To the Graduate Council:

I am submitting herewith a dissertation written by Kenneth E. Schmitt entitled "*Cura Animarum* in the Twentieth Century and Beyond: Toward the Development of an Ethical Framework for the Practice of Pastoral Counseling." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor in Philosophy, with a major in Philosophy.

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CURA ANIMARUM IN THE TWENTIETH CENTURY AND BEYOND: TOWARD THE DEVELOPMENT OF AN ETHICAL FRAMEWORK FOR THE PRACTICE OF PASTORAL COUNSELING

A Dissertation

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Degree

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Kenneth E. Schmitt

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To my parents,

Clyde and Rena Schmitt

who nurtured within me a love for learning

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ABSTRACT

The purpose of this study is to demonstrate the appropriate role of pastoral care and counseling in pluralistic society and to contribute to the development of an ethical framework for the practice of pastoral counseling. A survey of the history of pastoral care establishes that moral guidance traditionally has been the distinctive dimension of such care. The inevitability and appropriateness of value considerations in counseling contexts is discussed. The issues of paternalism, informed consent, and competence are considered in light of their contribution to an ethical framework from which pastoral counseling can function.

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INTRODUCTION

Cura Animarum, according to John T. McNeill, is as old as the family of man. He contends that human beings have always shared their personal problems with others in an attempt to find healing for the ills of both body and soul (McNeill, 1953). William Clebsch and Charles Jaekle eloquently echo this view in Pastoral Care in Historical Perspective:

> The...ministry of the cure of souls, or pastoral care, has been exercised on innumerable occasions and in every conceivable human circumstance, as it has aimed to relieve a plethora of perplexities besetting persons of every class and condition and mentality. Pastors rude and barely plucked from paganism, pastors sophisticated in the theory and practice of their profession, and pastors at every stage of adeptness between these extremes, have sought and wrought to help troubled people overcome their troubles. To view pastoral care in historical perspective is to survey a vast endeavor, to appreciate a noble profession, and to receive a grand tradition. (Clebsch and Jaekle, 1964, p.1).

Yet despite the vastness of the endeavor, the nobility of the profession, and the grandness of the tradition, the practice of pastoral care in the twentieth century has faced and continues to face unique and unprecedented challenges. The combination of technological innovation, the

bureaucratization of societal structures, rapid social change, the rise of pluralism, the development of psychodynamic and other psychological theories, and the proliferation of both religious and secular physicians of the soul, *iatros tes psyches*, has conspired to question pastoral care as historically practiced. My purposes are to demonstrate that there is indeed a role for the historical tradition of pastoral care in a pluralistic society and to contribute to the development of an ethical framework for the appropriate practice of the special function of pastoral counseling.

Chapter I surveys the history of pastoral care to establish that moral guidance has been a significant dimension in the tradition of cura animarum. Analysis reveals that the societal factors which fostered the development of psychology in general and pastoral psychology in particular, also posed difficult questions for pastoral counseling.

Chapter II posits that the dilemma confronting pastoral care and counseling is rooted in uncritical acceptance of a psychological modality and its positivistic methodology. Further, it demonstrates that the hope of value-free science, natural or behavioral, is illusory. There is and will be a value dimension in science and this element is appropriate, if not necessary, in helping activity. This value dimension, with its consideration of religious values.

defines the role of pastoral counseling in pluralistic society.

Chapter III considers the first of three notions which will prove helpful in the development of an ethical framework for pastoral counseling, the principle of paternalism. By virtue of the caregiver's commitment to an ultimate set of meanings and values, paternalism is an intrinsic aspect of pastoral care and counseling. The notion of a paternalism that maximizes autonomy in serving the ultimate good of the individual, operative within a stage model of care, facilitates the adherence of pastoral counselors to the moral and ethical implications of their faith without manifestation of the rigid moralism to which Freud reacted.

Chapter IV demonstrates that the doctrine of informed consent provides a means by which pastoral counselors are enabled to serve both the ethical implications of their faith tradition and the best interests of their clients, as their clients see them. Application of the doctrine of informed consent to the practice of pastoral counseling reveals specific challenges for the pastoral counseling roles which derive some measure of their authority from the psychotherapeutic tradition.

Chapter V discusses the question of the competence of pastoral counselors and the related obligation of referral. A methodology is proposed which permits consideration of

criteria of competence without reference to the veridicality of metaphysical presuppositions, thereby facilitating interdisciplinary synergism in service to those needing care.

CHAPTER I

HISTORICAL SURVEY OF PASTORAL CARE

Pre-Christian Pastoral Care

John T. McNeill's analysis of the history of pastoral care, A History of the Cure of Souls, demonstrates that, in addition to direct service, significant dimensions of the proffered care have been moral guidance and ethical rationality. For Socrates, who described himself as a physician of the soul, *iatros tes psyches*, men's souls are sick when they think erroneously. The cure Socrates offered was to lead them, through questioning, to a point of mental confusion and teachableness from which they would be receptive to truth. Socrates, Aristotle, and Plato as well as the Stoics, Epicureans and Cynics all functioned as physicians of the soul by providing moral guidance in which the body and its passions are governed by a system of ethical rationality. This guidance took various forms: virtue as a mean between two extremes, apatheia, and hedonism.

This emphasis on moral guidance was not exclusive to the western mind. The Vedic literature of ancient Hinduism describes the special task of the guru as spiritual direction of young men and boys. Through instruction and example they were to impart virtue, expel vice and inculcate religious belief and habit. Buddhism brought ascetic rules and organization to the cure of souls, among them elaborate liturgies of confession and tabulated prescriptions of penance as well as moral and religious counseling of laymen (McNeill, 1953).

When we turn to the Near East and the Judeo-Christian framework, from which the contemporary American practice of pastoral care and counseling grew, we again find an expression of *cura animarum* which was distinctively ethical. Judaism was, in terms of the categories of Max Weber's sociology of religion, a religion of "inner-worldly asceticism" which valued life in this world and approached it with a practical rationality that ordered impulses and needs by directive intention so as to bring them into conformity with guidelines of certain practical rules of behavior (Weber, 1958, pp.193-194). The practitioners of the cure of souls in ancient Israel, prophets, wise men, priests and scribes, were characterized by their exposition of the covenant law which provided the practical rules governing daily conduct. The prophets were primarily concerned with the covenant community as a whole, crying out

against national religious deterioration and unfaithfulness to the law of Yahweh. The Hebrew wisdom literature consisted of compilations of moral maxims for group and personal life. Primary activity for the Levitical priests was the implementation of ritualistic means to expiate guilt when the covenant law was violated. During the exile, when the covenant community was separated from the temple and cultic practices, the practical exposition of the social-ethical laws of the Torah gained ascendancy and led to the development of a distinct group of experts in the law: the scribes, teachers and Pharisees of later Judaism. Of these, Browning writes:

> In comparison to other religions, what is peculiar to them is their practical rationality - their lack of magical and mystical techniques, their interest in everyday behaviour, and their closeness to the lives of the average man. These were the practitioners of pastoral care par excellence. Their handling of problems of guilt, anxiety, confusion and forgiveness assumed a wealth of practical laws. Their primary tool was knowledge - not esoteric or mystical knowledge, not orgiastic or gnostic or secret wisdom - but rational knowledge of the law, its casuistry and everyday application (Browning, 1976, p.46).

Pastoral Care in Christian History

Christianity grew out of Judaism (Clebsch and Jaekle, 1964, p.14). Thus the notions of care and guidance in early Christianity reflect the Jewish ethos of the ordering of daily experience in accordance with a rational code predicated upon the will of God (Browning, 1976, pp.42-52).

Jesus himself was acknowledged as a "rabbi," an expert in the casuistry of the covenant law and its application to life situations, by both his followers and his opponents (McNeill, 1951, p.70). Though his ministry to individuals included many instances of physical healing and demon expulsion, its predominant theme was the liberation and transformation of the souls of men (McNeill, 1953). This was accomplished by repentance and faith which was exemplified by action consistent with the principles of the kingdom of God. Thus the element of moral guidance and ethical rationality which so characterized Judaism was operative in Christ's cure of souls. He announced that his intent was not to abrogate the law, but rather to fulfill it: "Do not think that I have come to abolish the Law or the Prophets; I have not come to abolish them but to fulfill them" (Matthew 5:17 NIV). Jesus' formula, "You have heard that it was said...but I tell you" (Matthew 5:21&22ff NIV), identifies him as a supralegalist (Browning, 1976, p.49). For the supralegalist the letter of the law is insufficient, the inner meaning or deeper objective of the law is of paramount importance and must guide action. However, to make a supralegalistic statement one must first assume a legalist code. Jesus assumed and accepted the ethical rationality of Judaism. His aim was not to denigrate or abrogate the law but rather to fulfill it through focusing on its deeper meaning.

The life and pastoral care of the early church was informed and animated by a belief in the risen Christ. The supralegalism of Jesus freed the Christian community from the ritual restrictions of Judaism regarding food and circumcision enabling Christianity to become a universal religion while at the same time perpetuating the social and ethical dimensions of the Jewish law as a standard for right conduct. The understanding of Christ as the head of the Church, which is his body, introduced an emphasis upon fellowship within the covenant community. Christians are to live "in Christ" as members of his body in brotherly love and mutual helpfulness. This note of mutual edification, *aedification mutua*, occurs frequently in the New Testament and in the literature of Christianity and is often associated with the injunction to brotherly correction, *correptio fraterna* (McNeill, 1953).

> In this context, pastoral care took the form of intense, warm and personally oriented instruction about the deeper meaning of the law and corporate efforts to discipline and forgive those who could not live by this new idealized law as a sign of their direct obedience to the will of God (Browning, 1976, pp.53-54).

William Clebsch and Charles Jaekle made a significant contribution to the understanding of pastoral care in Christian history with their book Pastoral Care in Historical Perspective. Their delineation of eight historical epochs of pastoral care indicates that the distinctive element of moral guidance which characterized

pre-Christian and early Christian *cura animarum* continued throughout Christian history as practitioners of the cure of souls healed, sustained, guided, and reconciled those for whom they cared. The first of these historical epochs, the era of primitive Christianity, lasted until around 180 A.D (Clebsch and Jaekle, 1964, p.13). During this time the perspective was future oriented as Christians awaited the imminent return of Christ and the end of the world. Pastoral care was primarily a matter of sustaining souls in the face of life's challenges until the Second Coming (Browning, 1976, p.60).

The modality of sustaining was supplemented by the modality of reconciling in the next hundred years (Browning, 1976, pp.60-61). As persecution of Christianity by civil authorities increased, the church was faced with the question of how to respond to the "lapsed," those who fell away in the face of persecution. In this second historical period, pastoral care focused on the reconciliation of lapsed souls and prevention of the need for such reconciliation (Clebsch and Jaekle, 1964, pp.17-19). Because various devices were used to avoid persecution, distinctions were drawn as to degrees of apostasy and procedures for reconciliation. A body of literature was developed advocating exomologesis, i.e. public confession, and penance (McNeill, 1951, pp.90-91).

Constantine's establishment of Christianity as the Imperial religion signalled a significant shift in the nature of pastoral care (Clebsch and Jaekle, 1964, pp.19-21). Within the Roman empire the church was thrust into a position of prominence as the unifier of society; whereas it had once been costly to be a member of the church, it now became costly not to be one. During this third period, the emphasis of pastoral care was on guiding people to behave in a manner consistent with the norms of the newly Christian culture. The newfound public strength of the church as an institution also led to its assumption of public responsibilities, particularly for medical institutions (McNeill, 1953).

