reduction of distressing symptoms (Smith and Glass, 1977; Froyd et al., 1996; Crawford et al., 2011).

Patients undergoing therapeutic treatment are almost never queried about how therapy has addressed or alleviated the kind of existential and spiritual malaise at the heart of our modern age. Furthermore, therapists are seldom, if ever, trained to gauge the success of their therapy by such measures that ask questions about the quality of the patient's relationship with their family members and other loved ones, their participation in their civic groups and religious communities, their general feelings and acts toward their fellow human beings, or their sense of moral connection and commitment to larger life meanings and purposes beyond their own emotional states. However, if the malaise of modernity described above is not merely symptomatic but existential, relational, and spiritual, then the way psychotherapy defines success matters.

Psychology's commitment to defining success as symptom reduction is evidenced in the usage of outcome measures that focus on just that. To be clear, this is not to say that outcome measures focused on meaning, morality, spirituality, and relational engagement do not exist. Measures such as the Meaning in Life Questionnaire assess the presence of and search for meaning in life (Steger et al., 2006), and recent work on moral injury has produced measures that assess cognitive, emotional, social, and spiritual concerns connected to morally injurious experiences (Griffin et al., 2025). There are also a number of measures designed to assess spiritual and religious experience more directly.

For example, the Spiritual Well-Being Scale assesses religious and existential well-being (Paloutzian and Ellison, 1982; Ellison, 1983), the Brief RCOPE assesses positive and negative religious coping in response to major life stressors (Pargament et al., 2011), and the Religious and Spiritual Struggles Scale assesses multiple domains of religious and spiritual struggle, including divine, interpersonal, moral, doubt-related, and ultimate meaning concerns (Exline et al., 2014). Similarly, relationally focused measures have been proposed (Muran et al., 1998; Muran, 2002), with the Inventory of Interpersonal Problems being one of the most widely used of such measures (Horowitz et al., 1988).[1] The existence of such measures demonstrates that psychology is not incapable of assessing meaning, moral distress, spiritual struggle, or relational engagement. Indeed, the fact that these measures do not appear to function as the primary way therapeutic success is typically defined in mainstream clinical research or practice provides concrete evidence of psychology's paradigms and priorities in spite of available resources.

It is also worth noting that many measures that initially seem to assess domains outside of symptom reduction nonetheless maintain a focus on how relationships, faith, or spirituality affect the respondent rather than on the ways in which the respondent gives him or herself over to truth, God, neighbor, covenant, duty, or transcendent purpose. For example, the Couples Satisfaction Index—an ostensibly relationally-focused measure—includes questions such as "My relationship with my partner makes me happy" and "I feel that I can confide in my partner about virtually anything" (Funk and Rogge, 2007, p. 582). Similarly, the Spiritual Well-Being Scale includes items assessing whether one receives personal strength and support from God/a Higher Power and whether one's relationship with God/a Higher Power contributes to one's sense of well-being (Paloutzian and Ellison, 1982; Ellison, 1983).

Such questions may provide useful information, but they assess relationships and spirituality largely in terms of the respondent's satisfaction, comfort, strength, support, peace, experience, or perceived benefit. In short, even when psychology moves beyond symptom reduction, it often remains centered on the individual's experience of distress, meaning, injury, satisfaction, functioning, or spiritual well-being rather than on the person's moral, spiritual, and relational engagement with God and others. This falls short of an LDS Christian approach that would holisti-

[1]The Mindset Styles Assessment created by the Arbinger Institute (The Arbinger Institute, nd) is one additional possible example of what a relational outcome measure might look like. However, this measure has not been marketed to nor is it being used regularly by therapists or psychological researchers as far as we are aware. Thus, its potential efficacy and general viability as a helpful indicator is somewhat uncertain.

cally account not only for one's internal emotional state or subjective experience, but also for one's engagement in the world, one's relationship with God and neighbor, and one's impact on others.

This individualizing tendency appears not only in how psychotherapy measures outcomes, but also in how it often explains therapeutic effectiveness. The heart of a therapy's effectiveness, or how it alleviates symptoms, is typically attributed to several crucial elements, among which are the quality of the therapeutic relationship, client motivation, client expectations, corrective experiencing, insight, empathy, cultural adaptation, and self-efficacy (see, e.g., Bailey and Ogles, 2023; Sprenkle et al., 2014; Wampold, 2015).[2]

In contrast, an LDS perspective would take an even more comprehensive approach when gauging the efficacy of its principles and beliefs in the context of therapeutic practice and outcome. Here, the notion of something or someone "working" is defined in a more global, and indeed spiritually expansive, sense—one that revolves around the concept of being reconciled with Christ and with one another by embarking on a journey to become more Christlike in thought, word, and deed, in and through our relationships with God and our neighbor. This does not mean, however, that therapy must be explicitly religious in its language or that patients must share the therapist's religious commitments in order to benefit from truthful and loving therapeutic work. Rather, from a faithful LDS perspective, the theological ground of healing is Christlike compassion, charity, truth, repentance, forgiveness, and reconciliation, even when these realities are approached clinically in language accessible to patients who may not understand or articulate their experience in explicitly religious terms.

Such healing, nonetheless, of course, requires the active participation of the Holy Spirit in the therapeutic relationship as a trustworthy guide for and influence in the therapeutic endeavor. "As Latter-day Saint psychologists," Gantt (2012) has observed, "[we do not] want to be in the confused position of seeking spiritual support while embracing professional and philosophical commitments that do not permit such guidance in the first place" (p. 12). The therapeutic transformation that is incumbent upon a faithfully LDS perspective in therapy is one in which transformation has not only social and psychological dimensions, but even more profoundly deeply spiritual and moral ones (Gantt, 2005). The truly transformative process of therapy in this view entails shedding one's old self, akin to the teachings of Paul, who suggests crucifying the old self on the cross with Christ (Romans 6:1-11).

A faithful LDS perspective and, when clinically indicated, a faith-focused one, both mirrors and expands many of the elements found in the common factors of psychology. The therapeutic relationship, motivation, corrective experience, insight, empathy, and efficacy are not rejected, but are understood within a more transcendent account of persons, healing, and change. Theologically, this is understood as including cultivating a deep and profound relationship with God and fellow men, nurturing the motivation to seek the kingdom of God, pursuing more profound and truthful experiences with God and others, gaining insight into one's understanding of self, God, and others, and attaining a sense of efficacy and competence when yoked with Christ.

What sets an LDS approach apart is the profound and transcendent nature of these components; without the transcendence inherent within the worldview of the Restored Gospel, psychology's common factors are sanitized and, in some ways, stripped of their potential power for wholehearted transformation of the kind many patients seek and desperately need, and which the apostle Paul advocated. Moreover, the measure of whether a genuinely Christian therapy is "working" is far more holistic in comparison to the traditional outcome and process measurements employed in mainstream, secular psychotherapy research (see Greggo and Sisemore, 2012; Jones and Butman, 2011; Wade et al., 2007).

A genuinely LDS perspective on therapy, like a Christian approach generally, is one that encompasses an evaluation of the very essence of the person one aims to become. This involves assessing

[2]The precise list of "common factors" vary from scholar to scholar (Elkins, 2019); however, the most well-researched and significantly impactful common factor is the therapeutic alliance or relationship (Flückiger et al., 2018; Horvath et al., 2011).

the quality of one's interactions with others, their psychological, emotional, physical, and spiritual well-being, as well as their capacity to navigate and find meaning in trials and suffering, among other things.

While this is certainly a topic worth further discussion, we'd like to focus our analysis on the second reason psychology cannot provide lasting and profound healing. That is, psychology is not built upon the foundation of Christlike compassion which necessitates both genuine charity and truth-telling.

