

PSYCHE AND FAITH - BEYOND PROFESSIONALISM

[This chapter appeared as G. Glas (1996). Psyche and faith - beyond professionalism. In: P.J. Verhagen & G. Glas (Eds.), *Psyche and Faith - Beyond Professionalism*. Boekencentrum: Zoetermeer, 167-184]

1. Introduction

The purpose of this paper is, first of all, to raise some of the questions which motivated the organizers of the conference.

Secondly, I will comment on the answers that have been given to these questions, especially in The Netherlands.

Next, an attempt will be made to systematize these answers and to sketch the outline of a synthesis and reformulation.

Finally, I will specify a number of subjects that might be put on the agenda of priorities for future investigations.

2. Professionalism and Secularization

First, which questions and preoccupations guided the organizers of the conference? From what background discussion did these questions and concerns originate?

The briefest way to clarify this is to focus on two terms: professionalism and secularization. What concerned the organizers is the tendency to secularism that seems to be inherent in professionalism, or, at least, in a rather common understanding of professionalism. This tendency should be distinguished from the secularism of professionals. Many professionals, certainly, do not adhere to any religion. They see their work as completely disengaged from any spiritual orientation, Christian or otherwise. However, the organizers of the conference had something else in mind. They were primarily concerned with the kind of secularism that seems to be implicated in professional activity as such, i.e., in a particular, overly narrow understanding of professional activity.

To be a professional implies that one is qualified to accomplish specific tasks and activities. The fulfillment of these tasks presupposes a certain level of expertise. To be professional implies that one is able to meet certain standards and criteria. These standards and criteria are related to a limited domain of activities. The boundaries of this domain are determined, in part, by the kinds of knowledge on which professionalism is based, i.e., scientific and technical knowledge. There are, of course, other features which contribute to the traditional notion of the professional: commitment to the good of others and a code of (professional) ethics. Both features leave room for professionals who ground their concern for others and their ethics in a religious tradition. In our age, however, the definition of professionalism is heavily dominated by the scientific point of view. To be an expert means that one's activities are based as much as possible on scientific knowledge and/or technical skill. Roughly speaking, scientific knowledge results from the process of abstraction. Scientists focus their attention on a small, often a microscopic segment of reality in order to unravel general relations between specific properties of that segment of reality. Consequently, scientific knowledge is both more general and more restricted than ordinary knowledge. The increase in accuracy and detail is achieved at the expense of a narrowing of one's view to a discrete part of reality. There is nothing

wrong with this, as long as the scientist acknowledges the abstract nature of scientific models and theories.

Clinicians, psychotherapists and other experts in mental health care, of course, are not scientists. However, their activities are guided by models and theories which draw upon scientific knowledge. The horizon of professional activity is shaped and narrowed by these models and theories. This narrowing and shaping is both logically necessary and practically unavoidable. It is precisely this which makes clinicians and therapists experts.

The critical issue, here, is that abstraction easily leads to isolation, i.e., to reductionism. As a result, clinicians may become blind to the intricate interconnections among emotional, motivational, and religious roots of psychopathology. Professionalism implies specialization, limiting oneself to a particular feature, and intervening in just that segment of behavior in which, according to the relevant theory or model, something doesn't function properly. However, in everyday practice the problems with which therapists are confronted are almost always multi-faceted and complex. They find expression in several domains of functioning. As a consequence, by concentrating on a limited characteristic of a particular problem one may overlook equally important features such as normative or religious issues. So, the unavoidable one-sidedness of scientific theories could amount to practical secularism.

Of course, this does not imply a rejection of abstraction as such. Scientific models reduce reality. They also mold our way of looking at reality. I repeat my assertion that there is nothing wrong with this. It is simply the way in which science works. Professionalism, also, cannot do without it. However, clinicians and therapists often find themselves in a situation in which this legitimate reduction can not be distinguished from illegitimate reductionism. Particularly susceptible to this reductionism are those clinicians and therapists who ignore the abstract nature of scientific knowledge. Theories and models are considered by them as accurate descriptions of reality itself. These practitioners forget that theories, first and foremost, try to explain, i.e., try to construe general relations among variables in discrete segments of reality, segments which as such are abstract and do not have an existence in themselves. Theories are answers to problems, often highly special and context-bound problems. Think, for instance, of the experimental context of the natural sciences and the historical context of the human sciences.

Professionalism is more vulnerable than science itself to this identification of theories with reality, or, to use a technical term, to reification. Therapists who identify their models with reality regard these models as paradigms, as normative descriptions of standard cases, with which their patients should comply. The now almost outdated model of emotional catharsis may serve as an illustration.