The fall of Rome to the barbarian hordes ushered in the "Dark Ages" and a concomitant change in cura animarum. Whereas guidance in the Imperial Church had been designed to fuse Christianity and classical civilization so that its ethical imperatives were both culturally significant and Christian in content, the pastoral task in the fourth epoch, that of the Dark Ages, was that of persuading European peoples to accept Christian description, diagnoses and remedies for their difficulties (Clebsch and Jaekle, 1964, pp.13,21-23). As guidance became increasingly inductive, the Benedictine monks with their twelve-step ladder of humility became the practitioners of pastoral care par excellence, while Augustine of Hippo provided an

intellectual and theological framework. This trend reached its peak in the late sixth century when Pope Gregory the Great, himself a monk, wrote his treatise Pastoral Care, which became a standard reference. Over the next two hundred years, the practice of moral guidance became reduced to a cataloging by clergy of sins and their penalties (Young and Griffith, 1989). Pastors were faced with the task of guiding raw and rough people into Christian belief and practice. The attempt to accomplish this was by the objectivization of spiritual reality, much as the Pharisees had done in ancient Judaism. For example, in addressing the sin of lust, one penitential distinguished three degrees of sinful kissing and provided appropriately graded periods of fasting for each (Clebsch and Jaekle, 1964, p.23).

The fifth historical epoch of pastoral care, Medieval Christendom, embodied healing as the primary modality of care (Clebsch and Jaekle, 1964, pp.23-26). As the Catholic church permeated the fabric of European society, social cohesion was built upon religious conformity. In the context of agrarian, manorial life, the medieval parish became a compact, inclusive geographical-social entity with the priest at the center of corporate life. This is reflected in a prominent medieval manual, *Corrector et medicus*, compiled by Burchard, Bishop of Worms:

> This book is called "the Corrector" and "the Physician" since it contains ample corrections for bodies and medicines for souls and teaches every priest, even the uneducated, how he shall be able to bring help to each person, ordained or unordained; poor or rich; boy, youth, or mature man; decrepit, healthy, or infirm; of every age; and of both sexes (Burchard, 1938, p.323).

The means by which this help was brought was a well-defined sacramental system through which grace was administered for every situation of common life. This system was codified through the designation of the seven official sacraments of the Catholic church and strengthened by the requirement that all the faithful participate in confession at least once a year (Clebsch and Jaekle, 1964, p.25). The emphasis on the modality of healing is obvious in Pope Innocent's canon on penance which enjoins the confessor to pour oil and wine on a sinner's wounds like a skillful physician (McNeill, 1953). This image of correction and comfort through sacramental application of grace at every juncture of life captures the essence of *cura animarum* in the medieval church.

In contrast to Clebsch and Jaekle's assertion that the Reformation's great upheaval in doctrine and ecclesiology never generated a corollary in the cure of souls, Browning argues that the changes in pastoral care precipitated by the Reformation are of great significance in human history:

> Anytime that you begin to depreciate the importance of pastoral care, remind yourself that it was over questions of conscience and guilt and how these are to be handled by the church that the Reformation began and one of the most dynamic

periods of world history started to unfold (Browning, 1976, p.63).

Though the focus of both the Renaissance and the Reformation, Clebsch and Jaekle's sixth historical epoch, was the reconciliation of individual persons to a righteous God, the Reformation signalled the decline of the systematic sacramental mode of *cura animarum* that had developed through the medieval church (Browning, 1976, pp.63-68). Luther's famous quest for assurance of personal salvation had led him to assail the abuses of the penitential system. He emphasized relief of distressed conscience and absolution through informal and occasional confession rather than obligatory seasonal attendance at the confessional and penitential satisfaction of enumerated sins (Clebsch and Jaekle, 1964, p.27). Among the implications for pastoral care were the association of the notion of therapy with the cure of souls (McNeill, 1953). Moreover, the focus of pastoral care became justification, understood as deliverance from bondage to sin, and sanctification, understood as the development of Christian character and righteousness (McNeill, 1953). With the abandonment of obligatory confession and the penitentials containing their calculus of sin and penance, the church lost most of its ways for guiding and directing the behavior of its members (Browning, 1976, p.64). In their place the Reformers espoused participation in the community of the redeemed through which comfort, correction and strength would be

mediated. This entailed a rediscovery of the "mutual edification" and "fraternal correction" of early Christianity. This development was facilitated by the doctrine of the priesthood of all believers which affirmed that any pious layperson could serve as confessor or spiritual director. These methods of guidance were especially evident in the pietism of the Moravians and the class meetings of Wesley's Methodism (McNeill, 1953).

In the seventeenth and eighteenth centuries the Enlightenment attempt to understand and explain life apart from reference to God and religion brought new challenges to pastoral care. During this seventh era, unbridled confidence in human nature freed from the fetters of tradition generated high hopes for this life. The need for Christianity was to sustain believers in their focus on the immortality of the soul and their individual destinies beyond this life as well as equip them to avoid the pitfalls and treacheries of an exceedingly wicked world (Clebsch and Jaekle, 1964, pp.28-30). Bunyan's classic, The Pilgrims Progress, epitomizes the cure of souls in this epoch as Pilgrim is sustained on his journey to Celestial City. This sustenance demanded discovery and description of both the nature of the Christian experience and the difficulties to be encountered thereby focusing attention on the psychology of religion and pastoral theology. Another development of this era was progress of medical practice such that ailments

and irrational behavior began to be explained in physical and psychological rather than spiritual terms (McNeill, 1953).

Pastoral Care in the Modern Era

Clebsch and Jaekle identify the eighth and final epoch of their historical delineation as "The Post-Christendom Era", noting that the concomitant revolution against "Christendom societies" and rise of pluralism created a context in which virtually unprecedented forms of pastoral care evolved. Browning claims "Pastoral care in twentieth century mainline Protestant churches has been vastly different from anything seen before in Jewish and Christian history" (Browning, 1976, p.68). E. Brooks Holifield, in History of Pastoral Care in America pp.349-356, describes this as a shift from salvation to self-realization. In general, twentieth-century *cura animarum* manifests a departure from the structured, well-articulated religiocultural context which has characterized its practice throughout the previous periods. The distinctive feature of moral guidance has been exchanged for the goals of acceptance and self-actualization derived from prevailing secular ideology.

Alison Stokes, in Ministry After Freud, pp.12-15, traces the roots of this shift to Schleiermacher's argument for religious-cultural accommodation. Faced with the

complex forces which converged to create upheaval in nineteenth century America, modernist religious leaders sought to make the gospel relevant to the culture of their era in a manner particularly reminiscent of the Imperial church. Industrial and urban expansion, scientific and technological discoveries, waves of immigrants, and breakdowns in the accepted morality demanded adaptation of practical theology and pastoral care to meet new challenges posed by these developments.

The rise of the Social Gospel was an attempt to relate the Christian ethic to modern industrial society. Hospitals, schools, labor unions and, according to Edward Everett Hale in When Jesus Came to Boston, even drinking fountains became instruments of the cure of souls in combatting the evils of urban dislocation, economic oppression and slums. Holifield offers the "church parlor" as the symbol of this development in parish life. Rather than simply being a center for worship and evangelism, with the addition of the parlor, the church became the site of social organizations. Some of these, Sunday school organizations, boys brigades, women's meetings, etc., were for the edification of the faithful, while others were directed toward providing ministry to the urban slums. (Holifield,1983, pp.164-175). This revolution in the nature of parish life brought about a corresponding change in the pastoral role. The administrative demands of leading a

burgeoning social organization both required interpersonal skills and limited the pastor's personal visitation. These dynamics, coupled with the concomitant rise of the scientific study of religion, set the stage for the emergence of the religion and health movement (Stokes, 1985, pp.14-15).

Motivated by the modernist impulse, G. Stanley Hall began to explore how the new theories of the subconscious being articulated in Europe could assist the practice of pastoral care, particularly by those committed to the liberal doctrine of divine immanence (Holifield, 1983, pp.185-186, 198-200). Hall's work was seminal in the development of the psychology of religion. With his publication of Principles of Psychology and Varieties of Religious Experience, William James synthesized the themes of the psychologists of religion and made them accessible to practitioners of pastoral care. Aware of the interest of the American public in psychology, James challenged the new breed of scientific psychologists to translate their work into pedagogical and therapeutic terms. His interpretation of the mind-body unity, examined in psychological laboratories throughout Europe, offered an alternative to the materialist claim that was compatible with religious metaphysical assumptions. Particularly, James' position that physical vitality determined psychological disposition thereby infusing mental life with a purposive, voluntarist

impulse yielded ethical implications pleasing to pastors. So much so, that it was said James' famous chapter on habits was preached in a thousand pulpits (Holifield, 1983, pp.186-192).

Elwood Worcester, Rector of Emmanuel Church in Boston, was the first to take practical steps to integrate the new psychology into the cure of souls (Stokes, 1985, pp.19-36). Worcester was motivated by a growing sense of the inadequacy of the Social Gospel; despite the significant social involvement of the church he sensed that it had lost its influence in the daily lives of Americans, and he was alarmed by what he termed a wholesale defection to Christian Science. In an attempt to recover the healing ministry of Christ, Worcester announced in an evening lecture at the Emmanuel Church that he, his associate, and two psychiatrists would be available for consultation the next day at the parish house. When 198 people responded, the Emmanuel Movement was launched. The popularization of this movement through articles in magazines such as Good Housekeeping and Ladies Home Journal helped to introduce the new psychology into the church.

Ensuing developments in pastoral care had their roots in three trends: a post World War I psychological revival, changes in the structure of the economy, and the modernist agenda of cultural accommodation. The use of psychological screening for soldiers in World War 1 was America's first

mass exposure to psychological methods. This, along with fascination for the Freudian notions of the unconscious, generated such interest in and enthusiasm for psychology that the decade following the first World War has been called "The Period of the Psyche" (Holifield, 1983, pp.210-221). This enthusiasm was fueled by the increased industrialization of the American economy with its accompanying corporate bureaucracy. The creation of a good personality and skill in working with others became of paramount importance and psychology was seen as the scientific means to happiness, wisdom and success. Pastoral theologians reflecting the experience of their era sought to incorporate the insights of this psychology for success into pastoral care. Attention shifted from institutional reform through the Social Gospel to individual fulfillment through applied psychology. Harry Emerson Fosdick, founding pastor of the Riverside Church in New York, exemplified this trend (Holifield, 1983, pp.219-221). Claiming that the Social Gospel had convinced him that the way to better institutions was through better individuals, Fosdick placed personal counseling at the heart of his ministry and encouraged other pastors to recognize that preaching offered an opportunity for personal counseling on a group scale and to therefore structure their sermons in the image of the counseling session (Fosdick, 1960).