Assumptions of Naturalism and Secular Humanism

Beyond the matter of how a faithful LDS perspective on therapy might call into question symptom reduction as a "stand-in" for therapeutic efficacy, and how it might offer both a broader and deeper understanding of the proper aims of the therapeutic endeavor, there is a second important reason that contemporary, secular approaches to therapy cannot provide the sort of lasting, truly transformative, and profoundly healing that is needed in this modern era of malaise (Gantt, 2005). Perhaps the most salient, at least to the present analysis, is the simple fact that contemporary psychotherapeutic theory and practice, as fundamentally secular enterprises, are not built upon the foundation of Christlike compassion which necessitates both genuine charity and truth-telling. In other words, being rooted in naturalism and secular humanism, contemporary psychology lacks the moral and spiritual underpinnings that are necessary for genuine healing—i.e., emotional, relational, and spiritual wholeness.

To ignore significant facets of human existence and experience such as "spiritual realism" (Wright, 2013), moral agency, and transcendent truth in the process of healing necessarily limits the scope of healing and, thereby, leaves psychology incapable of providing needed resources for the sort of genuine healing that it might otherwise be able to offer. Unfortunately, because contemporary psychological theory and practice are so often grounded in the philosophical traditions of naturalism, secular humanism, and scientism, professional neglect of (if not open hostility to) such things is commonplace.

Broadly defined, naturalism is the idea that all reality is ultimately material governed by self-existent universal, objective, and mechanical laws manifest as forces acting on material entities (Goetz and Taliaferro, 2008). As such, researchers that assume naturalism overly narrow their scope of study to physically measurable phenomena (Gantt and Williams, 2020; Gantt et al., 2021). Secular humanism assumes human beings can lead meaningful, ethical lives without the need for any transcendent beliefs or grounding, relying instead on human reason and individual autonomy (Harrison, 2024). In a therapeutic setting, humanistic therapies rely on unconditional positive regard, radical acceptance/support, and relativism for healing (see, e.g., Ellis, 1992; Fowers, 2010; Rogers, 1951; Wells and Burr, 2000). Neither naturalism nor secular humanism allow for serious consideration or inclusion of the moral and spiritual realities of human life in psychotherapy, realities that, from an LDS perspective, are ultimately the most important and defining aspects of human life.

Because secular humanism and naturalism, and therefore much of contemporary psychology, are not grounded in a holistic reality of what and who human beings actually are, the discipline does not have the resources necessary to provide holistic and profound healing of the sort required to provide relief from, solace in, or a viable path out of our present societal and moral malaise. Ultimately, while naturalism and secular humanism may have gotten us into this mess, so to speak, they are entirely inadequate to the task of getting us out. The Restored Gospel of Jesus Christ, on the other hand, with its commitment to truth-telling, compassion, human agency, and moral concern, provides more than ample resources, both spiritual and intellectual, for the kind of soul-care and soul-healing that is impossible with contemporary psychotherapies.

Furthermore, despite common caricatures employed by secular critics that depict Christian approaches to therapy as inherently rooted in condemnation or shame (see, e.g., Downie, 2022; Jasko, 2022; Venn-Brown, 2015), LDS (and many other Christian) teachings actually require that the truth-telling and empathic work of therapy be motivated entirely by compassion, grace, and charity,

or the "pure love of Christ" (Moroni 7:47).

Latter-day Saint Christianity as the Solution

The essence of Latter-day Saint Christian teachings is deeply rooted in the interwoven principles of truth and love, as outlined in both ancient and modern scripture. These two principles, far from being separate or distinct, are inseparably connected, each preserving the profound significance of the other. In the New Testament, for example, we find the apostle John portraying Christ as the truth of God's loving graciousness (and gracious love) when he writes, "And the Word was made flesh, and dwelt among us, (and we beheld his glory, the glory as of the only begotten of the Father,) full of grace and truth" (John 1:14). "Suppose we take that claim [that Christ is the truth made flesh] quite seriously," LDS philosopher James Faulconer (2012) suggests, "then the path and the truth and the force of life are the same thing in Jesus" (p. 80).

In the Epistle to the Ephesians, Paul teaches that we come to a "unity of the faith, and of the knowledge of the Son of God, unto a perfect man, unto the measure of the stature of the fulness of Christ" only by "speaking the truth in love" (Ephesians 4:13-15). Most importantly, Jesus Himself emphatically declared "I am the way, the truth, and the life: no man cometh unto the Father, but by me" (John 14:6). Echoing this, Alma taught his son Shiblon, "There is no other way or means whereby man can be saved, only in and through Christ. Behold, he is the life and the light of the world. Behold, he is the word of truth and righteousness" (Alma 38:9).

In both the New Testament and the Book of Mormon, the intimate relationship that inheres between love and truth is made clear in the teaching that "charity is the pure love of Christ" (Moroni 7:47) and, as such, "it rejoiceth in the truth" (Moroni 7:45). In the First Epistle of John, we learn that not only is God truth, but also that "God is love" (1 John 4:8). Illustrating this transcendentally beautiful reality, Elder Jeffrey R. Holland (2016) has taught that "the first great commandment of all eternity is to love God with all our heart, might, mind, and strength – that's the first great commandment. But the first great truth of all eternity is that God loves us with all of His heart, might, mind, and strength" (emphasis in the original). When understood in this way it becomes clear that Jesus is not just a messenger of truth or an example of love, but rather the very embodiment of truth and love as one whole and perfect being (Thayne and Gantt, 2019).

It is in this way that we can see truth and love are not individual and distinct principles or doctrinal tenets of the gospel of Christ, but rather that they are necessarily intertwined and must always be understood together lest they lose their meaning and power entirely. The synergy between truth and love is eloquently articulated in Paul's teachings to the Ephesians (4:7, 11-16) where he highlights the importance of the grace bestowed upon each individual by Christ and the diverse roles within the body of believers. He articulates that the purpose of these roles is the maturation of the saints and the edification of the body of Christ, striving for unity in faith and knowledge of the Son of God. Paul cautions the Ephesians against being swayed by varying doctrines and exhorts, "But speaking the truth in love, may grow up into him in all things, which is the head, even Christ" (Ephesians 4:15). This passage underscores that while truth is essential for spiritual growth, it must be rooted in the embrace of love in order to ultimately lead humanity to Christ. Christ Himself underscores the intrinsic connection between love and truth, affirming, "If ye love me, keep my commandments" (John 14:15). Here, He implies that obedience to His teachings is the embodiment of love, illustrating that love and truth are inextricably linked in Christian faith.

Conversely, much of psychology aims to remedy the malaise of our modern world by focusing on what is commonly thought to be love, or what is variously referred to in the professional literature as "unconditional positive regard," "affirmation," "non-possessive warmth," or "emotional strengthening" (see Norcross and Lambert, 2019). That is, the idea that people need to be loved and radically accepted for everything they are and want and that they each have a right to safe spaces and significant validation (Gantt and Thayne, 2017). It is by providing such regard that many psychologists and theorists believe our sick world can be healed. Even further, because of the pervasive nature of the therapeutic ethos

in our modern world, this view of love has also come to shape what many desire out of religion (see, e.g., Holmes and Burdge, 2022; Gantt and Thayne, 2017; Smith and Denton, 2009). Smith and Denton (2009) have drawn attention to the phenomenon of unconditional positive regard applied to religious practices/theology as reflecting what they have termed "Moral Therapeutic Deism." Gantt and Thayne (2017), while quoting Smith's original work, state:

> The God of this religion [Moral Therapeutic Deism] is a kind of (Rogerian) "Cosmic Therapist," a God who is "always on call, takes care of any problems that arise, professionally helps his people to feel better about themselves, and does not become too personally involved in the process" (Smith and Denton, 2009, Smith, 2005, p. 165). Such a God is by no means a demanding or commanding God. "He actually can't be," Smith says, "because his job is to solve our problems and make people feel good" (p. 165).