Generations of psychotherapists have used this model as the standard of therapeutic action and, even, of mental health in general. The cognitive model of affective and anxiety disorders is another example. This model seems to support a view in which humans primarily are seen as a self-reflective and active agents, who deliberately take their destiny in their own hands.

These examples also show the low degree of abstraction of many of our theories. Many theories that guide our therapeutic activities are mainly descriptive. In my opinion, this enhances the tendency to ignore the distinction between theory and clinical reality.

3. Some answers

In this section I will briefly review some of the answers that have been given to these concerns, especially in the Netherlands.

3.1. The 'just do your job' approach

The first approach is quite obvious from the preceding. I call it the 'just do your job approach'. The practitioner argues that if the main problem is the identification of theories with (descriptions of) reality, then the only thing we have to do is to be aware of the abstract nature of our theories and models. If reduction so easily leads to reductionism, we should realize that we are permanently inclined to hypostasize our theories and to falsely attribute to them a normative status.

I agree that it is important to accept these basic truths. However, this does not suffice. According to the 'just do your job approach' professionals should strictly limit their activities to those tasks or domains in which they are qualified. However, patients don't limit their problems and complaints to a particular domain. When they tell us about their suffering, often both psychological and religious components can be discovered. Hopelessness is a good example. It often has both an emotional and an existential meaning. Anxiety, fear, despair, feelings of worthlessness and insufficiency are other important examples. Should we ignore the existential and religious implications of these emotions, simply because we are not professionally qualified in these domains?

It is not easy to answer this question. We seem to be caught in a dilemma. Society, in particular the professional institutions and organizations of which we are members, increasingly compels us to professionalize our helping relationships, often at the expense of the patient as a believer. As Christians, however, we would like to interpret our actions as instances of the biblical, say more 'holistic', notion of healing, i.e., as expressions of the power of forgiveness, conversion, gratitude, and surrender. But this could imply an ignoring of the patient as a patient, i.e., as a person suffering from some particular kind of 'pathology', which can only be discovered with the assistance of a particular theory, or model.

3.2. The 'just be sure of your attitude' approach

At this stage in discussions like these, one almost always hears another voice, representing what I call the 'just be sure of your attitude' approach. People who adhere to this approach say that our discussion so far has omitted an important issue, namely the attitude of the therapist. The term attitude is used here in a broad sense and refers to the personality of the therapist, to his or her dedication to the patient, his or her capacity to empathize and to install hope, in short, to a number of personal qualities which embody a particular world view. Adherents of this view say that that these personal qualities are ultimately decisive in therapy. This approach amounts to a kind of relativism with regard to the role of theories and models in psychotherapy. Therapeutic success would depend primarily on how one behaves, and much less on what one says. In this approach the presumed tendency to secularism of psychotherapeutic models can be conquered - or at least undone or resisted - by the 'attitude' of the Christian therapist.

I think, that the 'just be sure of your attitude approach' is completely right in pointing to the difference between theory and therapy. Therapeutic interventions are not based on logical deductions from scientific theories. In this respect, therapy could be compared to playing chess. In order to win a match, chess players do not concentrate on the rules of chess as such, which are quite trivial. However, they do concentrate on all kinds of tactical manoeuvres and on special features of the opponent's game. Therapists also do not focus on theories and models for their own sake. For them also theories may become quite trivial. Therapists do, however, concentrate on special features of the patient's history, on types of interventions, on timing and phrasing, and on all sorts of things that belong to the tactical side of therapeutic action.

If the comparison of psychotherapy with a game of chess is valid, then Christian professionalism should be seen as primarily concerned with the discovery of new moves and tactical strategies, and not with the definition of new, constitutive rules, i.e., the formulation of new theories and models. And if this, indeed, would be our task, then we, as Christian professionals, should not cross the boundaries which are drawn by the established theories and models. These theories and models would then define the rules or boundary-conditions that are constitutive for professional activity. These boundary-conditions would determine which activities can count as therapy and which cannot.