Another innovation of the progressive movement, clinical pastoral education, was patterned after the development of clinical training in law and medicine and was seen as a means of enhancing the professional esteem of the clergy as well as offering more effective professional training through the use of scientific methods in the study of religious experience. Richard Cabot was the ideological father of the movement, while Anton Boisen, who had learned from Cabot the value of case study, launched the first effort (Holifield, 1983, pp.231-234). Boisen, through his own experience of mental illness and the insight he gained from Freudian concepts, developed the theory that mental illness is the result of inner conflict, much like that described in Romans 7. As such it is an encounter with God that contains the potential for spiritual growth and integration of personality, a view he articulated in Exploration of the Inner World. Boisen was convinced that if pastors were to be able to meet the challenges modernity presented to the cure of souls, scientific methods must be applied to their training in the form of experience with "living human documents." With Cabot's support, he initiated the first program for the clinical training of theological students in June, 1925 at Worcester State Hospital. In September of that year, Cabot drew national attention to the effort with the publication of an article "A Plea for a Clinical Year in the Course of Theological

Study." In 1930 they joined others in forming the Council for Clinical Training of Theological Students (Stokes, 1985, pp.51-54). Though originally intended as professional education for parish pastors, clinical pastoral education developed in such a way that it is viewed primarily as training for chaplains who function in institutional settings.

Questions as to the nature of appropriate care quickly surfaced in the new movement. Whereas Boisen's psychology of religion was an idiosyncratic mixture of psychoanalytic theory and Jamesian voluntarism, Cabot understood the cure of souls to be largely a matter of ethical appeal to the will (Holifield, 1983, pp.235-243). The Art of Ministering to the Sick, published by Cabot and Russell Dicks in 1936, expressed this in terms of the metaphor of the "growing edge." Within each person is a purposeful healing force; it is the minister's responsibility to discover and cultivate this growing edge through directive listening. The issue of psychodynamic orientation issued in a split, first between Boisen and Cabot, and then between Boisen's successor as director of the CCTTS and Cabot. This ideological polarization resulted in two groups committed to clinical pastoral education: the New York based Council for Clinical Training which embraced psychodynamic theory and the Boston based Institute for Pastoral Care which embodied Cabot's methodology of ethical formation (Stokes, 1985, pp.52-53).

The New York group, influenced by the psychoanalytic movement, became the dominant voice in shaping the direction that pastoral care would take for the next three decades. Leaders of the Council for Clinical Training shifted their focus in the cure of souls from ethical formation to liberation through insight (Holifield, 1983, pp.244-258). Informed by the Freudian dynamic psychology, they developed "a view of persons in which ethical statements were often perceived as destructive to the embattled ego and were thought to increase suffering and neuroses rather than promote healing" (Poling, 1984, p.107). In short, they concluded that much mental disturbance could be traced to moralism. Indeed, Paul Tillich, who reinterpreted traditional theological concepts in psychological terms and thereby provided theoretical underpinning for the movement, wrote:

> The tremendous growth of mental disturbances on Protestant soil is at least partly caused by the legalistic distortion of the Protestant message...when the disturbed theological students, together with many other disturbed active members of the congregations sought help, not from a minister, but a psychoanalyst, the churches began to realize that something was wrong in their preaching and teaching (Tillich, 1960, p.20).

The result was a revolt against moralism within the Council for Clinical Training, a rebellion fueled by social critics such as Erich Fromm, Escape from Freedom (1941) and Man for Himself (1947), Karen Horney, Neurotic Personality of Our Time (1937), and Harry Stack Sullivan, Conceptions of Modern

Psychiatry (1947), who decried modern culture as competitive, coercive and inimical to the mental health of those who live in it.

As did the first world war, the second brought about a dramatic upsurge of interest in psychology. Wartime exposure to the mystique of psychology and postwar economic developments which linked economic success and social status with skill in personal relationships led, once again, to the psychologizing of society. This, coupled with the revolt against moralism, was the context for the development of post World War II modalities of pastoral care. The emerging pastoral psychology movement sought to rectify the problems of previous forms of pastoral care by providing methods which avoided the authoritarian moralism of past generations and were rooted in psychological knowledge, while still being accessible to the parish pastor. Holifield acknowledges four pastoral theologians as providing primary intellectual leadership in this movement: Seward Hiltner, Pastoral Counseling (1949), The Counselor in Counseling (1950), Preface to Pastoral Theology (1958); Carroll Wise, Pastoral Counseling: Its Theory and Practice (1951), Psychiatry and the Bible (1956); Wayne Oates, The Christian Pastor (1951), The Bible in Pastoral Care (1953); and Paul Johnson, Psychology of Pastoral Care (1953). Gordon Allport contributed to the climate in which the movement flourished with his sympathetic treatment of religion, after almost two

decades in which scholarly work on religion was taboo because of its irrelevance to the scientific quest, and a move toward humanistic psychology in The Individual and His Religion. Albert Outler and David E. Roberts also served the rapprochement of theology and psychotherapy with their work respectively in Psychotherapy and the Christian Message and Psychotherapy and A Christian View of Man.

Hiltner, more than any other individual, emerged as the leading spokesperson for the pastoral psychology movement, this attempt to integrate psychological insight into the cure of souls. He was the first to coin the term "pastoral counseling," and he provided the paradigmatic methodology for post World War II pastoral care with his "eductive" approach. A central concern for Hiltner was eliminating moralism in pastoral care because, in his view, moral legalism was the primary impediment to moral development. For Hiltner, this moral legalism was the theological doctrine of "bondage to the law," an attitude of rigidity and demand for conformity rather than adherence to a particular ethical position. This "law conscience" is inimical to moral action because it prevents the necessary clarification and choice involved in development of ethical maturity by replacing it with moral judgment. Such legalism only serves to reinforce the unfreedom and psychic compulsion that led the person to seek help in the first place (Lyon, 1984). Hiltner's solution was to draw "more

and more of the solution to the situation out of the creative potentialities of the person needing help" through eductive counseling (Hiltner, 1949, p.97). In the eductive modality the counselor seeks to understand, accept, clarify and consolidate, while avoiding such common blunders as diverting, coercing and moralizing.

The Rogerian influence on Hiltner's method is obvious. Hiltner acknowledged that his approach was in the same direction as Roger's, yet differentiated between them in that the unique role of the pastoral counselor dictated flexibililty of method to allow for the pastor's precounseling work, that is, pastoral work with troubled individuals who had not yet come to the point of being able to seek or use pastoral counseling (Holifield, 1983, p.304; Hiltner, 1949, pp.253-255). Nevertheless, Roger's theory of psychotherapy was compelling to pastoral theologians for both pragmatic and philosophical reasons.

Pragmatically, counselors could be schooled in Roger's method in a comparatively brief period of time such as is available in seminary curriculum, and it is a relatively safe method for counselors with little training. In contrast, a Freudian approach requires extensive personal psychoanalysis as well as theoretical understanding of the dynamics of intrapsychic conflict and involves the counselor in the interpretation of such psychodynamics rather than the creation of an atmosphere of unconditional positive regard

as espoused by Rogers. Whereas the responsibility of the Rogerian counselor is to provide a context that facilitates the self-actualization of the client, other depth psychology approaches are understood as the application of scientific understanding to the sources of peoples' problems and therefore require much more thorough training (Stokes, 1985, pp.53-54).

Philosophically, the Rogerian optimistic image of the self as capable of growth was appealing to Protestant liberals with their distaste for moralism; and for those whose anthropology was more pessimistic than his, Rogers' notions of acceptance and non-judging positive regard evoked biblical images of grace and unconditional love. So much so that Tillich claimed that the:

> pattern of a non-judging and non-directing acceptance of the mentally disturbed became the model for Christian counseling, and through counseling for teaching, and through teaching, for theological inquiry. Present theology can say again that acceptance by God of him who is not able to accept himself is the center of the Christian message and the theological foundation of preaching and pastoral counseling (Tillich, 1960, p.20).

In evaluating the impact of Rogerian psychotherapy on the cure of souls, Clebsch and Jaekle asserted that Roger's type of therapuetic counseling exerted an almost normative influence upon pastoral counseling in American Protestant circles in that its methodology became the standard by which

effective pastoral care was judged (Clebsch and Jaekle, 1964, p.9).

If Carl Rogers provided the methodology for pastoral psychotherapy, Paul Tillich provided the theology. Faced with the early post-war interest in the therapeutic potential of psychology, Hiltner urged ministers to recognize that unless they developed skills in human relations and pastoral counseling they would find themselves not only unable, but also without the opportunity to help troubled people in their congregations because their parishioners would seek out other sources of help. The psychological intellectual climate of the day presented pastors with the challenge of demonstrating that theology and psychology were compatible (Hiltner, 1959). As did many other thinkers in the 1930's confronted with Freudian thought, Tillich grappled with the place of psychoanalytic insights in his philosophical system (Stokes, 1985, p.118). His systematic method of correlation, in which the philosophical or psychological analysis of existence and the questions it raised shaped the form of the answer presented by the theologian, translated theological notions, such as sin, grace and justification, into the psychological idiom of twentieth century thought (Holifield, 1983, p.329). In memoriam of Tillich, Wayne Oates wrote that Tillich's translation of theological concepts into psychological vocabulary "bridged the gap between the disciplined naivete

of Biblical images of man and the secular images of man set forth by contemporary psychology and psychotherapy" (Oates, 1968, p.12). He went on to say:

> Pastoral psychology by definition is the application of the empirical data of the field of psychology to the functional responsibilities of the pastor. Tillich's contribution to the field of pastoral psychology, in conclusion, consists of a theological "raison d'etre" for the unique function of the minister, as such (Oates, 1968, p.16).

The postwar wedding of psychology and religion produced a veritable baby boom of literature, research and activity in the field of pastoral psychology. The Academy of Religion and Mental Health was founded in 1954 and began to sponsor symposia on research in psychology and religion. Bibliographies reflect an outpouring of clinical and research literature: Albert and Kluckhohn (1959) show 1991 items on values and ethics; Meissner (1961) lists 2905 entries on religion and psychology; the National Institute of Mental Health bibliography covering 1960-1964 includes 1000 items on religion and mental health (Pattison, 1978). Journals proliferated; among them were the Journal of Pastoral Care, Pastoral Psychology, The Journal of Pastoral Counseling, Journal of Religion and Health, Cura Animarum, Journal of Psychology and Theology, Journal of Psychology and Christianity, and Pastoral Psychotherapy.

Another significant development in this period was the emergence of pastoral counseling as a specialty. In a

context of unparalleled interest in mental health and the general trend toward specialization in society due to the increased complexity of professional knowledge, Howard Clinebell (1964) claimed that it was inevitable that some clergymen would follow the model of secular psychotherapists and devote themselves exclusively to pastoral counseling. In 1963 The American Association of Pastoral Counselors was established, to be followed by the American Association of Clinical Pastoral Education and The Association of Mental Health Chaplains. Whereas the AAPC was comprised of pastoral counseling specialists and adopted the psychoanalytic model in its training standards, the AACPE emphasized the pastoral role of chaplains in organizational contexts and the AMHC organized clergy working as chaplains specifically in mental hospitals and later in community mental health centers.

This was an entirely new dynamic in the history of pastoral care. Throughout Christian history, *cura animarum* was the domain of the ordained clergy functioning within the context of the church. In the last half of the twentieth century, practitioners of the cure of souls began to present certification from a variety of organizations and to function in a multiplicity of contexts. The changes were not limited to context but affected the content of the cure of souls as well. Historical survey has shown that moral guidance has been a significant, if not predominant,

dimension of pastoral care in every age until the modern era. Faced with the psychologization of society, physicians of the soul reinterpreted their practice in the prevailing idiom such that pastoral care practically came to mean pastoral counseling qua psychotherapy (Holifield, 1983, pp.349-356). Borrowing from the insights and techniques of psychotherapy, especially Rogerian client-centered counseling, pastoral counseling replaced ethical guidance with an eductive model in which unconditional positive regard was designed to provide counselees with freedom from moral expectations and an opportunity to marshal their own capacities for growth. "Psychology swept across pastoral care and reshaped it from moral guidance into self-exploration and self-discovery" (Poling, 1984a, p.107).