Anticipating this mindset over sixty years ago, C.S. Lewis (2001) wrote:

> Some conceptions of the Divine goodness which tend to dominate our thought, though seldom expressed in so many words, are open to criticism. By the goodness of God we mean nowadays almost exclusively His lovingness; and in this we may be right. And by Love, in this context, most of us mean kindness—the desire to see others than the self happy; not happy in this way or in that, but just happy. What would really satisfy us would be a God who said of anything we happened to like doing, "What does it matter so long as they are contented?" We want, in fact, not so much a Father in Heaven as a grandfather in heaven—a senile benevolence who, as they say, "liked to see young people enjoying themselves" and whose plan for the universe was simply that it might be truly said at the end of each day, "a good time was had by all". Not many people, I admit, would formulate a theology in precisely those terms: but a conception not very different lurks at the back of many minds. I do not claim to be an exception: I should very much like to live in a universe which was governed on such lines. But since it is abundantly clear that I don't, and since I have reason to believe, nevertheless, that God is Love, I conclude that my conception of love needs correction. (p. 31)

Commensurate with Lewis, Paul teaches us that there can be no Christlike love, compassion, and charity without the truth of Jesus Christ.

There can be no love without truth and no truth without love. This is because, ultimately, the truth of the Christian gospel is that we ought to be more concerned with the well-being of others than we are with our own well-being, just as Christ demonstrated. While unconditional positive regard and similar affirming approaches to therapy are easy to teach and almost always make all parties, including the therapist, feel good, doing therapy in a Christian way requires that we are more concerned about the well-being of our patients than we are about our own feeling good and comfortable. To Lewis's point, our modern therapeutic understanding of love needs correction, which is what we hope to illustrate (within a therapeutic context) in the remainder of this piece.

Christian Principles in a Therapeutic Context: Becoming Disciple-Clinicians

Ultimately, to appropriately integrate Christian teachings in a therapeutic framework, therapists must first be committed disciples of Christ. A disciple of Christ is not merely a follower but a dedicated student of Jesus, committed to embodying His teachings and emulating His character in all of one's actions and interactions. Being a "disciple-clinician" demands that as therapists we love and value others as Christ loves and values them, responding to them with Christ-like compassion, and prioritizing their well-being as Christ would. Such an approach requires thera-

pists to strive to understand and treat individuals as God intends, seeking to act in their best interest, whether they are one's patients or not. This constitutes a foundational commitment even if it means being disliked or misunderstood, as Christ Himself often was: "He was despised and rejected by mankind, a man of suffering, and familiar with pain. Like one from whom people hide their faces he was despised, and we held him in low esteem" (Isaiah 53:3, NIV).

More specifically, in the therapeutic context, we believe that becoming a genuinely faithful disciple-clinician involves at least three essential features: (1) developing sensitivity to truth and love, (2) consistently telling the truth, and (3) capitalizing on and fostering the innate spiritual and moral sensitivities of patients.

Developing Sensitivity to Truth and Love

> "My son, do not make light of the Lord's discipline, and do not lose heart when he rebukes you, because the Lord disciplines the one he loves, and he chastens everyone he accepts as his son." (Hebrews 12:5-6, NIV)

One of the basic ways in which we can become disciple-clinicians is to cultivate a deep sensitivity to both truth and love. This involves living in accordance with truth by demonstrating genuine, Christ-like love for others. Living truthfully and loving others truly means seeing people as they really are and as God sees and knows them. We have been taught to understand how God sees our fellow human beings in various biblical verses:

- "For God so loved the world that he gave his only begotten Son, that whoever believeth in him should not perish, but have everlasting life" (John 3:16).
- "For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well" (Psalm 139:13-14, NIV).
- "He doeth not anything save it be for the benefit of the world; for he loveth the world, even that he layeth down his own life that he may draw all men unto him. Wherefore, he commandeth none that they shall not partake of his salvation" (2 Nephi 26:24).
- "And the great God has had mercy on us, and made these things known unto us that we might not perish; yea, and he has made these things known unto us beforehand, because he loveth our souls as well as he loveth our children; therefore, in his mercy he doth visit us by his angels, that the plan of salvation might be made known unto us as well as unto future generations" (Alma 24:14).
- "But God commendeth his love toward us, in that, while we were yet sinners, Christ died for us" (Romans 5:8).
- "For the mountains shall depart, and the hills be removed; but my kindness shall not depart from thee, neither shall the covenant of my peace be removed, saith the Lord that hath mercy on thee" (Isaiah 54:10).
- "Greater love hath no man than this, that a man lay down his life for his friends" (John 15:13).

Seeing people this way—as loved enough for God to send His Son, as children of God, as made in God's image, and as fearfully and wonderfully made by God, as ever worthy of His life and sacrifice—allows us to see and know others as actual persons worthy of love and capable of change, and not as objects, mere manifestations of diagnostic categories, or as passive victims of mysterious causal forces and traumatic conditions.

We do this best when we recognize that people have a lot more going on behind-the-scenes, so to speak, and look beyond the "masks" that many people wear out into the world, seeing beyond their behaviors and defenses such that we come to understand the deeper, often hidden, transcendent/existential aspects of their life and its meanings. We also come to recognize that as therapists we exist for their sake, for their well-being, both as professionals and brothers and sisters in Christ. This principle is taught repeatedly and clearly in scripture:

- "Let nothing be done through strife or vainglory; but in lowliness of mind let each esteem other better than themselves. Look not every man on his own things, but every man also on the things of others" (Philippians 2:3-4).
- "For, brethren, ye have been called unto liberty; only use not liberty for an occasion to the flesh, but by love serve one another" (Galatians 5:13).
- "Hereby perceive we the love of God, because he laid down his life for us: and we ought to lay down our lives for the brethren" (1 John 3:16).
- "But ye will teach them to walk in the ways of truth and soberness; ye will teach them to love one another, and to serve one another. And also, ye yourselves will succor those that stand in need of your succor; ye will administer of your substance unto him that standeth in need; and ye will not suffer that the beggar putteth up his petition to you in vain, and turn him out to perish" (Mosiah 4:15-16).

Clearly, genuine care for and love of others is a central teaching of the Gospel of Christ, and thus, we would argue, a basic expectation of any disciple-clinician seeking to honor God and bless the lives of His children as a counseling professional. There are several ways in which we can be disciple-clinicians who are sensitive to truth and love; namely, by (1) filling our minds with truth from faithful and rigorous sources, (2) by seeking God's guidance as we do therapy, and (3) purposefully and intentionally developing Christlike love and compassion for everyone we encounter.

Filling Our Minds with Truth Becoming a disciple-clinician who is sensitive to truth and love requires that we fill our minds with truth from faithful and rigorous sources. One such obvious resource is scripture and the teachings of prophets, seers, and revelators. However, we must do more than this for the impact of scripture to be both truthful and rigorous. We must put in the time and energy necessary to truly study, ponder, and meditate on scripture. As articulated in 2 Timothy 2:15, we must "Study to shew thyself approved unto God, a workman that needeth not to be ashamed, rightly dividing the word of truth."

We can do this by examining word usage and etymology, studying scripture in its historical and literary context, attending to the patterns of teachings in scripture, asking questions and comparing alternative readings, and more (see, e.g., Bailey, 2008; Bauer and Traina, 2011; Faulconer, 1999; Klein et al., 2017; Richards and O'Brien, 2012). Scriptures should also be studied in prayerful dialogue with the Savior so that we understand what the Lord would have us learn from our studies. It is by studying scripture rigorously that we can align ourselves with the truth of the gospel as God provided it to us and continually have our own preconceived and often false notions about life and truth challenged, expanded, and edified.