As I have said, the 'just be sure of your attitude' approach is right in pointing to the distinction between theory and method (or therapy). However, it goes too far. The ideal of a scientific account of the intricate relations between psychology and religion is given up too soon. By drawing back to the 'attitudinal' (personal) aspects of the therapeutic endeavor, this approach implicitly assumes that the existential and religious roots of psychopathology cannot be studied from a scientific point of view. Moreover, this approach accepts too easily the established theories and models, as if an empirical or philosophical critique of these theories and models would be superfluous. And, finally, it seems to overlook the fact that the distinction between 'attitude' (in the broad sense just mentioned) and content, between 'how' and 'what', is perhaps not as tight as the analogy with a game of chess seems to suggest. The relation between theory and therapy is often compared with that between science and art. However, the art of therapy is penetrated by theory. The exercise of psychotherapeutic skills always involves a 'what'. We should know what to listen to, what to ask, and what to interpret. Theories have much to say about this 'what'.

3.3. The 'just be aware of the presuppositions' approach

We come to what I would like to call the 'just be aware of the presuppositions approach'. This third approach is based on the kind of philosophical critique which I just mentioned. It emphasizes that theories are not entities in themselves, but should be evaluated as articulations of a pre-scientific understanding of the world. Theories, it says, are based on presuppositions which often are value-laden. They are condensations of a particular social, moral and/or religious outlook. The basic premises of our theories sometimes remain hidden. Despite their hiddenness these premises may be very influential in professional practice. So we must be aware of these premises, in order to avoid their creeping in through the back door.

In my opinion, this third approach also highlights an important point. Psychodynamic, behavioral, and systemic theories all have a specific flavor. They conjure up a certain image of the human person. These images have a normative status. This normativity is rarely discussed but is inevitably influential in therapeutic practice. This influence is strongly enhanced by another factor which is worth mentioning, i.e., the institutional embeddedness of the great schools of psychotherapy. Most of these schools have their own institutions, with their own training programs, standards of certification, and more or less articulated philosophies. These philosophies contribute in a rather intractable but powerful way to the 'Bildung' of psychotherapists. So, there is indeed the important task of a philosophical analysis and critique of the images of the human person that are transmitted from one generation to the other in these training institutes. We may add that this critique extends to other institutions in the field of mental health care, although the picture may be less clear here from a philosophical point of view. My only objection to this third approach is that it is largely negative and global. It does not contribute very much to a positive formulation of the identity of Christian psychotherapists.

I conclude, and return to my initial point regarding the relation between professionalism and secularization. We have recognized a tendency to secularism both in the disregard of the abstract

nature of scientific theories and models and in the uncritical assumption of the basic premises of the major psychotherapeutic schools. I refer to what has been said with respect to the first and the third approach, respectively. To withdraw to the position - expressed by the second approach - in which it is only one's attitude, that matters, turned out to be unsatisfactory, since it gave up the whole idea of a scientific approach of the interrelatedness of emotion, motivation, and spirituality. Finally, we have underscored that norms, values, and various images of the human person, are embodied in the institutional practices in which trainees are immersed during their professional education. There are many ways in which professionalism reinforces secularism, and vice versa.

4. Outline of a synthesis and reformulation

4.1. Values in professional practice

I will now formulate some of my own convictions, in order to find a way out of the dilemmas of being a Christian professional. My sketch will be mainly integrative, since there was a kernel of truth in all three of the approaches discussed above.

As Tjeltveit has argued in his chapter in this book, the concept of professionalism is still strongly associated with the idea that psychotherapy and other kinds of mental help should be value-free. I have attacked that idea from two sides: from a practical point of view by pointing to the personal qualities of therapists, which always involve a normative aspect, even in the very standard of professionalism; and from a philosophical point of view, by referring to the basic premises that underlie theories and the institutional practices which are based on them. We can add to this a third consideration, which was pointed out by Vande Kemp in her contribution. Historically, psychology and psychotherapy can be seen as emancipatory movements that tried to liberate the soul from quackery, ill-founded medical treatment, and clerical authority. Seen from this perspective, it comes as no surprise that there has been much more discussion between the spokesmen of these new movements and representatives of more traditional approaches, in particular the clergy, than generally is acknowledged - think for instance of the classical debate between Freud and Pfister. When, today, these discussions seem to be reiterated, they should not be considered as a kind of *corpus alienum* in a field which as such has to be regarded as value-free. On the contrary, these discussions, which psychology and psychiatry simply have forgotten, bring these disciplines back to their roots and touch the nerve of our therapeutic endeavor.