The result of these changes was an identity crisis in pastoral care. Clebsch and Jaekle wrote, "The predicaments, fashions, and experimentations of Christian pastoral care in our century all indicate that ours is a transitional period, characterized by confusion as to the nature, purpose, and functions of pastoral care" (Clebsch and Jaekle, 1964, pp.73-74). As the methodology and ideology of pastoral caregiving became increasingly indistinguishable from accepted therapuetic practice, questions emerged: "What is distinctive about pastoral counseling?" "In what way is he (a pastor) different from other counselors?" (Oates, 1964, p.7). "What does "pastoral" mean in such a phrase as

"pastoral counseling center"?" (Hiltner, 1964, p.16). Holifield's (1983, p.355) analysis of the situation was that, in an era of individual religious doubt and self-doubt within religious institutions, pastoral counseling gave way to the all but irresistible temptation to allow the psychological to overwhelm the religious tradition. In an appeal to the pastoral ministry to operate out of its distinctive tradition, Clebsch and Jaekle asserted that by imitating other helping professions pastors became "incompetent amateurs" and "inexpert apprentices in arts properly belonging to others" (Clebsch and Jaekle, 1964, p.68). O. Hobart Mowrer's Crisis in Psychiatry and Religion states it somewhat more polemically:

> Has evangelical religion sold its birthright for a mess of psychological pottage? In attempting to rectify their disastrous early neglect of psychopathology, have the churches and seminaries assimilated a viewpoint and value system more destructive and deadly than the evil they were attempting to eliminate? As a psychologist and churchman, I believe the answer to these questions is in the affirmative (Mowrer, 1961, p.60).

As pastoral theologians sought to identify the distinctiveness of pastoral counseling, the search focused on "context." In The Context of Pastoral Counseling pp.218-220, Hiltner and an associate, Lowell Colston, suggested that the ecclesiastical setting was the distinctive element of pastoral counseling. They offered counseling to a group of clients in a counseling center and to another group in a local church and found that the clients seen in the church

made better progress than those seen in the counseling center. Their conclusion was that the physical setting and the expectations associated with it comprises a significant dimension of the distinctiveness of pastoral counseling. Oates echoed this perspective, Protestant Pastoral Counseling p.43, with the assertion that all pastoral counseling should take place in a church building.

Others, Paul Johnson (1962), Carroll Wise (1966) and Howard Clinebell (1966) among them, offered an "interpersonal" context as the unique dimension of pastoral counseling. Drawing upon the perspectives of Karen Horney and Harry Stack Sullivan, Clinebell proposed a relational approach to the problems presented in pastoral counseling, the goal of which would be positive change through improved relationships rather than intrapsychic change. Clinebell identified his purpose as a shift away from a Rogerian dynamic model to what he termed a "relationship-centered counseling model." He wrote: "It is the purpose of this book to offer a revised model for pastoral counseling based not on insight-oriented, uncovering psychotherapy, but on relational, supportive, ego-adaptive, reality-oriented approaches therapy" (Clinebell,1966, p.23). Browning identifies the publication of Basic Types of Pastoral Counseling by Clinebell, with its delineation of Marriage, Family, Group, Supportive, Crisis, Referral, and Confrontational Counseling, as the signal of a new stage of

development in contemporary pastoral care (Browning, 1976, p.77-78). A 1975 survey of recommended readings by theological schools in the field of pastoral care and counseling showed Clinebell's to be the book most frequently used in the training of pastoral caregivers (Haugk and Hong, 1975).

Don Browning, the author of The Moral Context of Pastoral Care and Religious Ethics and Pastoral Care, became the leading spokesman for those who identify commitment to a normative ethic as the distinctive theological context of pastoral care and counseling. Thomas Oden, Kerygma and Counseling and Contemporary Theology and Psychotherapy, Charles Gerkin, James Gustafson, and James Poling are proponents of this perspective as well.

Recently, concern to rediscover the distinctive theological basis of pastoral theology has resulted in a new type of religious counseling. Clinical and counseling psychologists trained in secular programs have attempted to integrate their religious faith and clinical practice. Simultaneously, graduate programs have been developed that both meet American Psychological Association accreditation requirements and provide training in religious content. For the most part, these developments have taken place amongst theologically conservative Christians. J. D. Carter and Bruce Narramore, The Integration of Psychology and Theology, L. J. Crabb, Effective Biblical Counseling, Gary Collins,

Helping People Grow: Practical Approaches to Christian Counseling, and J. H. Ellens, God's Grace and Human Health, are among those who have attempted this integration of theology and psychology.

Yet another development has been the emergence of lay counseling. In arguing against the specialist role of pastoral counseling, Oates contended that pastoral counseling was appropriately a function of the traditional clergy within the context of the church. He predicted that in order to fulfill this function pastors would utilize lay resources:

> He will begin to build a community of other helping persons about him as "corpsmen." He will draw upon the resources of other counselors he has helped. The next thing he knows, he will realize that he needs the church in order to be a counselor in the pastoral meaning of the term (Oates, 1964, p.7).

Oates' prediction came to pass in the decade of the eighties with the development and maturation of the lay Christian counseling movement. Reminiscent of the mutual edification and fraternal correction of early Christianity and the Reformation era, this effort has received impetus from the work of Jay Adams, The Christian Counselor's Manual, Gary Collins, Innovative Approaches to Counseling, and Siang-Yang Tan, Lay Counseling: Equipping Christians for a Helping Ministry.

Consideration of the history of the cure of souls clearly reveals that the twentieth century has presented the

ancient art of *cura animarum* with unique and unprecedented challenges. The technological innovations implicit within industrialization and concomitant rapid social change have challenged the normative order of society and given rise to a pluralism in which value statements are regarded as expression of preference. Psychodynamic theory coupled with the bureaucratization of society resulted in a revolt against moralism which regards the traditional function of moral guidance, historically central to pastoral care, destructive to individual development rather than productive of wholeness and healing. The result has been a bifurcation of ethics and pastoral care, a methodology for counseling in which value statements are inappropriate, and a proliferation of pastoral caregivers functioning in a variety of contexts. These developments have posed numerous and difficult questions for the practice of pastoral care and specifically, pastoral counseling: Is there a place for moral guidance and ethical statements in counseling and psychotherapy? Does a pastoral counselor have an appropriate role in a pluralistic society? Who qualifies as a pastor counselor? What is it that makes pastoral counseling "pastoral?" It is to these questions that we turn our attention.

CHAPTER II

VALUES AND PASTORAL COUNSELING

The twentieth-century revolution against authoritarian religion and the concomitant rise of pluralism resulted in a shift in the focus of pastoral care from salvation to self-realization. These developments created questions concerning both the role of moral guidance in counseling and, because this function has historically been a significant dimension of pastoral care, the role of pastoral counseling in a pluralistic society. Confronted with this challenge, pastoral counseling, as a movement, responded from the modernist impulse of cultural accommodation and, in the process, exacerbated rather than eliminated the identity crisis it was experiencing. Counselor and client alike began to ask "What is distinctive or 'pastoral' about pastoral counseling?" Perry London, in Modes and Morals of Psychotherapy, succinctly summarizes the situation:

> Science is our sacred cow, and psychotherapists, with their apparent roots in scientific knowledge and method, can lay their claims to preach whatever codes they do, not merely on the grounds

> of great truth,... but also on the apparent facts that the clergy have tended to abdicate their claim to moral competence in favor of psychology and the congregations have, by and large, resigned from their clergy (London, 1964, p.172).

I will proceed by demonstrating that the origin of the dilemma facing the discipline of pastoral counseling is found in uncritical acceptance of the psychological modality with its commitment to the positivistic methodology of empirical science. I will contend that the promise of a value-free science and, especially, a value-free psychotherapy is illusory; there is and, moreover, needs to be a value dimension in helping activity. It is precisely this dimension, with its consideration of religious values, that defines the role of pastoral counseling and its respective practitioners in a pluralistic society.

Psychology and Science

Psychology, as a discipline, developed in the intellectual and academic milieu which fostered the emergence of the natural sciences. The seventeenth through the nineteenth centuries, characterized by rise of secularism and technology, provided the context for the formation of both the natural and behavioral sciences. Wilhelm Wundt inaugurated the era of "scientific psychology" with the establishment of the first psychology laboratory in 1879. Van Leeuwen observes that:

> ...mid nineteenth-century psychology eagerly attached itself to the approach and methods of the natural sciences, reasoning that their almost magical power to predict and control the ways of inanimate objects and nonhuman organisms would also supply a key to the complete understanding and management of human beings (Van Leeuwen, 1982, p.16).

Beginning with Wundt, through William James, G. Stanley Hall, Sigmund Freud and J. B. Watson, among others, psychology emerged as an academic discipline distinct from philosophy and aligned itself with physiology, thus adopting empiricism as a methodology for studying mental processes.

C. Stephen Evans argues in Preserving the Person, that the pioneers of modern psychology attempted to make the discipline a science by viewing man as "homo natura," a natural creature whose behavior can be explained totally by scientific principles. He quotes Freud as stating in Project for a Scientific Psychology that his goal was "to furnish us with a psychology which shall be a natural science...to represent psychical processes as quantitatively determined states of specifiable material particles" (Evans, 1977, p.43). J. B. Watson, whose legacy of behaviorism remains a force in psychology, wrote:

> Human beings do not want to class themselves with other animals. They are willing to admit that they are animals, but "something else in addition." It is this "something else" that causes the trouble. In this "something else" is bound up everything that is classed as religion, the life hereafter, morals, love of children, parents, country and the like. The raw fact that you, as a psychologist, if you are to remain scientific, must describe the behavior of man in no other terms than those you would use in

> describing the behavior of the ox you slaughter, drove and still drives many timid souls away from behaviorism (Watson, 1930, p.v).

Granted, Watson's statement represents somewhat of an extreme, but the point stands nonetheless, that those who shaped psychology as a discipline accepted, in an effort to be "scientific," a methodology which focuses on empirical knowledge, efficient causality of a mechanistic sort, and measurable, quantifiable observations. This commitment to positivistic methodology removed from the purview of psychology consideration of that "something else," including values and morals.

The paradigmatic commitment to the methodology and correlated metaphysical assumptions of natural science is reflected in the claim that "the principles and basic methods of studying normal and abnormal behavior in individuals and in populations, in clinical practice, as well as under experimental conditions are the same as in other naturalistic sciences" (Macklin, 1972, p.358). The medical model of conceptualizing and treating mental illness, which is predominant in the contemporary mental health field, is derivative of this perspective. Its emphasis on linear causation, bio-chemical basis for psychological aberration and disease entity-illness approach identifies it as an expression of the methodology and metaphysics of natural science. S. S. Kety asserts that "the medical model is an evolving intellectual process,

consonant with the scientific method" (Kety, 1974, p.959). Sounding very much like Freud and Watson, Gorenstein reinforces this perspective with the observation that:

> Those who defend the illness model of mental disorders do so principally in the interest of preserving an enlightened scientific approach to the research and treatment of deviant behavior (Gorenstein, 1984, p.54).