Moreover, recognizing other writings born out of faithful scholarship and a desire to stand as a witness of the truth can supplement scriptural study and provide guidance in how to think through a number of challenging issues in psychology and psychotherapy. There are far too many sources that qualify to name even a small subset of them all here but some examples would include C.S. Lewis (2002) *Mere Christianity*, Jones and Butman (2011) *Modern Psychotherapies: A Comprehensive Christian Appraisal*, M. L. Cunnoe (2022) *The Person in Psychology and Christianity*, Abigail Favale (2022) *The Genesis of Gender*, Alan Noble (2021) *You Are Not Your Own*, Wilkens and Sanford (2009) *Hidden Worldviews*, Marilynne Robinson (2010) *Absence of Mind*, Carl Trueman (2020) *The Rise and Triumph of the Modern Self*, David Bentley Hart (2024) *All Things are Full of Gods*, and C. Terry Warner (2001) *Bonds That Make Us Free*, among many others.

Staying grounded in the scriptures and "the best books" center our minds on the gospel of Christ which enables us to discern and integrate faithful and rigorous sources of truth because we will recognize when information, principles, and teachings align with Scripture and, most importantly, when they do not. Understanding the philosophical (and even theological) underpinnings of psychological theories and practices, and their alignment or dis-alignment, with scriptural teaching is vital in the discernment process. As Paul

and Timothy warned the early saints in Colossae, "Beware lest any man spoil you through philosophy and vain deceit, after the tradition of men, after the rudiments of the world, and not after Christ" (Colossians 2:8). Furthermore, living out the principles we learn about through careful, reflective and prayerful scripture study helps us maintain a truthful and loving relationship not only with God but also with others, particularly our patients.

Seeking God's Guidance Seeking God's guidance while doing therapy is of paramount importance. This involves praying for patients, developing discernment between truth and falsity, and being receptive to the promptings of the Holy Spirit during sessions. All of these actions are ultimately part of the gift of discernment. In the June 2018 edition of the *New Era* (New Era, 2018, "What is the gift of discernment?"), discernment is articulated as follows:

> The scriptures talk about the "discerning of spirits" as a gift of the Spirit (1 Corinthians 12:10; D&C 46:23). It means "to understand or know something through the power of the Spirit. . . . It includes perceiving the true character of people and the source and meaning of spiritual manifestations" (Guide to the Scriptures, "Discernment, Gift of," scriptures.lds.org). Elder David A. Bednar of the Quorum of the Twelve Apostles has taught that the gift of discernment can help us (1) "detect hidden error and evil in others," (2) "detect hidden errors and evil in ourselves," (3) "find and bring forth the good that may be concealed in others," and (4) "find and bring forth the good that may be concealed in us" ("Quick to Observe," Ensign, Dec. 2006, 35).

The ability to "detect hidden error and evil" in oneself and others, as well as to "find and bring forth the good" in others, is deeply relevant to the work of an LDS therapist. In therapy, discernment includes the humility to recognize one's own distortions, assumptions, or self-protective reactions, while also seeking to see the patient truthfully before God. It also includes the ability to notice, name, and invite forth the good in patients, even when that good may not yet be the dominant force in their lives. In this sense, discernment is not merely the ability to identify what is wrong, distorted, false, or self-deceived. It is also the spiritually informed capacity to perceive what is good, true, agentic, and responsive in the patient and to help call that forth with wisdom and love.

This might mean naming a patient's courage, tenderness, honesty, longing for goodness, capacity for repentance, or desire to love well, even when those qualities are still emerging or inconsistently lived. Such discernment allows the therapist to see more truthfully and to respond in a way that is aligned with God's love for the patient.

Because of this, it is crucial to have both humility and confidence in the Lord. Therapists often do not know, on their own, what patients most need in a given moment. However, by remaining teachable and trusting in the wisdom and love of God, therapists can have confidence that God knows what is best for both them and their patients. Thus, developing spiritual sensitivity is vital to ensuring that therapists can navigate the complex and tender situations they face with patients with divine insight and act as instruments of God's will and healing grace. As James 1:5 reminds us: "If any of you lack wisdom, let him ask of God, that giveth to all men liberally, and upbraideth not; and it shall be given him." Likewise, Alma taught his son Helaman that "whosoever shall put their trust in God shall be supported in their trials, and their troubles, and their afflictions, and shall be lifted up at the last day" (Alma 36:3).

Continually seeking God's guidance in therapeutic endeavors is pivotal for fostering trust in the therapeutic relationship, ensuring that patients perceive and experience therapists as consistently truthful, genuinely loving, and competent. Therapists can only do what is needed in therapy most effectively and properly as they seek to embody Christlike discipleship holistically, not only in their professional role but in their personal and professional lives more broadly. In essence, therapists must strive to live the very principle they invite patients to consider—that is, prioritizing the well-being of others, advocating for the sig-

nificance of doing so, and supporting those who are endeavoring to embrace and understand this Christlike approach to living.

As therapists strive to embody Christlike love and truth, they bring this ethos into therapy by focusing intently on what is best for their patients while remaining attuned to the Spirit's loving guidance in truth. Being led by the Spirit involves listening to promptings and courageously acting on them, even when doing so feels challenging or risks straining the therapeutic relationship. It constitutes developing the type of discernment Christ exemplified both when He perceived the unspoken longing of the Nephite multitude and responded with compassion (3 Nephi 17:5–6), and when He perceived the thoughts of the scribes and responded truthfully to what they had not spoken aloud (Mark 2:8).

Ultimately, seeking God's guidance acknowledges that patients are God's children and that He knows best how to aid them. Relying on God's wisdom positions the therapist to better serve the patient because it allows the therapist to move beyond individual judgment and education alone in order to prioritize divine insight and service to the patient. Of course, as noted above, it is imperative that therapists develop a strong sense of spiritual discernment and faithful trust in order to distinguish between fleeting impulses and genuine spiritual promptings. As with finely honed professional skills and depthful academic understanding, spiritual discernment cannot be mastered without serious effort, discipline, and repeated confirmatory experience.

Developing Christlike Love and Compassion for Everyone Finally, it is important to develop Christlike love for everyone we encounter, in or outside the therapy office. It requires seeing others as God sees them, the same way He sees us—compassionately within our context and understanding of our real and unique identity and experience. But because Christlike love is not simply about experiencing a particular emotional state or momentary feeling, it must be developed through service and compassion-oriented actions; that is, by purposefully and intentionally seeking to act in the best interest of others, out of a genuine concern for their welfare and benefit. Christlike love can precede such acts of service but often we grow to love others as Christ loves us when we serve others the way that Christ serves us, putting our concerns for the welfare of others above ourselves, and embodying the sacrificial love Christ embodied. Truly compassionate service involves being fully present, listening actively, and showing sincere and honest regard for the other in both words and actions. This approach fosters authentic, earnest connections, making the therapeutic relationship vibrantly collaborative and deeply human.

Developing Christlike love requires us to see people as "the other" rather than seeing them as object-like, manifestations of the operations of abstract diagnostic categories, or as a "variable machine" (Brinkmann, 2023); that is, as a thing—albeit a very complex, unique sort of thing—to be acted upon or which acts upon us. This perspective has been well-articulated by French Jewish philosopher, Emmanuel Levinas, who endured the atrocities of World War II. He has stated:

> The Other as Other is not only an alter ego [or another version of ourselves]: the Other is what I myself am not. The Other is this, not because of the Other's character, or physiognomy, or psychology, but because of the Other's very alterity. . . . It can be said that the intersubjective space is not symmetrical. . . . The relationship with alterity is neither spatial nor conceptual. . . . Does not the essential difference between charity and justice come from the preference of charity for the other, even when, from the point of view of justice, no preference is any longer possible? (Levinas, 1987, pp. 83-84)

In encountering the face of another person, we are immediately invested with moral responsibility for them, for our actions, our intentions, and our very being-in-the-world. And from Levinas's perspective, charity is only truly charity when such is simply offered to the other because of his or her status as "other," i.e., he or she is not me. "[T]he relation to the face is straightaway ethical," Levinas (1985, p. 87) writes, "The face is what one cannot kill, or at least it is that whose meaning

consists in saying: 'thou shalt not kill'." For Levinas, the Face denotes not simply the empirical visage of another that we observe with our eyes, but rather a phenomenological event, the moment when we experience the otherness of the other, find ourselves interrupted by the stunningly excessive humanness of the other as other (Levinas, 1969, 1985).