When it is acknowledged that professionalism never can be value-free, one may wonder why the second part of the title of this conference has been formulated as it is: Beyond Professionalism. Does this expression not implicitly suggest that professionalism is something in itself, without any intrinsic relation with norms and values, and with faith and religion as belonging to a realm 'beyond professionalism'? This issue was raised by Labooy (cf. his chapter in this book). He expressed his doubts about the traditional accounts of professionalism by declaring that faith is not external to (or beyond) the therapeutic process, but that it is at the very heart of it. It is even constitutive of professionalism. I am sympathetic to his account, in the sense that there is a strong similarity between some of the constituents of the life of a Christian and non-specific therapeutic factors such as hope, trust, and altruism. However, what has to be clarified further is whether this similarity can be interpreted as an identity, and, if so, under which conditions. In other words, we must ask what kind of faith is fundamental for the therapeutic process: is it Christian faith only? or are more general types of hope and trust also to be included? What does this position imply for psychotherapy and psychiatry as

scientifically based, professional activities?

To answer these questions systematically, we should take into account a number of distinctions. Some of them have been mentioned previously, others will be introduced here. In my argument, I will take three steps:

- (1) First, I will introduce a distinction among four levels of analysis in the conceptualization of psychopathology, i.e., four types of knowledge that are involved in the study and treatment of mental disorder.
- (2) Second, a distinction will be made between the conceptual (or structural) and the practical dimensions of therapy; i.e., between the conceptual matrix on which therapy is based, and the contexts and practices in which these concepts are used and/or mediated.
- (3) Third, I will briefly concentrate on the opening up of the affective aspect, in particular the opening up of the moment of faith in psychotherapy.

4.2. The distinction among four levels of analysis

To clarify what goes on in the office of the doctor or the therapist, I think, it is useful to make a distinction among four types of knowledge. These types of knowledge are characterized by an increasing degree of abstraction. I have first formulated this scheme in my thesis on anxiety disorders (Glas 1991). I believe it can be applied to the entire field of psychotherapy and psychology.

- (1) The level of everyday experience of signs and symptoms as they are communicated to the doctor in his or her office;
- (2) The clinical level, i.e., the level of clinical diagnosis and decision making, characterized by the three-step process of
 - (a) trying to discern a pattern in the story of the patient (signs, complaints),
 - (b) identifying the disorder (diagnosis), and
 - (c) taking some therapeutical action (clinical decision making);
- (3) The scientific level, i.e. biological, psychological, social, and developmental research, characterized by the analysis and abstraction of affective, cognitive and social processes, and disordered functions and relations;
- (4) The meta-theoretical or philosophical level, which describes the basic premises of theoretical models in medicine and psychology.

There is one point in this scheme that immediately attracts attention. This is the distinction of the clinical as a separate level representing a separate knowledge type. I think, indeed, that this is an important distinction. At least in psychiatry, as a branch of medicine, there is a strong tendency to reduce clinical practice to the (scientific) application of general concepts to individual cases. Clinical practice, it is said, should become 'clinical science'. The distinction of the clinical level as a separate level is an attempt to do justice to clinical knowledge as a kind of knowledge that aims at the individual patient (cf. Albert et al. 1988; Hunter 1989; Munson 1981; Thomasma 1988; Toulmin 1976). Earlier, I pointed to the importance of the distinction between theory and therapy by referring to the tactical

aspect of therapy (the metaphor of a game of chess). Here I state my rationale for this assertion. Clinical practice is concentrated on the patient in his or her unique life situation. In principle, there is no function or quality which can be excluded from consideration by the clinician. Science, on the other hand, is concentrated on a particular aspect of reality. It excludes many facets of individual functioning. Because of this concentration on the unique coherence of functions in the individual patient, clinical knowledge has a peculiar conceptual nature: it points to both the individual and the universal. It refers to the individual because of the uniqueness of the patient, including his or her pathology. It aims at the universal by referring to general concepts, like depression, oedipal conflict, or narcissistic collusion. Miss A and Mister B both have a depression. This is the universal dimension. However, Miss A's depression differs in many respects from Mister B's depression. This is the individual dimension. This clarifies why the second admonition 'be sure of your attitude' makes some sense. The clinical orientation of the therapist is only partly based on theoretical constructs and ideas. It belongs to the kind of expertise that is learned in practice, rather than by studying textbooks. This expertise consists of the capacity to diagnose correctly and to treat properly in the individual situation. It is a capacity to act in a proper way in situations in which there is both similarity and dissimilarity with respect to standard cases.¹

The scheme also illustrates some of the merits of the first and the third approach. The first approach ('just do your job') emphasized the abstract nature of theoretical concepts and models. Science searches for general relations, rather than individual specificity. Its focus is in the opposite direction as that of clinical practice. The third approach highlighted the importance of basic premises. This is worked out in the distinctions of the fourth level.