In some respects, this methodological commitment has served the discipline of psychology well. Considering the application of a similar commitment to the field of sociology, Alvin Gouldner argues that one positive consequence of the value-free principle was a temporary suspension of the moralizing reflex within society so that sociology, psychology, etc. had a "breathing space" within which to develop (Gouldner, 1962). Moreover, much of the esteem and acceptance that psychology as a discipline enjoys can be traced to its identification with science. In a world where science is master, the "behavioral scientist" is seen as the source of knowledge and skill regarding interpersonal and intrapersonal difficulties. "Much of the psychotherapist's appeal seems to derive from his claim to be an expert whose knowledge has been scientifically validated" (Lowe, 1969, p.14).

However, psychology's acceptance of the value-free positivism of empirical science is problematic in two respects, philosophically and pragmatically. Philosophically, the assumption that psychology in general

and psychotherapy in particular are value-free, scientifically based clinical arts has become less and less plausible (Erickson, 1989). Pragmatically, the positivistic approach has produced much less than it has promised.

Psychology and Values

> This is an account of a myth created by and about a magnificent minotaur named Max - Max Weber, to be exact; his myth was that social science should and could be value-free. The lair of this minotaur, although reached only by a labyrinthian logic and visited only by a few who never return, is still regarded by many...as a holy place (Gouldner, 1962, p.199).

In this compelling essay, "Anti-Minotaur: The Myth of a Value-Free Sociology," Gouldner contends that the notion of a value-free behavioral science is not so much untrue as it is absurd. He acknowledges that the argument for it, especially as presented by Weber regarding the field of sociology, is logically unassailable yet likens it to Berkeley's argument for solipsism in that it appeals to reason but ignores experience. He goes on to allege that this myth was accepted as normative for the behavioral sciences because it was useful to those who accepted it.

As we have seen, the ideal of value-free science has been useful to psychology, but, like the minotaur it does not fit the facts of human experience. Despite the discipline's attempt to model itself after the positivistic methodology of empirical science and offer a psychology devoid of a moral dimension, Allen E. Bergin argues that a

value-free approach to psychology and psychotherapy is impossible (Bergin, 1980). Perhaps, in part, this is attributable to the fact that a value-free natural science is as much of a myth as a value-free behavioral science.

The virtue of moral detachment in scientific investigation received its greatest shock with the explosion of the first atomic bomb (London, 1964, p.177). The reality of nuclear devastation raised grave doubt about the claim that technological advance through empirical science is without a value dimension. Williamson cites Taylor's definition of a value as an idea or principle which guides action to show that every action or choice is based upon implicit or explicit acceptance of values. From this he argues that even the "most rigorously disciplined scientist" is unable to function independently of his values despite his attempts to do so in order to maintain scientific objectivity (Williamson, 1958). Smith demonstrates the multipliicity of ways that values influence the scientific process:

> The claim to a value-free science when it goes beyond insistence on a disciplined regard for fact whether or not it accords with our wishes, only obscures the value elements in the choice of problem, of research setting, of conceptual framework, in the decision as to when to rest with negative findings, when results are reportable, and so on endlessly (Smith, 1954, p.515).

Thomas Kuhn's provocative analysis of the history of science, The Structure of Scientific Revolutions,

demonstrated conclusively that natural science is an intuitive and value-laden cultural form.

If natural scientists, dealing with questions of "what is," find it impossible to escape the influence of their moral principles and value judgments, how can behavioral scientists, dealing with questions of "what should be," realistically expect or be expected to do so? Thomas Szasz was one of the first to challenge the purported positivistic orientation of psychology. In The Myth of Mental Illness, he wrote:

> Anything that people do - in contrast to things that happen to them - takes place in a context of value....The discipline of medicine, both as a pure science (for example, research) and as a technology (for example, therapy), contains many ethical considerations and judgments. Unfortunately, these are often denied, minimized, or merely kept out of focus; for the ideal of the medical profession as well as of the people whom it serves seems to be having a system of medicine (allegedly) free of ethical value....The practice of medicine is intimately tied to ethics; and the first thing that we must do, it seems to me, is to try to make this clear and explicit....Psychiatry, I submit, is very much more intimately tied to problems of ethics than is medicine....Problems in human relations can be analyzed, interpreted, and given meaning only within given social and ethical contexts. Accordingly, it does make a difference - arguments to the contrary notwithstanding - what the psychiatrist's socioethical orientations happen to be; for these will influence his ideas on what is wrong with the patient, what deserves comment or interpretation, in what possible directions change might be desirable, and so forth. (Szasz, 1982, pp.23-24).

The fact that psychology is an applied field directed toward practical goals makes the value dimension an inevitable and pervasive part of the discipline.

Ruth Macklin delineates five different levels at which values are embedded in psychotherapeutic theory and practice. From general to specific, they are: 1) value considerations involved in definition of the basic concepts of mental health and mental illness, normal and abnormal behavior; 2) values implicit in the model according to which mental disorders are classified and treated; 3) values underlying various psychotherapeutic theories; 4) values actually held by the therapist; and 5) values actually held by the client (Macklin, 1973). This pervasiveness of values in the psychotherapeutic process is the basis for the claims that "every aspect of psychotherapy presupposes some implicit moral doctrine" (London, 1964, p.6) and that psychotherapy is, in actuality, applied ethics (Breggin, 1971).

The very nature of the therapeutic interaction is such that the psychological practitioner is cast in the role of a moral agent in the life of his or her clients. The therapist becomes a moral agent as the client interprets his or her response to the moral concerns he or she, the client, expresses (London, 1964). From its earliest Freudian roots, there has been all but universal agreement that the counselor-client relationship is central to the efficacy of the therapeutic interaction. Indeed, some have suggested that this function of common human interaction may be the very core of therapuetic change rather than psychological

theory or psychotherapeutic technique (Bergin, 1980; Worthington, 1986; Wyatt and Johnson, 1990). The highly personal climate of the counseling relationship is incongruous with the traditional stance that the therapist should maintain a posture of neutrality, striving to keep the client from being influenced by and even knowing his beliefs. If the therapist is to build an interpersonal relationship of trust and openness which facilitates growth and change, it is inevitable that dimensions of the therapist's belief system would become apparent in the interaction. Williamson contends:

> I cannot conceive that effacement is ever achieved by a structured personality, since individuality is an inherent part of personality. Therefore, it seems evident that at least some dimensions of the value orientation and commitment of the counselor would be perceived by the counselee and, thereby, would be functionally of some influence in the counseling relationship (Williamson, 1958, p.520).

Data indicates that this is the case despite efforts otherwise. Carl Rogers, father of the twentieth-century non-directive approach, espoused a therapeutic attitude of "unconditional positive regard." Yet when E. J. Murray applied his "content-analysis method" for studying psychotherapy to Roger's verbatim case study of eight hours of therapy with Herbert Bryan, Murray discovered ninety-two statements of therapist approval and sixty-five statements of therapist disapproval. Murray demonstrated that Rogers consistently approved certain categories of verbal behavior such as independence and dependence anxiety, while

disapproving of others, i.e. independence anxiety, intellectual defenses and sex. As might be expected, client verbal behavior in the therapist approved categories increased as the therapy progressed while it decreased in the disapproved categories. Murray's conclusion,

> The therapist in the case of Mr. Bryan seemed to influence the verbal behavior of the patient by subtly approving independence and self-assertion and mildly disapproving intellectual defenses and discussion of sexual problems. The therapist appeared to play an important role in the major decision of the patient (Murray, 1956, p.15),

corroborates London's claim that clients' moral decisions are informed, in part, by their interpretation of their therapists' response to their moral concerns. A similar study conducted by Charles Truax, a decade later, confirmed the conclusion that Rogers responded differentially to different patient behaviors. Consideration of these studies prompted Bergin to observe that Rogers' "values significantly regulated the structure and content of therapuetic sessions as well as their outcomes. If a person who intends to be nondirective cannot be, then it is likely that the rest of us cannot either" (Bergin, 1980, p.97).

If, perchance, the individual practitioner should somehow satisfy the seemingly impossible Rogerian ideal and avoid the imposition of personal values into the therapeutic process, he would still be cast in the role of moral agent by virtue of his professional associations (London, 1964). Professional societies which certify practitioners generally

have published codes of ethical conduct which are explicit statements of values. C. Marshall Lowe offers, as an example, a pronouncement from the American Psychological Association's 1953 statement of "Ethical Standards of Psychologists:"

> The psychologist's ultimate allegiance is to society and his professional behavior should demonstrate an awareness of his social responsibilities (Lowe, 1959, p.689).

Lowe's premise in the essay "Value Orientations - An Ethical Dilemma" is that every psychological theory and intervention technique is inextricably interwoven with a value orientation. The particular orientation demonstrated by the APA statement is identified as "culturalism," in which the supreme value is loyalty to the culture from which one is derived. The point is that when a therapist complies with the ethical code of his society at critical junctures in therapy he is serving an explicit moral agency. This dynamic is also present for those psychologists who function in institutional settings. For example, can psychologists working in educational institutions meet their professional obligations without adherence to an underlying philosophy of education? (Williamson, 1958). Is not the activity of the industrial psychologist ultimately in service to the profit motivation of his employer? (Lowe, 1959).

This inevitable and pervasive introduction of values into the therapeutic process gave rise to Bergin's

statement, "A value-free approach is impossible," and the somewhat more pointed observation:

> The concept of mental health is little more than a therapist's or a personality theorist's description of the ideal person and in large measure is therefore a projection of the therapist's own highly personal values (Lowe, 1969, p.50).

Dorothea and Benjamin Braginsky make the point, and defend it rather convincingly, that theoretical constructions of mental illness and practical application of these notions are projections of personal values, citing studies by Steven Lee and Carol Efrom which demonstrate that psychiatric diagnosis is affected by the socio-economic status of the patient. In both studies, patients described as "lower class" were evaluated to be extremely psychotic with a very poor prognosis, whereas patients described as "upper class" received a more favorable diagnosis and prognosis. In an experiment of their own, the Braginskys discovered a spectacular change in the diagnostician's perception of a patient related to that patient's perception of mental health practitioners. A "patient" judged to be seriously mentally disturbed "suddenly got well" when he expressed views regarding the role of mental health professionals in a positive light:

> Mysteriously, there was a complete remission of his symptoms, and a new-found normality. Very simply, the cure consisted of telling the doctors, social workers, nurses and aides that they are kind, helpful, competent, and, in general, terrific human beings (Braginsky and Braginsky, 1973, p.142).

The Braginskys conclude that, in contemporary culture, the psychologist functions as the high priest, preserving the dominant values of society. Basically, their work confirms the assertion that every aspect of the psychotherapeutic process implies some value judgment and that client selection as well as therapeutic aim and method are determined by the values of the practitioner.

Clearly, the psychologist has been called upon to play a role much different than that envisioned by Wilhelm Wundt, one that calls him or her out of the laboratory and demands that he or she divest himself or herself of the robes of scientific impartiality. In a world where science is master, the behavioral scientist has become the source of moral authority and is fulfilling many of the professional functions previously performed by the priest or minister. This is, in fact, a role envisioned by Freud:

> Indeed, the words, "secular pastoral worker," might well serve as a general formula for describing the function which the analyst, whether he is a doctor or a layman, has to perform in his relation to the public...We do not seek to bring him relief by receiving him into the Catholic, Protestant or socialist community. We seek rather to enrich him from his own internal sources...Such activity as this is pastoral work in the best sense of the words (Freud, 1950, pp.108-109).