When we come face-to-face with another person we experience them as fully human and other than, and in this experience it becomes clear that we are responsible to know, love, and serve them, and in so doing offer response for our actions and inactions, for our inhumanity and egoism. This requires seeing others not as objects but as real people with their own stories, struggles, and intrinsic, infinite worth. We see the other as other when we confront the reality that they are human, prior to and beyond any conceptual, societal, or psychological labels we might tend to apply to them for our own purposes. The other is not a category of person, not an object of egoistic cognition, or stimulus configuration that elicits reflexive responses in us, but rather is a human being who lives, breathes, fears, hungers, suffers, worries, dreams, feels, struggles, and pleads for respite and respect.

Martin Buber (1996) also wrote at length about this relational encounter with the other, suggesting that there are ways of living in which we see and treat others as objects for our use—what he termed the "I-It" mode—and ways of living in which we see and treat others as the fully human beings they are, beings whose lives and experiences are just as real and important as our own. This mode of being-with he termed the "I-Thou" or "I-You" mode.

According to Buber, we engage an "I-Thou" way of being in the world when we serve another, and purposefully and intentionally engage with them compassionately and respectfully. To honestly be of service to an-other fundamentally requires that we focus on the other and on doing, or perhaps most poignantly, being what is best for them (Levinas, 1985, i.e., "being-for-the other;"). Genuinely loving service, however, does not manifest in only one particular way. Importantly, it does not consist of what a sort of "cheap" or "easy" Christianity might prescribe—that to love another means only that we are always nice, affirming, and unconditionally accepting of them. Granted, intentional and purposeful service may at times look like ordinary, commonplace "niceness"—i.e., saying and doing things that the other person wants and that make the other person happy and comfortable.

More holistically and specifically within the therapeutic relationship, Christlike compassionate, purposeful, and intentional service in the other's best interest often takes the form of attentive, critical listening and a willingness to communicate truth—both easy and hard truth. Christlike compassion involves not only showing honest interest and sincere respect for the other and their experiences, which may include helping the other feel safe and comfortable, but also recognizing their responsibility to yet others and holding them accountable to that responsibility. While this may not always provide the warm and fuzzy feelings that some may want from therapy, or even seek in Christianity, this kind of other-focused service—genuinely doing what is in the best interest of the other whether or not they like you for it or accept the truth you communicate—respects and values the patient for who they are and what they are genuinely capable of as a human being.

Indeed, Christlike compassion in the therapeutic setting refuses to infantilize the other by consigning them to perpetual dependency, fragility, or victimhood. Rather, it invites them to the truth that as beloved children of God they can handle difficult truths, shoulder accountability, and actively work toward meaningful personal, interpersonal, and moral change. Therapy conducted at this level of moral engagement also invites patients to see themselves as truly valuable and worth engaging, rather than as a defective object who is boring the therapist, wasting time, or incapable of living a truly full and human life.

Clinically, Christlike love is about serving, about compassion (lit., "suffering-with"), about being fully present with and for the patient. Such compassionate love can take a variety of forms. At times, the most compassionate thing one can do as a therapist is to simply sit with a patient while he or she talks and the therapist says nothing, striving to be as hospitable and welcoming as possible, open to the patient as other. At other times, there

may be silence amongst all parties or the therapist and patient may cry together. And, at yet other times, it may be necessary to confront delusion, manipulation, falsity and self-deception, speaking with "boldness, but not overbearance" (Alma 38:12) by way of an invitation for the patient to be truthful by choosing to live truthfully and shoulder their own moral responsibility to others.[3]

When therapists relate to their patients in this compassionate and present way, especially in a consistent and authentic manner, they are able to establish rapport and truly human relationships with their patients. Furthermore, the relationship becomes radically collaborative as therapists actively value and consider the knowledge and understanding the patient has in his or her own life, even when it challenges or questions our own prior understandings, personal and professional projects, or conceptual commitments. It becomes possible to work intimately together with an-other toward healing; that is, toward the sort of divine, pervasive, world-altering transformative change that comes only through divine channels and relational receptivity to the Spirit of God. Such is, in fact, the only sort of healing that can mend the souls and sufferings of both patient and therapist. Engaging with patients in Christlike compassion and the spirit of love, when received in that same spirit, leaves the patient with a clear understanding that the therapist is there with and for him or her, and that the therapist is honored that the patient has shared him- or herself with the therapist.

An approach such as this recognizes the genuine and holistic personhood of both the therapist and the patient such that both parties can see one another as other, as real people, living, vibrant, infinite and deep. Other approaches, however, all too often encourage the establishment of a strict therapist/client relationship with proscribed and rigid boundaries, where the therapist is not permitted to transgress professional "best practices" and the strictures of "empirically supported treatment" regimes to allow the intimate, moral possibilities of such a relationship to be explored and unfold. Such professional principles conceptualize the therapist-patient relationship in essentially adversarial terms, assuming that the patient cannot fully trust the therapist to love and care about them enough to be truthful with them and sit with them in their pain. This may lead them to guard themselves from fully opening themselves up vulnerably and disclose the things with which they need help.

While we want to be clear that we are not arguing against the engagement of best ethical practices—after all, we are arguing that at every moment, the therapist is always striving to act in the best interest of his or her patients and a therapist that does any less is at risk of harming patients—there are certain professional conventions about what is acceptable or not acceptable within therapeutic practice that we believe can hinder genuine Christlike relationship between patient and therapist. One such example is that of self-disclosure.

There are several schools of thought within psychotherapy that argue against significant or even minimal disclosure from the therapist about his or her life, internal world, relationships, etc. From these perspectives, if a patient were to ask the therapist their relationship status ("Are you married?"), their religious affiliation ("Are you Christian too?"), or if they've experienced something similar to the patient ("Have you ever felt so crippled by anxiety about something in your life?"), the "proper" answer might be something like, "I'm curious why you're asking that question?" or "What kind of answer are you hoping to hear from me?"

While these questions are not inherently bad in the slightest—in fact the authors have asked these very questions of patients from time to time—being content with redirecting the conversation entirely back to the patient under the guise of "professionalism" limits our ability to genuinely be for the sake of our patients. This is also, of course, the case if a therapist were to begin to self-disclose for self-focused purposes (e.g., disclosing such for the purpose of getting personal support from the patient). However, we suggest that

[3]For example, Levinas (1989) has said: "The other is the neighbour, who is not necessarily kin, but who can be. And in that sense, if you're for the other, you're for the neighbour. But if your neighbour attacks another neighbour or treats him unjustly, what can you do? Then alterity takes on another character, in alterity we can find an enemy, or at least then we are faced with the problem of knowing who is right and who is wrong, who is just and who is unjust. There are people who are wrong" (p. 294).

the particular circumstances and experiences we have had in our lives as therapists have likely been bestowed upon us such that we can extend deep compassion to our patients. In each of the questions above (barring patients who may be predatory or manipulative—and such is typically easy to spot), a therapist based in Christlike love ought to hear cries of "Do you understand me? Can you really help me? Will you lead me astray?" as opposed to a mal-intended intrusion into the facade of perfect unconditional positive regard and professionalism. For a patient, knowing that his or her therapist cares about him or her deeply and is willing to get into the trenches alongside him or her, so to speak, is exactly the kind of Christlike love we are calling Christian therapists to and will create the kind of relationship that is actually healing.

Consistently Telling Our Patients the Truth

A second basic way in which we can readily apply the gospel principles of compassion/charity and being truthful is by straightforwardly telling patients the truth and challenging the lies they believe and false and falsifying ways of being-in-the-world they have come to embrace—i.e., lies they believe about themselves and subsequently live out in their relationships with others (and with God). This may be easier to see in cases where the gospel clearly calls us to discern between truth and error, even when those matters are not easy to address therapeutically. This may be the case with morally serious and often controversial issues such as infidelity, lying, abortion, pornography, illicit drug use, etc. For example, helping an unapologetic patient realize that cheating on his or her spouse is wrong is something most committed Christian psychologists would find to be a fairly straightforward requirement for bringing about gospel-centered therapeutic aims.