4.3. The distinction between conceptual structure and practice

There is, however, a weakness in this scheme which basically refers to different degrees of abstraction in the conceptualization of psychopathology, i.e. to different knowledge types. These different degrees (or levels) of abstraction were indicated by referring to the different practices or situations, in which the languages of the patient, the clinician, the scientist, and the philosopher, respectively, are born. But can we maintain that these situations or practices in every respect correspond to knowledge types? Are the activities of the clinician or the scientist as such always more abstract than the activities of the patient in the consulting room? Does not the opposite hold too, that the activity of a scientist in the laboratory is, in a certain sense, just as concrete as the activity of the patient who tells us about her complaints?

In my opinion, this objection is partly valid. It points to the need of another distinction, i.e., that between knowledge types and the practices, in which these knowledge types are embedded. Making this additional distinction offers us the advantage of a more fine-grained account of the complexity of clinical reality. First, it enables us to do justice to different types of practice. Second, it underscores a point that was already mentioned, that theories and models do not have reality as entities in themselves. The meaning of a particular piece of knowledge is molded by the practice in which it is developed or used.

From now on, I will concentrate my argument on the nature of clinical practice, the second level. I believe that at least three inter-related types of practice can be discerned at the clinical level, each with their own rules governing them (Table 1).

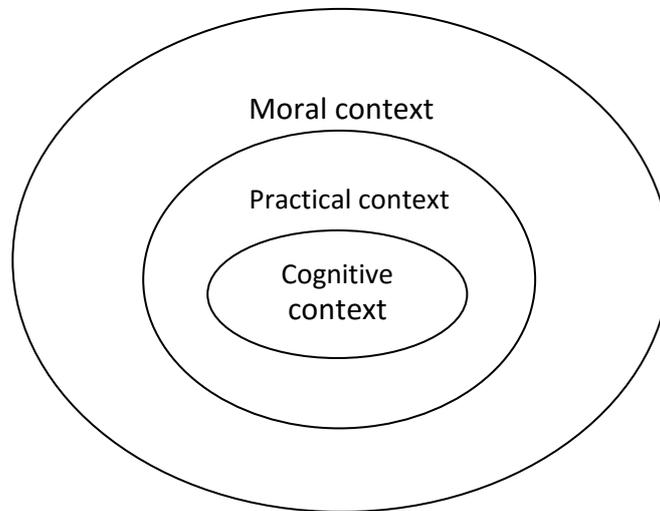


Table 1

First, there is the cognitive practice of diagnosis and clinical decision making. Generally speaking, this process is guided by cognitive rules. It can, to a certain extent, be simulated by computer programs. Second, there is the practice of treatment and care. This practice is based on diagnosis. It demands a lot of expertise, because of the individual features of the case. The general treatment regime should be adapted to the individual patient. The rules involved here relate to what might be called 'clinical' or 'practical wisdom'.

Third, we may delineate a wider context determined by the moral appeal of the patient. The answer to this appeal depends on the moral and religious rules with respect to which therapist and patient have reached mutual agreement.

To summarize, the clinical knowledge type is molded to the individual case. The clinical situation in which this happens is determined by cognitive, 'practical wisdom'-like, and moral rules. These rules show a certain order which can be represented in a scheme of three concentric circles, the inner one related to cognitive rules, the middle one to rules of practical wisdom and therapeutic expertise, and the outer one to moral (and religious) rules.

4.4. The opening up of the affective aspect

A full account of the process of opening up (or disclosure) would require a short introduction into the systematic philosophy of the Dutch philosopher Herman Dooyeweerd (1953-1958). I will not offer this introduction here. I refer to the work of Dooyeweerd himself or one of the introductions to his work (Kalsbeek 1975; Van Woudenberg 1992), and also to my attempts to apply and refine some of his distinctions in the field of emotions and emotion theory (Glas 1989).

It is here that, I think, we may find a key component of the solution for the quandary about being a secularized professional or a Christian non-professional. Of course the affective or emotional

dimensions of the person are not the only significant area in psychotherapy. There are other variables as well, especially distortions and deficits in cognitive and social functioning. For sake of brevity, however, let me concentrate on affect. I will limit my argument to three remarks.

First, human functioning can be analyzed as a structural whole, in which a number of substructures are bound in what might be called the act-structure (Tabel 2).