Whether the title is "secular pastoral worker" as per Freud or "Secular Priest" as per London (1964, pp.160-166) and Lowe (1964, pp.16-23), the function is the same. Since much of the authority traditionally invested in the church has devolved upon science, the therapist is called upon to

provide moral guidance in the name of science much as the clergy was called upon to do in the name of the church. The expectation is that the justification for the pronouncements of this priest of the scientific order will be rooted in the laboratory rather than revelation.

That psychologists and other behavioral science professionals are viewed as a resource for resolution of issues containing a value dimension is not an inappropriate expectation. In discussing the role of helping professions in Social Structure and Personality, pp. 265-277, Talcott Parsons delineates two dimensions involved in his definition of health and illness. The first of these, termed the "Situational Focus" by Parsons, deals with the problem of capacity for task and role performance within the individual and the problem of commitment to collectivities in regard to the larger society. The second, the "Normative Focus," pertains to the problem of commitments to values or morality in reference to the individual and to the problem of commitment to norms or legality when viewed in the larger social context. Thus health and illness have both a situational and a normative component, a task and a value dimension.

If a person subscribes to the normative dimension of a given social role but does not have the capacity to perform the task, that person is regarded as ill. If the person does not subscribe to the values of that role, regardless of

capacity or incapacity to perform the task, that person is regarded as deviant. Inasmuch as health, to Parsons, is primarily a matter of capacity to function within socially prescribed roles and those roles contain both task and value dimensions, the helping professions must of necessity deal with both. Furthermore, he indicates that successful resolution of the task dimension depends upon resolution of the value dimension:

> ...capacity can seldom if ever be improved without attempted clarification of what it is that the patient most fundamentally wants (Parsons, 1964, p.319).

Though Parsons argues for a structural differentiation within society in which legitimation of value commitments is the domain of the church and clergy while capacity for implementation of values is the role of psychiatry, in the absence of such a differentiation those who function within the helping professions find themselves faced with both dimensions.

The necessity of the value dimension is driven home by Don Browning's discussion of technological rationalization as the principal cultural commitment of Western society (Browning, 1976, pp.23-27). He defines technological rationalization as the application of modern methods of efficiency and scientific control to the improvement of the material standard of living. A technological society generates a diversity of occupational subgroups with divergent interests and goals resulting in pluralism. It

also gives rise to rapid social change which strains the normative order of the society; new inventions and institutions create challenges and questions which are not answered by the existing normative guidelines. Technological rationalization creates a demand for a perpetually revised, normative cultural order.

Not only is there a value dimension in psychology and the other helping professions, there needs to be one. Parsons' work demonstrates that the very structure of human personality requires clarification of value orientation as a basis for the capacity to function. Browning's analysis demonstrates the dynamics in contemporary culture which exacerbate this need. The very fact that, as secularism eroded confidence in the traditional moral arbiters, society ordained therapists as the secular priesthood demonstrates that people will have a voice that speaks with moral authority. The problem is that psychology has not provided what it promised - answers to questions about the meaning of life and how it can best be lived that are naturalistic and derived empirically rather than an expression of subjective value orientation. The white-coated aura of empirical objectivity created by psychology's commitment to positivistic methodology has served rather to cloak the introduction of very definitive metaphysical presuppositions into the therapeutic process and obscure the implications of these value orientations. Again, it is not the presence of

a value dimension in the helping professions that is problematic so much as the failure to acknowledge it. In the words of the Braginskys:

> What upsets us, and in our opinion jeopardizes the entire psychological enterprise, is that psychology should be closely bound up with any value system without its owning up to the fact (Braginsky and Braginsky, 1973, p.18).

The danger is that this image of scientific neutrality prevents psychology as a discipline, and individuals affected by it, from critically evaluating and making informed choices regarding value orientation. This is the note of warning sounded in the concluding comments of Macklin's survey and analysis of values in psychotherapy:

> There is no good reason to judge that the entrance of value considerations into psychotherapeutic theory and practice is pernicious or undesirable; what needs to be done is to clarify the multifarious ways in which this occurs. Theorists and clinicians alike need to examine with honesty their value assumptions and commitments with respect to their theoretical orientations, methodological approaches, and therapeutic judgments. Only then can the meta-value judgment be made concerning which explicit or implicit values are worth maintaining and which ought to be eschewed. The price paid by dogmatic adherence to scientific neutrality may be the erosion of those values most worth preserving (Macklin, 1973, p.149).

The price of dogmatic adherence to the illusion of scientific neutrality has indeed been erosion of a sense of meaning and value that is central to human experience. Inasmuch as psychology has been separate from philosophy for almost a century and has clearly established itself as an independent branch of empirical science, one expects

scientific answers to questions about human nature. Instead, the history of psychology as a discipline indicates that the positivistic methodology and metaphysical assumptions of naturalistic science are inadequate to accommodate the complex, multi-faceted phenomena of humanness. It is striking that the compilers of Human Behavior: An Inventory of Scientific Findings, a volume which catalogs 1,045 scientific findings about human behavior, would assess their work as follows:

> Indeed, as one reviews this set of findings, he may well be impressed by (a) striking omission. As one lives life or observes it around him, or within himself, or finds it in a work of art, he sees a richness that has somehow fallen through the present screen of the behavioral sciences. This book, for example, has rather little to say about the central human concerns: nobility, moral courage, ethical torments, the delicate relation of a father and a son or the marriage state, life's way of corrupting innocence, the rightness and wrongness of acts, evil, happiness, love and hate, death - even sex (Berelson and Steiner, 1964, pp.76-77).

Experience has shown that studying only those human concerns which are adaptable to the positivistic methodology of quantification, operationalization and manipulation results in a fragmented psychology lacking overall integration and attention to much that is uniquely human.

When the church, as the traditional authority in matters of morality, began to retreat in the late nineteenth century from the advances of technical scientific success, the scientifically-robed apparatus of psychotherapy rushed into the vacuum offering "a culture-free, value-free,

ideology-free cure for the human condition under the universalistic rubric of mental health" (Pattison, 1978a, p.13). However, this naturalistic system has provided only partial and limited explanations of isolated fragments of human life. Bergin contends psychology, shaped by mechanistic thought and ethical naturalism, has proven insufficient so that interest in it as a source of authority for human action is declining (Bergin, 1980). As we have seen, there have been value orientations implicit in every aspect of the development and practice of psychology. But, the very nature of these orientations, with their positivistic metaphysical assumptions, and the fact that neither the orientations nor their implications have been made explicit, have rendered psychology unable to provide an ontological grounding that gives meaning and purpose to life. Pattison observes that the optimism of late nineteenth century and early twentieth century scientific humanism has degenerated into despair and existential cynicism at the end of the twentieth century, a despair created by the realization that science cannot provide the certainty that it once promised. His analysis,

> The import of this change is the loss of any synthesizing and superordinant belief system which can evoke commitment and integration. The religious system of the west was disenfranchised, and now the scientific system has been likewise disenfranchised (Pattison, 1978a, pp.11-12),

supports the fact that the ontological underpinning of any belief system, be it religious or psychotherapeutic, is

essential to its relevance and efficacy.

Psychology and Religious Values

Survey of the development of psychology demonstrates not only that the value dimension is an inevitable and essential aspect of the cure of souls, but that this dimension entails consideration of religious values or a spiritual perspective. One no less eminent in the history of psychology than Carl Jung said as much:

> I should like to call attention to the following facts. During the past thirty years, people from all the civilized countries of the earth have consulted me. Many hundreds of patients have passed through my hands...Among all my patients in the second half of life - that is to say, over thirty-five - there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook. This of course has nothing whatever to do with a particular creed or membership of a church (Jung, 1932, p.334).

Bergin's observation is that people want and need something more (Bergin, 1980). The failure of organized religious systems, in the first half of the twentieth century, to meet the spiritual and social needs of people has been followed by the failure of secular approaches, in the second half of the twentieth century, to meet those same needs. The result has been a renewal of interest in spiritual phenomena. Tracing this development in the past few decades, Pattison

remarked:

> Psychiatry brought man from outer reality into himself and only himself, and left man there. Psychiatry as the science of the treatment of the mentally ill has become psychotherapy as the spiritual quest. But when psychiatry, qua psychotherapy, could not deliver on the spiritual quest it has turned in retreat to its biological base and modern man has turned from the psychotherapist to the exorcist (Pattison, 1978, p.12).

It is ironic that in the 1970's and 1980's, psychology became more and more biological as society became more and more metaphysical. Pattison argues that the failure of the naturalistic system of psychotherapy to provide meaning paved the way for the resurgence of supernatural belief systems and, particularly, for the re-emergence of demonology and exorcism. Edward Stein's pointed observation is that while many ministers nowadays are embarrassed by prayer and the spiritual dimension it entails, the new generation is not and is eager for transcendence:

> If they cannot get it from Presbyterians and Methodists, they will get it from Jesus Freaks, from Hare Krishna or Zen. One can hear them saying: "If your God is dead, then 'by God,' we'll find a live one." (Stein, 1974, p.102).

The positive dimension of this has been the publication of a number of thoughtful attempts to restore a spiritual perspective to the psychological enterprise (Collins, 1980; Crabb, 1977; Evans, 1977; Van Leeuwen, 1982). Even Carl Rogers, whose entire therapeutic methodology is predicated on the naturalistic assumption that all the resources

necessary for growth and change are within the individual, acknowledged the need to consider the spiritual dimension in psychotherapy. In an article entitled "Some New Challenges" he wrote:

> There may be a few who will dare to investigate the possibility that there is a lawful reality which is not open to our five senses; a reality in which present, past, and future are intermingled, in which space is not a barrier and time has disappeared....It is one of the most exciting challenges posed to psychology (Rogers, 1973, p.386).

Donald Campbell's presidential address to the 1975 convention of the American Psychological Association posited the social functionality and psychological validity of religious concepts such as sin and temptation. In considering the interface of biological and social evolution, he concluded that, based on the problems of complex social coordination and the population genetics of altruistic traits, social systems work best when participants in them behave in a way as to optimize system purposes rather than individual purposes when these conflict.

> Committing oneself to living for a transcendent Good's purposes, not one's own, is a commitment to optimize the social system rather than the individual system. Social groups effectively indoctrinating such individual commitments might well have had a social-evolutionary advantage and thus have discovered a functional adaptive truth (Campbell, 1975, 1117).

Campbell advocated a two-system model in which biological

evolution stands in creative tension with social evolution. Biological evolution selects individual selfish tendencies which insure survival in the face of competition. Sociocultural evolution focuses on the selective accumulation of skills retained through social, rather than genetic, modes of transmission and maintains that many of the individualistic traits which biological evolution selects must be curbed if optimal social coordination is to be achieved. His thesis is that human social complexity is facilitated by sociocultural evolution rather than biological evolution.

The fact that belief in transcendent deities concerned with the morality of human behavior toward others occurs more frequently in complex societies suggests that such belief may be functionally adaptive truth. Campbell compares the "respect-for-tradition" perspective, in which the evolutionary biologist assumes that functional wisdom lies behind inexplicable and even bizarre behavior, with the attitude of modern psychology. Respect for tradition assumes a measure of validity in "recipes for living that have been evolved, tested and winnowed through hundreds of generations," which when eventually understood will make some adaptive sense. In contrast, epistemic arrogance has characterized the behavioral scientist's rejection of traditional religious belief as superstitious and harmful.