However, a therapist's obligation to tell his or her patients the truth is not limited to these more obvious or morally charged situations. More often, truthful compassion will require therapists to speak truth in the often seemingly "low-stakes" areas of patients' everyday lives, those spaces in which they learn and grow daily into the particular kind of people they are and are becoming. This may include the excuses they make, the resentments they justify, the ways they avoid responsibility, the stories they tell about themselves and others, the injuries they refuse to repair, or the small dishonesties by which they preserve a false way of being. Thus, consistently telling patients the truth does not mean only naming obviously sinful or destructive behavior when it appears (and when moved upon by the Spirit). It means being moved by charity and, when guided by the Spirit, helping patients see and relinquish the falsehoods they are living by, even when those falsehoods appear ordinary, socially acceptable, or therapeutically easy to affirm.

For example, one issue that often requires addressing therapeutically in the spirit of love and truth is a patient's attempts at impression management (Frühauf et al., 2015). Impression management is essentially presenting oneself in a particular way to create a certain desired impression on others, typically to manipulatively, even if unintentionally, elicit a particular response from others in order to garner respect, sympathy, moral support, pity, or envy and esteem. A patient may find themselves in a therapy session monitoring their therapist's "micro-expressions," for example, so as to ascertain and give the therapist the "the right answer" to questions that are asked in hopes that the therapist will be more interested in them, value them more, or perhaps come to like them more than other patients the therapist is seeing.

The problem here is, of course, that the patient becomes fixated on pleasing the therapist rather than focused on their own work that needs to be done, and thereby impeding their own progress in therapy, halting growth and authenticity in the therapeutic relationship. In such cases, the therapist needs to be willing to lovingly point out that such image management is taking place, that it is counterproductive, and invite the patient to collaborate in recognizing and exploring the intentions and meanings that undergird attempts at image management. Further, the therapist should explain the moral, interpersonal, and, when appropriate, spiritual dangers of engaging in such strategies, highlighting not only that therapeutic progress ceases when both therapist and patient are operating on false pretenses, but also that our capacity to live fully in truth and love is stymied and stunted when we create false images for our-

selves and others to worship.

In other words, the therapist must invite the patient to understand the essential nature that truth, humility, and honesty must play in the therapeutic relationship if real healing is to occur and genuine wholeness to be found. As discussed above, as we strive to become the sorts of persons who are always seeking to serve others with Christlike compassion, even difficult, painful truth can be acknowledged and honored in love and with proper timing for each individual patient, allowing them to be called to engage the world and others in a higher, holier, and more truthful way.

Fostering the Innate Spiritual and Moral Sensitivities of Patients

Finally, as disciple-clinicians we can capitalize on and encourage the innate spiritual and moral sensitivities of our patients already always experience by not only recognizing the light of Christ in them, that "Spirit [which] giveth light to every man that cometh into the world" (D&C 84:46), but also by helping them (in whatever way and in whatever language is available for them) to also recognize the "whisperings of the spirit" in their own lives and relationships. Because patients are children of God, made in His image and endowed with divine nature (Genesis 1:26–27; Moses 2:26–27), they are not morally inert beings. Rather, they possess a nature capable of recognizing goodness, sensing moral obligation, and desiring to do what is right. Patients may resist, distort, or misunderstand these sensitivities, but they nonetheless come to therapy with moral questions and speak in morality-laden language.

As prolific couple and family therapist and professor William Doherty (2022, p. 9) states, "because clients don't separate the psychological and ethical aspects of their lives—'What am I feeling' is not separated from 'What should I do?'—we owe it to them to become more skilled at ethical consultation." Similarly, Cushman (1995, p. 295) argues that "It is the job of the psychotherapist to demonstrate the existence of a world constituted by different rules and to encourage patients to be aware of available moral traditions that oppose the moral frame by which they presently shape their lives."

We believe that as LDS therapists seeking to be disciple-clinicians it is vital to the relational healing processes of therapy that we encourage our patients to consider seriously the spiritual and moral resources they already possess, but have likely been ignoring or muting, to both "think and feel anew" the emotional, moral, and relational conundrums that have brought them to therapy in the first place. In so doing, we can open a space in the therapeutic relationship for acknowledging and exploring what Williams and Gantt (2012), drawing on the work of C. Terry Warner (1987, 2001), identify as our "felt moral obligation," or that basic understanding of right and wrong, that sense of "oughtness" regarding how we should be with and towards others in particular settings—a concept that is in some important ways reflective of (or, at least, reminiscent of) gospel teachings regarding the light of Christ and the promptings of the Holy Ghost.

Indeed, as Tjeltveit (2004, p. 158) observes, if a meaningful therapeutic alliance is to be established by having therapist and patient truly collaborate "in determining therapy goals, then therapists must take very seriously client obligations, which form one aspect of the ethical context of psychotherapy."

It is important to note here that an extensive and penetrating literature exists demonstrating that not only is therapy an inescapably value-laden endeavor but also that therapists have a professional obligation to highlight the moral assumptions and language by which patients are making sense of their world and relationships in order to help patients better understand the implications of their decisions (see, e.g., Holmes and Lindley, 2018; Martin, 2006; Slife et al., 2019; Tjeltveit, 1999, 2016; Trachsel et al., 2021; Waring, 2016). As Tjeltveit (2004, p. 149) notes:

> therapists and clients bring to therapy a variety of (usually implicit) ethical emotions, perceptions, behaviors, and convictions that profoundly shape any therapeutic relationship. Indeed, the very nature of contemporary psychotherapy, as practiced, reflects certain ethical assumptions. Because psychotherapy is thus an inextricably ethical endeavor, a full understanding of it requires that one see

therapy in its ethical contexts.

Thus, just as we should not brush past our patients' mentions of moral feelings or "promptings," neither should we discourage them from experiencing or exploring such feelings.

For example, from a Gospel-centered perspective, a therapist should not discourage a patient from feeling guilty about cheating on his pregnant wife, or dismiss such feelings as arbitrary or unhealthy, even if the patient says he personally values his right to seek sexual fulfillment in whatever way and whenever he desires it. Regarding engaging in moral consultation or dialogue with patients in therapy, Doherty (2022, p. 9) states:

> To engage in moral consultation, therapists do not have to dictate moral rules or claim to have all the answers. Rather, our role is not so different from how sociologist Alan Wolfe (1989) described the role of the social scientist when dealing with moral issues: "to locate a sense of moral obligation in common sense, ordinary emotions, and everyday life. . . . to help individuals discover and apply for themselves the moral rules they already, as social beings, possess (pp. 214–215)."

Further, Doherty explores how one might affirm patients' ethical feelings:

> In general, ethical affirmations are simple interventions, not complex ones. They have to come spontaneously in the moment and from the therapist's heart, or otherwise, they will sound patronizing. . . . Sometimes an affirmation can be quite brief, as when the mother in a family arrived a couple of minutes late for a family therapy session and said, "I'm sorry I am late. I was taking care of my mother. As you know, she's dying and in hospice. . . She was not the best mother in the world, but I feel an obligation to be there for her as she's dying." My response was, "Of course you do," a simple affirmation of her sense of moral obligation. (Doherty, 2022, p. 45)

Doherty (2022) later presents a model for moral consultation in therapy that he calls "the LEAP-C model." This is one possible model that could prove helpful for LDS therapists in learning to "speak the truth in love" amid the challenges and complexities of therapeutic engagement. However, whether this particular model is employed or not, the central point here is that therapists ought not brush past, ignore, or immediately pathologize the patient's experience and expression of moral feelings (i.e., whether a sense of guilt and shame or a sense of "ought" and "should"), nor should they discourage them from acknowledging and exploring such things; for example, by suggesting that the patient need never feel guilty as long as their actions are congruent with their stated values. Indeed, the patient's moral sense can be indicative of their awareness of their own moral impact on others and, thus, ought to be cultivated for their benefit and the benefit of those around them.