These substructures are: the physical, the biological, and the psychic. These structures are called substructures because of their relative independence on the one hand and their integral relation to the other substructures and the act-structure on the other hand. The act-structure is not bound to a particular aspect of human functioning. That is to say, our acts certainly can be distinguished with respect to their cognitive, social, economical, juridical, aesthetic, ethical and/or religious qualities, but these qualities pass into each other and vary virtually every moment. Because of these transitions our acts seem to possess a much more flexible structure than do the substructures.

Human emotional life, which partly belongs to the psychic substructure, functions autonomously to a certain extent, but at the same time never exists as an entity in itself. Emotions are often taken up in intentional actions and other kinds of behavior. The feeling of anger may be taken up in the acts of clenching one's fists and of shouting to the person who is the object of one's anger. The feeling of anxiety is an important factor in the genesis of avoidance behavior. The feeling component is strongly connected with the behavior component.

Human being

God; origin of meaning

- Modal aspects
- Pistic aspect
- Ethical aspect
- Juridical aspect
- Aesthetic aspect
- Economic aspect
- Social aspect
- Lingual aspect
- Historical aspect
- Logical aspect
- Psychical aspect
- Physical aspect
- Kinetical aspect

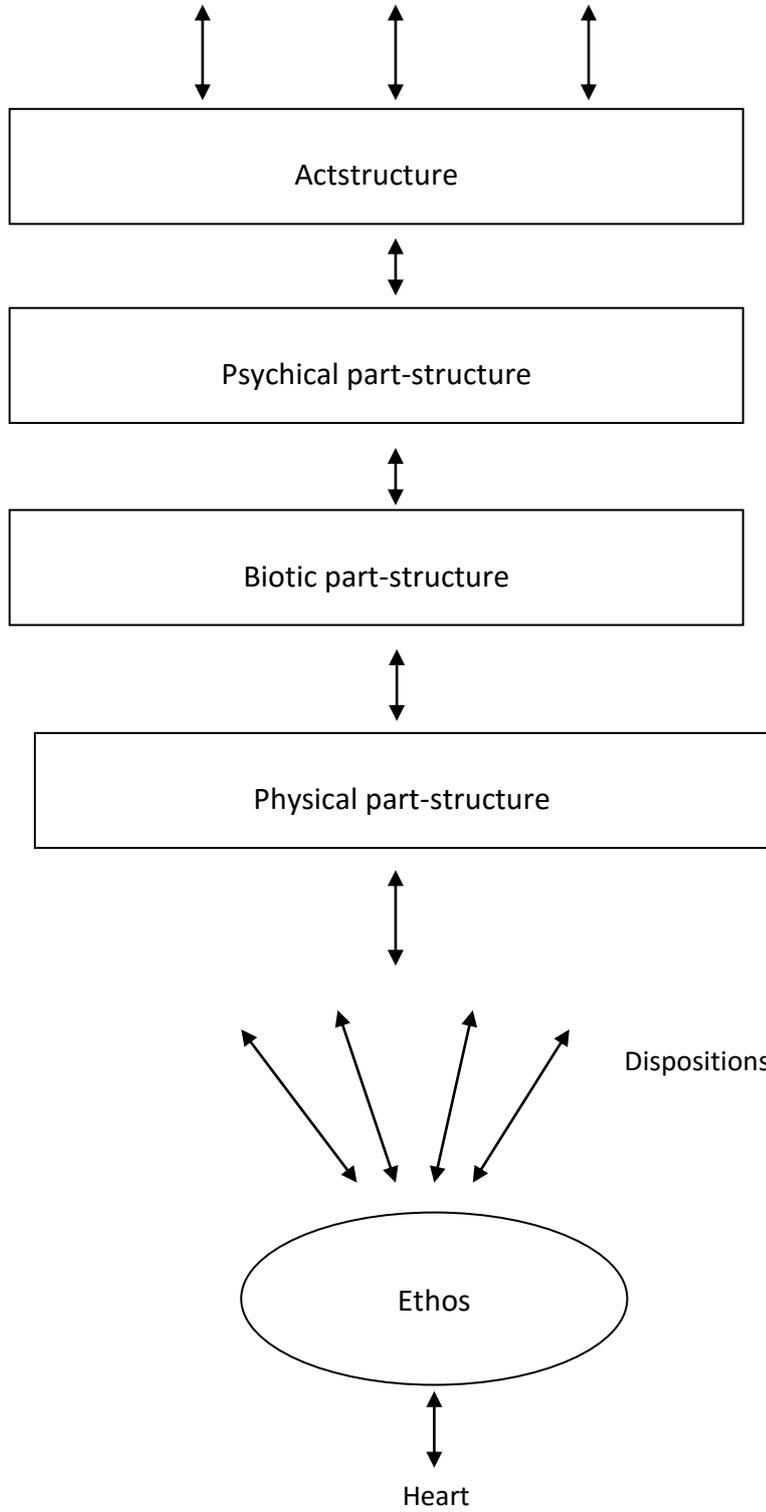


Table 2

This brings me to my second remark.