The basic background assumption of modern psychology is that the biological evolutionary impulse toward self-preservation, expression, and gratification is appropriate and optimal whereas repression or inhibition of individual impulse, as inculcated by religious moral tradition, is undesirable and productive of neurotic individual guilt and collective social prejudice. Campbell's conclusion is that, in light of population genetics and social system evolution, this assumption should be regarded as "scientifically wrong" and that, on purely scientific grounds, the recipes for living embodied in the moral traditions winnowed through hundreds of generations of human history can be regarded as having been better tested than psychology's speculations. In propagating this perspective

> ...psychology may be contributing to the undermining of the retention of what may be extremely valuable social-evolutionary inhibitory systems which we do not fully understand (Campbell, 1975, p.1120).

His recommendation is an epistemic humility which eschews arrogant scientific certainty that current belief is the final word, emphasizes modesty in areas that cannot be tested by experimentation, and enlarges the focus beyond a narrow individualistic perspective to accommodate social system functioning and the possibility that well-winnowed traditions may contain wisdom about how life should be lived.

The Role of Pastoral Counseling

The positivistic promise of scientific solutions for problems of human meaning and value is illusory. Value-free science is a myth. There is a value dimension in natural and behavioral science; moreover, there needs to be. The structure of human personality requires the clarification of fundamental norms that facilitate functioning. The contemporary cultural context of Western society demands perpetual revision of the normative cultural order to integrate technological innovation. Recent experience has demonstrated the necessity of ontological grounding for meaningful existence and the fact that man has come full circle in seeking it in a spiritual dimension. All of this serves to indicate that there is indeed an appropriate role for the ancient art of *cura animarum*, complete with its historical function of moral guidance, in contemporary pluralistic society.

In The Moral Context of Pastoral Care, Browning decries the fact that

> At a time when moral clarification is most needed because normative cultural values are in a state of crisis, pastoral care and counseling have, for the most part, abandoned the task of moral guidance (Browning, 1976, p.25).

The uncritical adoption, by twentieth-century practitioners of the cure of souls, of the model and methodology of secular psychology, symbolized by the development of eductive counseling, resulted in confusion regarding their

roles as shapers of values and maintainers of meaning. Stein's rather scathing indictment serves to focus the issue:

> Too many of us have thrown away our surplices for white coats, our crosses for ink-blots, our Christ-centered wholeness for ego-centered partialness. We have learned our personality theories and the realities of id and back-alley (and we ought to know them), but too often we have forgotten the perspective of one who preached and healed on a mountain and died on a hill. There is not much that is new in this world except the Good News when it now and then gets lived. In our world, that is news (Stein, 1974, p.102).

Pastoral caregivers and, especially, counselors need to know personality theory, existential interpersonal reality and psychotherapeutic technique. But they must realize that the distinctive contribution they have to make, as helping professionals, is ultimately an expression of the moral vision and ethical framework to which they are committed, be it Christian, Jewish (Goldman and Davidson, 1985), Hindu (Williams, 1986), etc. For the sake of simplicity, however, I will confine my comments to the context of Christianity.

Clebsch and Jaekle's definition of pastoral care as "helping acts, done by representative Christian persons...in the context of ultimate meanings and concerns" (Clebsch and Jaekle, 1964, p.4) underscores this distinction. The difference between pastoral counseling and the help offered by psychologists, psychiatrists, social workers, doctors, lawyers, etc. is that the pastoral counselor functions as a representative of the Christian faith and brings to bear the

resources, wisdom and authority of that faith upon the troubles of the person whom he is helping. Pastoral counseling is, and in order to be pastoral must be, confessional as well as analytical (Aden, 1984). The unique professional activity of the pastoral counselor is the guidance of persons toward a life lived out in accordance with a set of ultimate values and meanings (Howe, 1989). This direct professional responsibility to help shape the moral universe of values and meaning, both in the individual and in the larger culture, determines the context, content and the resources of the care and counsel that a pastoral counselor offers.

Both Browning and Parsons envision, in my opinion rather unrealistically, the pastoral counselor fulfilling this role of shaper of moral vision in a meta-ethical manner that facilitates the functioning of secular psychotherapists. As we have noted, Parsons promulgates a differentiation of professional roles in which pastoral caregivers attend to the value dimension of societal expectations while psychotherapists attend to the task dimension. Whereas the church and religious practitioners of the cure of souls are the primary locus of the regulation and stabilization of the motivational structures and value systems of the society, "the primary focus of the psychiatric role should be on the problem of the capacity of the individual to implement the values and other commitments

which he may come to regard as legitimized for his life" (Parsons, 1964, p.319). Browning argues that the pastoral counselor must function as a moral philosopher in order to fulfill his or her role as mediator of religiocultural values and also "for the sake of the secular counseling specialist who wants to attend primarily to the exploration of emotional and interpersonal dynamics" (Browning, 1976, p.37). This expectation is unrealistic because psychotherapists, though purportedly operating out of universalistic and non-normative moral positions, actually offer a covert "religious" ideology that is, according to Lowe's delineation (Lowe, 1958), either naturalistic, culturalistic, humanistic, or theistic.

A more realistic role for pastoral counselors in the contemporary milieu of pluralism is suggested by Pattison's expectation of the development of particularistic oriented mental health services which serve different segments of a pluralistic society (Pattison, 1978a). A number of psychologists have expressed the opinion that the most helpful way of dealing with the value dimension in psychotherapy is as objectively as possible, making one's value orientation explicit and assisting clients in making informed choices of their own (Williamson, 1958; Lowe, 1958; Kitchner, 1980; Bergin, 1980). Lowe suggests

> that each area in psychology become more fully aware of the implications of its efforts, much as education does through a philosophy of education. We would further suggest that, as psychologists

> familiarize themselves with the value orientation under which they operate, that they confess their philosophic biases and then turn those to fullest advantage by being of professional assistance to the special interest groups with which their values coincide (Lowe, 1958, p.692).

This is not to suggest that the church or ministers should abandon their traditional attempt to influence the moral and ethical tenor of society. However, in regard to the provision of pastoral care specifically, it implies that a realistic expectation is that the role of pastoral counselors in a pluralistic society will be to serve those segments of the population which share the set of ultimate meanings and values they represent.

Numerous recent studies (King, 1978; Gilbert, 1981; Worthington and Scott, 1983; Cross and Khan, 1983, 1984) Worthington and Gascoyne, 1985; Quackenbos, Privette, and Klentz, 1986; Larson, Pattison, Blazer, Omran, and Kaplan, 1986; Godwin and Crouch, 1989; Wyatt and Johnson, 1990) indicate that such a role is not only realistic, but necessary in contemporary culture. Larson et al. observed that "religious thought and behavior have moved dramatically into the forefront of American cultural concerns in the past decade" (Larson et al., 1986, p.329)and cited surveys which show that there is a significant disparity between the religious orientation of mental health providers and the general population at large. Polls show that more than 90% of the population of the United States believes in God, more that 40% attend religious services weekly or more often, and

more than 20% feel that religion is a very important part of their lives. In contrast, surveys of the membership of the American Psychiatric Association and the American Psychological Association showed that 43% of the psychiatrists and only 5% of the psychologists believed in God (Larson et al., 1986). Cross and Kahn conducted a similar study in Australia and concluded that "mental health professionals showed themselves to be substantially less religious than the population they serve" (Cross and Khan, 1983, p.17-18).

Even more striking was the profile generated by Henry, Sims and Spray's analysis of 3992 psychotherapists, from the disciplines of psychoanalysis, psychiatry, psychology and social work, in The Fifth Profession. They discovered that private practice psychotherapists are remarkably similar in socio-economic and religious background. Although 87% came from religious backgrounds, only 36% currently professed religious faith. 70% of those who did not adhere to a religious position were from religious backgrounds. Henry et al. compared this tendency on the part of psychotherapists to renounce their religious heritage with the tendency within the general population for religious commitment to be transmitted intergenerationally. They described this tendency as religious apostasy and concluded that a psychotherapeutic belief system had replaced the religious belief system of their past.

In light of the foregoing discussion of values in psychotherapy, these findings have important ramifications. King (1978) discovered that 89% of evangelical Christians who were dissatisfied with available mental health services were concerned that their faith would be misunderstood, unappreciated, or perhaps even ridiculed or eroded by a therapist who did not share their religious beliefs. Worthington and Scott (1983) confirmed that conservative Christians fear having their values misunderstood or changed and being misdiagnosed because of their beliefs.

Evidence indicates these fears are not unfounded. Larson et al. suggest, on the basis of review of literature describing the perceptions of the general population and mental health professionals regarding religious belief, it is appropriate to generalize that:

> The public views mental health professionals as unknowing or unappreciative of the role of religion in their own lives...whereas many psychiatrists view the religious public as naive, neurotic, or unsophisticated (Larson, Pattison, Blazer, Omran, Kaplan, 1986, pp.330-331).

If there is no such thing as value-free therapy and mental health professionals do not espouse the religious and moral values of their clients, then it can be expected that clients will indeed alter their attitudes and values as a result of interaction with a practitioner (Cross and Kahn, 1983). Analyses of the efficacy of therapy indicate that when counseling is effective, clients change their values, specifically moving in the direction of the counselor's

values (Worthington, 1986). Abroms (1968) and McEniry (1982) envision therapy as an educational process that is successful when the client uses the model of the therapist to perceive life situations and events differently. Beutler et al. (1974, p.552) suggested that "psychotherapy may have its greatest effect on attitudes of a philosophical nature dealing with ethics and religion."

In examining the religious orientation of psychotherapists and their clientele, Marx and Spray (1972) found that a salient factor in recruitment and acceptance of clients by therapists was similarity between the religious background of the therapist's family and the client's current religious position. The implication of this is that the secular therapist, who, as we have seen, has developed a secular belief system as an alternative to his religious past, selectively offers psychotherapy, and in the process his alternative belief system, to clients from a similar religious past.

The multiplicity of value systems in a pluralistic society, the fact that therapy is a powerful mechanism for shaping values, and the resurgence of religious thought and behavior conspire to create a very definite role for pastoral counseling in a pluralistic society. The growing realization on the part of both secular and religious professionals that there are people who need and desire treatment that integrates psychotherapy and religion has

resulted in the emergence of a variety of providers of pastoral care: ordained clergy, pastoral counseling specialists, chaplains in institutional settings, secular counselors seeking to integrate faith and lay counselors, each of which have an appropriate role in a pluralistic society.

Clemens, Corradi and Wasman (1978, p.228) state that "whether he (or she) likes it or not, the clergyman (or woman) is a front-line worker in dealing with mental and emotional problems." With approximately 40% of people turning first to the clergy when in trouble, the clergy is the most sought out source of help for personal problems, primarily because of the minster's role within the parish and the community. He or she embodies centuries of tradition, as well as values of receptivity and concern for individuals and their problems. His or her participation in the major developmental events and life crises of parishioners, weddings, baptisms, hospital visitation, funerals, provides both opportunity to initiate intervention when difficulties arise and a basis for follow through. His or her availability is further enhanced by flexibility of schedule and the fact that he or she does not charge a fee. Because of these factors

> ministers do have a unique role in the lives of many people and are often the most appropriate and effective helper to persons who are facing critical operations, terminal illnesses, the death of a loved one, times of hard ethical decisions, and crises of many kinds (Switzer, 1983, p.32).