An essential part of fostering and nurturing a patient's inherent moral sensitivities is being willing to engage in a line of questioning and exploration that helps patients come to understand the moral implications of their feelings, thoughts, and behaviors. In so doing, we can gently guide and encourage reflection that allows our patients to come to their own understanding of the impact they have on others, in various ways and for both good and ill, and thereby invite them to seek after and exercise Christlike love, putting others and their needs before themselves. An essential part of fostering and evoking our patients' inherent moral sensitivities and helping expose them to a more truthful world is asking good, penetrating questions that induce honest self-reflection.

Although not a psychotherapist, we would do well to take a cue from Søren Kierkegaard, the 19th Century Christian Philosopher and oft-cited father of existential thought (Austin, 2013). In his book, *Søren Kierkegaard's Christian Psychology: Insights for Counseling and Pastoral Care*, C. Stephen Evans (1990, p. 117) discussed Kierkegaard's use of Socratic questioning, a common intervention in cognitive behavioral therapy (Neenan, 2009):

> Kierkegaard's indirect method for helping his contemporaries is modeled on Socrates. Socrates described himself as a midwife, who had no wisdom of his own to impart but saw it as his task to help others give birth to their own ideas. In this view Socrates did not see himself as superior to anyone else, but was essentially equal to those he hoped to teach. Consistent with this stance, Socrates adopted a method of critical questioning. When he encountered a politician who claimed to know what was right and just, he did not begin by telling the fellow he was wrong and proceeding to give him a better theory. Rather, he took the person's word for it and, on the assumption that the politician did indeed know about justice, began to question him. The end result, of course, was that the politician got an inkling that he did not understand what he was talking about. He was reduced from 'knowledge' to ignorance, but in recognizing his ignorance lay the beginning of wisdom. Socrates' image of a midwife could be described as the maieutic ideal, the term 'maieutic' being drawn from the Greek word for a midwife. Kierkegaard believed strongly in the maieutic ideal.

Asking probing, evocative questions of this sort are an important feature of ethically and relationally-focused therapy because they facilitate a genuinely collaborative relationship between therapist and patient, one which honors the responsibility the patient has not only for his or her own life, but also for moral response to and in the lives of others. Furthermore, seriously entertaining these sorts of questions in therapy allows the patient to step-back a moment and take time to think through their beliefs, feelings, and behaviors and come to some conclusions about themselves that they can take full responsibility for—as opposed to having all of their attitudes, choices, meanings, and behaviors dictated for them by an outside party. In fact, put another way, this method of Socratic questioning ensures that it is ultimately the patient's responsibility and knowledge that dictates what he or she ought to do, without asserting the therapist has any superior or specific knowledge of the particular people and obligations the patient faces.

While therapy rooted in Christian love and a commitment to truth-telling should never rely solely on the therapist dictating to patients what they ought to do or how they ought to be, there are ways in which a therapist can firmly and resolutely offer a more loving and truthful perspective for patients' thoughtful and serious consideration. Doherty (2022), for example, provides an insightful real-world example of how a therapist might walk alongside a patient with Christlike compassion by both asking the right questions at the right time and in the right way and by providing genuine and truthful insights on the patient's situation—what he calls challenging his patient on "ethical terms:"

> My clinical turning point came with a client I will call Bruce, a 40ish-yearold man whose wife, Elaine, had just ended their marriage. I had worked with them as a couple in the past. Bruce returned from work one day to find that Elaine had tossed his belongings into his car and changed the locks on the house. Overwhelmed and depressed, Bruce called me for a session. When we met, he told me he couldn't face the thought of going back to his house to pick up his children, a 3-year-old and a 6-year-old, for a visit. Even more intolerable was the prospect of returning alone to his small apartment after bringing them back to their mother. Tearfully, he said that he could not interact with Elaine after what she had done to him, although he still loved her and wanted to salvage their marriage. To compound matters, he had been fired from his job because he had not been showing up at work.
>
> The more Bruce talked, the more he began to sprinkle in comments such as, "Maybe the kids would be

better off if I just stayed away," and "I think I might need a complete break; maybe I should just pack up and move far away. There is nothing keeping me here now." In fact, a decade earlier, Bruce had given up contact with a child he had fathered with a woman he did not marry. Now that he had no job, the prospect of "starting all over somewhere else" was appealing to him.

I felt dismayed when he talked about abandoning his children, but my training had only equipped me with responses such as, "What do you need to do for yourself right now to get through this?" The most challenging statements from the traditional therapy paradigm I could offer a client like Bruce would be something such as, "I wonder whether you have considered the regret you will feel if you take yourself out of your children's lives," or "You may not be in a healthy enough frame of mind right now to make long-term decisions." There is nothing wrong with these statements; I used them in my conversation with Bruce. But I also decided to do something decidedly nontraditional: to challenge him in ethical terms. After listening to his pain over the end of his marriage and his desire to start over somewhere else, I asked him the kind of question considered out of bounds in my training: "How do you think it will affect your kids if you leave their lives?" He answered, "I think it will bother them for a while, but they'll get over it before long." I moved into deeper water by saying, "I think it will affect them for a long time, not just a short time. I'm concerned about them." Bruce was listening. His reply—"I'm worried about that too, but what kind of father will I be if I am an emotional wreck?"—gave me an opening.

Throughout the conversation that ensued, I emphasized how important he was to them, even if he didn't think so right now and even if he was not emotionally at his best. I told him I could certainly understand that he might need a short time-out to collect himself before going back to his old house and facing his wife again. But he was irreplaceable to his children, and in my judgment, they would carry a lifelong emotional burden if he simply disappeared from their lives. Finally, I reminded him that his children were not responsible for the marital breakup and that it was not fair that they should be its casualties. I made these points not in the form of a lecture but as perspectives and opinions I offered as the conversation unfolded and Bruce pondered his course of action.

By both asking pertinent, evocative questions and being willing to provide insights grounded in genuine love and a commitment to truth-telling, Doherty was able to provide valuable perspective to his patient and possibly save his patient's children many years of heartache.

Alterity Focused Therapy: Another Clinical Example

Another therapeutic approach that recognizes and seeks to instantiate the central importance of Christlike love and truth-telling is Alterity Focused Therapy (see Burdge, 2000; Burdge et al., 2022, 2024; Burdge, 2024). Within this approach, patients are encouraged to live according to three key tenets or "rules" that mirror commitment to Christlike love and truth-telling: (1) Always do what is best for the other, (2) always gather more information, curiously and without judgement, and (3) live these principles, share these principles, and support others in living these principles. These tenets provide a practical grammar through which therapists and patients can move from centering therapy around self-oriented distress toward truthful, compassionate responsibility for one another.

The first rule emphasizes prioritizing and engaging action in pursuit of the long-term well-

being and interests of others. To do what is best for the other is not to please, rescue, enable, or erase oneself. It is to ask what love and truth require for the other person's long-term, even eternal, well-being.[4] At times this may require tenderness, listening, apology, sacrifice, or patient presence. At other times it may require a boundary, confrontation, discipline, or allowing consequences. The AFT therapist's role, then, is to utilize clinical skills (e.g., perspective taking, Socratic questioning, reflection, etc.) to help the patient come to realize what it means specifically to do what is best for the other people in his or her life.

The second rule encourages individuals to continuously seek and learn about others and the world around them, allowing for deeper understanding and connection.[5] Put another way, AFT encourages patients to be genuinely curious about, and not judgmental of, themselves, others, and the world. While the time for judgments always comes, good decisions—in this case, determining what is best for the other—come when one has good information and a clear perspective undistorted by self-deception, delusion, or ulterior motive. Curiosity is not moral relativism, avoidance, or an unwillingness to judge. Rather, it is the refusal to treat one's first interpretation as the whole truth and to suspend final judgment until adequate information is gathered.