Human emotions differ from animal emotions because of their richness of meaning. They may prepare for, or be an element of an immense diversity of acts and act-like behaviors, such as thinking, remembering, desiring, avoiding, sighing, groaning, grumbling, and so on. This richness and this preparing for all kinds of activities can be captured by the technical term 'anticipation' (Tabel 3).

The opening-up of structures in the anticipatory direction

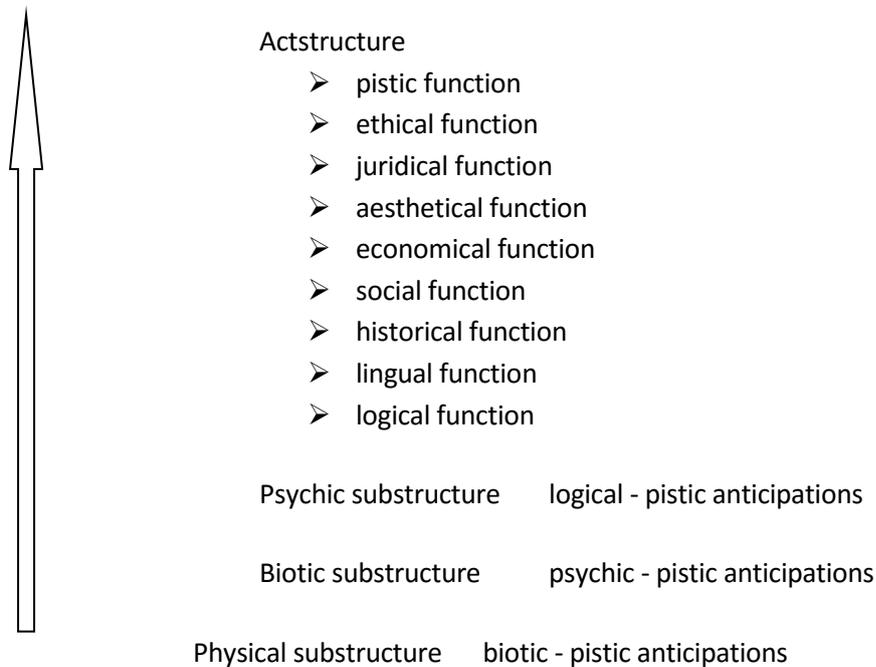


Table 3

Anticipation in particular refers to the reflection of elements of the higher functions in human emotional life which as such is a part of the psychic substructure. Dooyeweerd called these elements 'analogies' or 'analogical moments'. So, emotional life is co-determined by analogical moments which anticipate the higher functions of the act-structure. It is important to note that these elements, as such, belong to the affective domain. Feelings of trust and hope, for instance, can be interpreted as feelings that anticipate faith. As such, i.e. as feelings, they remain within the boundaries of emotional life. The words 'trust' and 'hope', of course, may denote other events, acts of trust or hope, for instance, acts that bear witness of our confidence in somebody or in a particular state of affairs. In the affective domain, however, they denote trust and hope as feelings.

Saying that these feelings are instances of the opening up of affective life means that in these feelings those moments of our emotive life are activated or articulated which anticipate faith. To imagine what is meant here, one may recall what happens in cases in which these anticipatory moments seem to be atrophied. In severe depression, for instance, the psychic or, more precisely, the affective component of the psychic substructure, is closed. The expression and articulation of anticipatory moments is impeded. Consequently, the actstructure is distorted also: psychomotor behavior is retarded and there

is a lack of initiative. In the most severe cases even a term like hopelessness seems to say too much, since there is virtually nothing to be hopeless about. Hopelessness may become a state without an object. What remains is the psychical experience as such, without reference to an object or a cause, a dull, nagging, pressing feeling of fatigue and of complete inefficacy. In less severe cases the feeling of hopelessness has an object (or a series of objects), for instance, one's failure with respect to a particular task or the conviction that one is rejected by God or one's fellow humans.