Patients often enter therapy with a story that feels self-evident: what the other person meant, why the other person acted, what the other person's behavior proves, and what their own feelings finally authorize. AFT therapists, then, work to slow down that process by asking what is known, what is assumed, what has not yet been asked, and what a more truthful understanding of the other might require. Curiosity, then, or better yet, truth seeking, is preparation for more responsible judgment, action, and relating.

Finally, living by and embodying the principles of doing what is best for the other and gathering more information with curiosity rather than judgment, the third rule involves inviting individuals to be for the other and walking alongside them compassionately, both as patients and therapists. This tenet prevents compassion and truth from remaining private insight or abstract virtue language. To "live" these principles means practicing them in actual relationships. To "share" them means inviting others into the same way of being through example, honest conversation, and patient instruction. To "support" them means helping others continue in these principles when doing what is best for another becomes difficult, costly, or uncomfortable.

That is to say, a patient ought to do what is best for the others in their lives; at least, in part, by helping those others to also learn to do what is best for yet others by gathering more information and forgoing the enticements of self-deception or immoral self-justification. Healing is not complete because a patient has learned new terms for distress or has acquired a more flattering account of the self. Healing must become visible in ordinary relationships: marriages, families, friendships, congregations, workplaces, and communities.[6]

In this respect, AFT is especially consonant

[4]Secular research suggests that prosocial behavior and prosocial interventions are associated with well-being and health-related outcomes (Byrne et al., 2023; Hui et al., 2020), while empirical reviews of compassion describe it as a social and moral emotion oriented toward suffering, caregiving, and approach rather than withdrawal or self-absorption (Goetz et al., 2010). Similarly, forgiveness research suggests that movement away from resentment and toward morally serious repair can be associated with improved mental health and well-being (Akhtar & Barlow, 2018; Rasmussen et al., 2019), though forgiveness should never be confused with excusing harm or requiring unsafe reconciliation nor should it be pursued for merely the sake of the individual offering forgiveness.

[5]This tenet overlaps with empirical work on intellectual humility, perspective-taking, and nonjudgmental awareness. Reviews of intellectual humility link it to openness, learning, relational security, and prosocial dispositions (Porter et al., 2022), while work on mindfulness and emotion regulation suggests that nonjudgmental attention can help reduce reactivity and support better regulation of emotion (Guendelman et al., 2017; Hoge et al., 2021).

[6]Research on religious communities and mental health supports this communal emphasis. VanderWeele (2017) argues that communal religious participation is associated with multiple dimensions of human flourishing, including meaning, close social relationships, character, health, and life satisfaction. Similarly, systematic reviews and meta-analyses indicate that religiosity and spirituality, especially when connected to meaning, social support, and positive coping, are often associated with better mental-health outcomes (Aggarwal et al., 2023; Ano & Vasconcelles, 2005; Coelho-Júnior et al., 2022; Pankowski & Wytrychiewicz-Pankowska, 2023).

with LDS Christianity because moral formation within this framework is communal before it is merely individually therapeutic. One learns to love, forgive, confess, repent, serve, and endure within a community of persons who can support, correct, and sustain one another. In other words, AFT is commensurate with the idea of encouraging patients to always act out of Christlike love for others, seeking their long-term best interest, gathering and living according to truthful understanding, and encouraging others to "Go, and do thou likewise" (Luke 10:37).

While there is currently no direct literature assessing the effectiveness of AFT specifically, there is quite a bit of literature that provides indirect support for the plausible positive impact of the application of AFT's core assumptions. Research suggests that persons often do better when they are drawn out of isolated self-preoccupation and into compassion, humble inquiry, responsibility, forgiveness, meaning, and supportive community. The literature also clarifies a crucial distinction: religious and moral frameworks appear most psychologically beneficial when they are lived through compassion, humility, forgiveness, social support, and meaning-making, and not through coercion, contempt, shame, fear, or exclusion.

Negative religious coping, including feeling punished, abandoned, or rejected by God, has been associated with poorer psychological adjustment (Aggarwal et al., 2023; Ano and Vasconcelles, 2005; Pankowski and Wytrychiewicz-Pankowska, 2023). Therefore, we have further evidence to support the invaluable nature of speaking the truth in love for human flourishing. Thus, AFT is best presented here not as an empirically settled treatment protocol, but as a theologically and philosophically grounded clinical framework whose component processes are supported by adjacent empirical literatures. Its value for the present argument is that it articulates a way forward for clinical practice in practical terms.

AFT begins with the conviction that the self is not healed by becoming the final object of therapeutic attention. This does not mean that the patient's suffering is dismissed, that symptoms are irrelevant, or that personal safety and boundaries do not matter. It means that the person is understood as an agentive and relational being, one whose healing is inseparable from how he or she sees, loves, harms, repairs, serves, forgives, and tells the truth to others. In this respect, AFT gives clinical form to the Christian claim that persons are not saved into isolation, but are invited into reconciled life with Christ and their neighbor.

If the failure of the therapeutic is that modern psychology too often reduces healing to symptom relief, self-validation, or nonjudgmental affirmation detached from truth, then AFT provides a concrete alternative: therapy ordered toward the good of the other, disciplined by curiosity, sustained in community, and animated by compassion that refuses to abandon truth.

Conclusion

In conclusion, we must emphasize one last point: bringing Christlike-love and truth-telling into the therapy room cannot be accomplished by simply "sprinkling some gospel terminology" on top of whatever secular theory or set of techniques a therapist has decided to adopt. Rather, the Christ-centered approach we are describing here requires a complete overhaul, not simply a slight adjustment, of why and how one does what one does as a therapist, as well as often exactly what one does as a therapist. Doherty (1995, pp. 72-73) makes a relevant point in this direction when he writes:

> [Insight oriented, humanistic, and growth-oriented therapies] stress honest expression of wants and feelings, but more for the sake of authenticity and self-development than as a moral mandate. The emphasis is on my need and right to express what is true for me, rather than on your need and right to hear the truth from me. The distinction is not a trivial one. . . . My point is not that a psychodynamically [or humanistically] oriented therapist would never address the moral dimension of lying, but that the therapeutic discourse generated by the model itself cannot generate moral discussion.

In short, it is essential for patients' healing that the discourse fostered by therapists and the models to which they ascribe invite fully moral, truly

loving, and truthful conversations regarding what Christ termed, "the weightier matters of the law" (Matthew 23:23).

By embracing the intimately intertwined nature of truth and love, the Gospel of Jesus Christ offers a surer, more complete foundation for emotional, psychological, spiritual, and moral healing and reconciliation (i.e., atonement), bridging relational divides and fostering compassion, forgiveness, humility, and that deep sense of mutual love and respect that brings peace to the troubled soul. Let us strive to bring genuine compassion and truth-telling to the forefront of our practice, taking upon ourselves not only a commitment to "suffer-with" our patients in their suffering (see Gantt, 2000, 2005) but also to invite them to engage the very real possibilities of transformative change that are entailed in the prophetic promise that "the merciful obtain mercy" (Uchtdorf, 2012).

In doing so, we can contribute to the redemption of sorrowing souls and restoration of our fractured society by offering a path toward the profound and lasting healing that knits together souls, minds, and hearts promised by and only truly found in the Savior Himself. Psychotherapy has many aims and performs many functions, not the least of which—at least, for committed Latter-day Saint practitioners—must be the intentional, gentle, loving encouragement of our patients to become better people by treating their fellow human beings in the way that God has both commanded and in which all deserve.

A Latter-day Saint Christian therapist's most basic aim, both professionally and in covenant, ought to be to assist their patients in being properly equipped to go out into the world as better people, ones who can truly desire and intentionally help alleviate the suffering and burdens of others, and, hopefully, in so doing, help renew and re-invigorate a world immersed in discord, confusion, and pain.

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