In my opinion, this provisional analysis may clarify why the dilemma about being either a secularized professional or a Christian non-professional is based on such an inadequate conception of professionalism. Our analysis suggests that psychotherapy can be seen as an activity that aims at the opening up of the affective domain, i.e., at the creation and/or re-construction of all sorts of anticipatory moments, the moment of faith included. When this analysis is accepted, the only conclusion can be that this opening up is both a highly professional and a thoroughly normative activity. It is professional because of the degree of sensitivity and expertise that is required to perceive which aspects of the disrupted affective structure should be reorganized and/or strengthened. It is normative because of the moral and religious choices which inevitably emerge when the process of opening up of affectivity proceeds.

With respect to normativity one final question must be faced. What kind of guidance or help should the therapist offer with respect to moral and religious choices? I have already clarified that the opening up process as such is a normative process and that, because of this, psychotherapy is both professional and normative. However, ultimately patients may choose for a tragic vision on life or for resignation, instead of for a rich and hopeful or even a Christian view. From a practical point of view, the answer is not as difficult as it may seem. First, guidance depends on the kind of negotiations between the patient and the therapist in their initial meetings. Second, it depends on the kind of therapy. Non-directive therapies don't lend themselves for active guidance and advice, directive therapies do. Third, it depends on the kind of pathology. Strong suggestions and advice may induce regression and dependency. Finally, it depends on the stage of the therapy. In my experience, a free discussion of religious and moral issues is natural in the final stages of some kinds of therapy. Careful suggestions may then be appropriate. These suggestions almost never come as a surprise. They were already in the air. They articulate what in an implicit way was always present, namely the moral and/or religious outlook which was embodied in the attitude of the therapist.

My final word here is hope. The suggestive effects of the Christian outlook, embodied in our professional attitudes, are well-founded. If God has created our earth and the order on which our insights are based, then our efforts to open up parts of created reality point to Him. Hopelessness never will bring about the fullness of creational possibilities, it can only lead to atrophy and boredom. Our hope, embodied in our attitude, will be a manifestation of the coming Kingdom.

5. Summary and suggestions

The professionalization of psychotherapy and psychiatry seems almost inevitably to imply a secularization of the helping relationship. By focussing on specific qualities of the patient's pathology, the therapist ignores other aspects, for instance the intricate interlacing of psychopathology and existential problems. We seem to be trapped in a dilemma, the choice between the institutional and societal pressures to professionalize our helping relationships on the one hand (at the expense of the patient as a believer) and the biblical notion of 'wholeness' and healing on the other hand (at the expense of the patient as a patient, i.e. as a person suffering from some particular kind of pathology).

However, there is a way to resolve this apparent dilemma,

- (1) when human functioning is conceptualized as an ordered complex of hierarchically layered functional modes,
- (2) when the abstract nature of the theories on which therapeutic interventions are based is acknowledged, and
- (3) when a distinction is made between theory and therapy (with its own normativity).

I finish with some recommendations.

My argument, briefly stated, points to diversification and refinement. Let me mention in which directions we might search for this refinement. What we need first is a clear delineation and enumeration of what I have called 'anticipatory moments', in particular of those moments that anticipate faith. Trust, gratitude, surrender, guilt, reciprocity, and love are mentioned as potential candidates.

Second, there is the challenge of developing a Christian existential approach to psychotherapy, which could expand on elements of the work of Viktor Frankl, Rollo May and Irving Yalom. I recognize that these great psychotherapists were more or less inspired by humanism. In my opinion, however, their attempts are in the right direction. A number of contributions in this book, in particular those that are concentrated on the treatment of traumatized people, point to the need for an existential approach. Traumas threaten the core values on which our self-esteem is based. Traditional psychodynamic treatments sometimes reach the existential level, but they are seldom adequate to encompass the full range of questions which are at stake here.

Next, empirical research could unravel some of the therapeutic factors which are so important in therapy, in particular those related to ultimate commitments.

Fourth, more work must be done on the elucidation of the relations between theory, methods, and therapeutic attitudes. Clarifying these relations would greatly improve our insight into the relations among psychotherapy, counseling, and pastoral care.

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Note

1. The process of clinical decision making can be compared to what Aristotle, in his *Ethica Nicomachea*, has called *phronèsis* (practical wisdom, prudence). *Phronèsis* is the disposition to act in a morally justified way in situations in which a given moral rule does not provide a clue which is immediately applicable. The background of this notion is that courageous behavior in one situation may become recklessness in another situation. The virtue of courage as such does not provide a clue in that case with respect to the type of behavior which can count as courageous. The capacity to act morally in such situations depends on the virtue of practical wisdom, and not on the ability to infer particular types of behavior from general rules by the faculty of reason.