However, the considerable demands and multiple roles of the parish structure give rise to situations in which time constraints, training or interpersonal dynamics prevent a pastor from functioning as the primary therapeutic agent. In response to these situations, "pastoral counseling specialists" have emerged. Howard Clinebell defines the "specialist in pastoral counseling" as any minister whose primary focus of professional functioning is counseling and suggests as minimal criteria 1) seminary training, 2) ordination and active denominational affiliation and approval of his activity, 3) post-seminary clinical and academic training in a counseling discipline, 4) holds ministry as his primary professional identity (Clinebell, 1964). With the argument that the roles of moral standard bearer and therapeutic agent are incompatible, Talcott Parsons provides a powerful justification for the specialized counselor.

> I should suggest that the leader of the congregation is handicapped in performing this role in a sense directly parallel to that in which a family member is handicapped in performing a psychiatric role. In the nature of the case he is the primary focus of the sanction system on which the functioning of the collectivity he leads is dependent. He is responsible for exhorting to a proper participation in ritual, proper affirmation of belief and proper moral conduct. At the very least he must show disapproval of acts and attitudes which are deviant from these standards....The exigencies of this collective leadership role constitute a formidable barrier to effective implementation of the permissive and supportive components of the "therapeutic" role...That a profession of spiritual counselors in this sense should be a specialized

> group...seems to me to be strongly indicated (Parsons, 1964, pp.320-321).

The helping professions fragmented into disparate professional disciplines during the first half of the twentieth-century with psychiatrists, psychologists, social workers, pastoral counselors, and chaplains each carving out their own territory in the domain of human helping (Pattison, 1978a). By 1950 a "team concept" had developed in which each specialist would contribute his unique expertise to the delivery of mental health care. The one arena in which this has proven viable is the institutional setting where the different professionals are brought together in the same organizational milieu. In this context, pastoral care is provided by practitioners who have received Clinical Pastoral Education, which emphasizes the chaplain as the religious specialist working as a consultant and collaborator with the institution's other professional staff as well as a counselor per se. For instance, Cairns and Hunter (1984) define the contribution of the chaplain in the medical setting as dialogical and hermeneutical in contrast to the empirical and technical methodology of the medical personnel. The medical professional operates within the technical sphere, while the chaplain helps the patient deal with the meaning of his illness. The literature focusing on the unique ministry of chaplains in private psychiatric hospitals (Bruce and Bruce, 1989), medical centers (Cairns and Hunter, 1984; Parkhum, 1985), hospices

(Franco, 1985), home health care (DeMarinis, 1987), mental hospitals (Morrow and Matthews, 1966; Hiltner, 1972), geriatric centers (Harrison and Law, 1985), community mental health centers (Pattison, 1965; Haugk, 1976), and the military (Abercrombie, 1977) demonstrates both the opportunity and the need for the practice of pastoral care and counseling in the institutional context.

In "Psychotherapy and Religion: Rapprochement or Antithesis?" Quackenbos et al. acknowledge religion as a pervasive force in society and, in light of its virtual exclusion from most of psychotherapy, argue the need for rapprochement between religion and psychotherapy. They suggest that this can be facilitated by both sides as clergy receive rigorous training in counseling and secular psychotherapists receive special preparation for dealing with religious issues, much like certification in specialties such as sex therapy, marriage and family counseling, etc.

> The time is ripe for seriously considering specialized education or certification in religious counseling for secular psychotherapists. Secular psychotherapists then could function not as ministers or religious teachers, but as facilitators for clients with religious questions as well as concerns in the secular realm (Quackenbos, Privette and Klenz, 1986, p.85).

Clinical and counseling psychologists trained in programs which both satisfy secular licensing standards and provide religious content approximate this model. To avoid being, in Clebsch and Jaekles' words, "incompetent amateurs and

inexpert apprentices in arts properly belonging to others," some Christians, generally theologically conservative, have trained in secular Ph.D. programs and attempted to integrate their faith and clinical practice. As we have seen, graduate programs which meet secular accreditation requirements and offer training in religious integration have also been developed. This is an expression of the particularistic oriented mental health services that Pattison predicted (1978a) and justification for it would be the same as justification for psychotherapeutic practice from any other perspective, be it psychodynamic, behavioral or humanistic.

The roots of the lay counseling movement are in the *aedification mutua* and *correptio fraterna* of the first century church with its emphasis on fellowship in the covenant community. Reformation doctrine of the priesthood of all believers facilitated the rediscovery of the biblical emphasis on equipping saints for ministry. The systemic view of the church which Paul presents in scripture, I Corinthians 12 and Ephesians 4, suggests that growth and healing are mediated through the interaction of believers and provides a conceptual basis for the provision of pastoral care and counseling by lay people. As might be expected, the development of lay pastoral counselors has paralleled a similar development in mental health. When Carkhuff reviewed the literature comparing lay counselors

with professional counselors he discovered that the counselees of paraprofessionals improved as much or more than the counselees of the professionals (Carkhuff, 1967). Lay pastoral counseling seems to be justified experientially as well as theoretically.

In offering obeisance at the altar of the sacred cow, science, twentieth-century physicians of the soul inappropriately abdicated their claim to moral competence in favor of psychology and, as a result, were in danger of losing their audience. Subsequent developments have demonstrated that the positivistic promise of value-free solutions to problems of human meaning is a chimera. There is and will be a value dimension in all science, natural and especially behavioral. Moreover, human experience demonstrates the necessity of that value dimension; people will find a live god. Yes, there is an appropriate place for moral guidance and ethical statements in counseling and psychotherapy. Yes, a pastoral counselor does have an appropriate role in a pluralistic society. A theistic value orientation is just as viable in a culture of pluralism as any other. The defining feature of a pastoral counselor is that the help he offers is ultimately an expression of the moral vision and ethical framework he represents, whether he be ordained clergy, counseling specialist, chaplain, secularly trained therapist or church member.

However, the attempts of these practitioners of *cura animarum* to function as persons representative of the resources, wisdom, and authority of Christian faith in the pluralism of our culture give rise to a number of ethical issues. In an attempt to provide an ethical framework from which pastoral counseling can appropriately function, I shall consider three such issues which specifically grow out of pastoral care's commitment to shaping moral vision and which will prove helpful in constructing this functional framework: Paternalism, Informed Consent and Competence.

CHAPTER III

PATERNALISM IN PASTORAL COUNSELING

Jung cited a well-known anecdote to demonstrate a difficulty that is inherent in pastoral counseling:

> There is a good story about the American president, "silent Cal" Coolidge. When he returned after an absence one Sunday morning his wife asked him where he had been. "To church," he replied. "What did the minister say?" "He talked about sin." "And what did he say about sin?" "He was against it." (Jung, 1932, p.338).

His analysis of the relationship between psychotherapy and religion in "Psychotherapists or the Clergy" was that the loss of the spiritual dimension which the living religions of every age have given their followers was at the root of the difficulties that his patients experienced.

This puts the clergyman on the threshold of a vast horizon of opportunity, but, in his words, "it would seem as if no one had noticed." The reason Jung offered for what he saw to be a growing indifference about religion was that people believed they knew what clergymen would and had to say in response to questions about the meaning and nature of life.

What else could Coolidge's minister say about sin other than, ultimately, he was against it?

The problem is that this commitment to an ethical framework is perceived by the patient as dogmatic bias that is indicative of even stronger moral prejudice. If he feels that way about sin, "what would the parson say if I began to tell him of the painful details of my sexual disturbances?" is the question in the mind of Jung's patient. The result is estrangement; despite the fact that the religious outlook which the clergyman has to offer is central to healing, no one seems to notice. From this, it is clear that the very commitment to a set of ultimate values and meanings, which as we have seen is definitive of pastoral counseling, becomes an impediment to the practice of the cure of souls. This realization led to Browning's observation:

> How to enter into sensitive moral inquiry with troubled and confused individuals without becoming moralistic is, I contend, the major technical and methodological task for training in pastoral care in the future (Browning, 1976, p.26).

Consideration of the philosophical notion of paternalism will facilitate both understanding of the difficulties involved in Browning's challenge and discovery of a means of answering it. I will show that, though paternalism is an intrinsic dimension of pastoral care and counseling, the paradoxical nature of paternalistic intervention demands demonstration of its justification within the framework of ordinary ethical norms. This, coupled with a stage model of

caregiving which acknowledges differentiation of role responsibilities, will provide the insights that will enable pastoral counselors to remain faithful to the moral framework of their faith without returning to a repressive moralism that prevents people from noticing what they have to offer.

Prima Facie Duties and the Principle of Paternalism

The work of ethical theorists has been the elucidation of fundamental values and principles which justify moral action. W. D. Ross made a significant contribution to this process with his distinction between "prima facie" and "actual" duties. For Ross, prima facie duties are those ethical acts which any mentally mature person, given sufficient reflection, would recognize as self-evident (Ross, 1930). The term "prima facie" indicates that though these duties are morally relevant and provide strong reasons for performing or prohibiting the particular actions in question, they are not applicable without exception. Prima facie duties are binding on all occasions unless they are in conflict with an overriding duty; actual duties are determined by "balancing" all the competing prima facie duties (Beauchamp and Childress, 1979, pp.45-47).

From the notion of prima facie duties developed by Ross, numerous lists of such duties have been generated and significant consensus has developed that five such duties

are most relevant to psychological caregiving and constitute the evaluative level of ethical reasoning in psychology (Kitchener, 1984; Powell, 1984; Thompson, 1990). These principles are: 1) Autonomy - freedom to do what one wants to do based on a plan chosen by oneself; 2) Fidelity - promise keeping and truthtelling; 3) Justice - fairness; 4) Beneficence - doing good to others; 5) Nonmaleficence - not causing harm to others.

Paternalism is an expression of the prima facie duty of beneficence. The notion literally means acting like a father toward someone else. Edwards and Graber (1988, p.110) utilize this image of "the stern but kindly father who exercises authority by making all the decisions, yet who does not make choices capriciously or selfishly, but rather in terms of his best judgments as to the well-being of his family" to demonstrate that the two defining features of the paternalist are that he makes decisions for others and that he is beneficent, that he has his own notion of the best interests of those for whom he makes decisions at heart.

Paternalism and Pastoral Counseling

Parsons' use of this image of the kindly father in delineating the role of the minister of religion implies that paternalism is an inherent dimension of that role.

> He is in a certain sense parallel to the "father" of the family. What I mean here is that he is, in certain respects which need careful defining, the responsible leader of a collectivity, a

> collectivity to which the welfare of individuals in very crucial respects has been entrusted (Parsons, 1964, pp.316-317).

The point is that a pastoral caregiver is by very definition committed to a paternalistic position. As a representative person of the Christian faith with its resources, wisdom and authority, his or her commitment to the best interests, as he or she understands it, of those whose welfare, in very crucial respects, has been entrusted to him or her demands that he or she respond to questions regarding the meaning and nature of life, as well as how it should be lived, by reference to the ultimate values which he or she espouses. That a notion of transcendent truth is involved in the identification of a pastoral counselor insinuates that "father knows best." Though especially acute for a pastor in his or her role of leader of the collectivity, this dimension is operative in any situation in which the practitioner distinguishes the care or counsel he or she provides by reference to a set of ultimate meanings or values.

Parsons echoed the difficulty, identified by Jung, which this inherent dimension of paternalism poses to the therapeutic efficacy of the pastoral caregiver:

> The exigencies of this collective leadership role constitute a formidable barrier to effective implementation of the permissive and supportive components of the "therapeutic" role (Parsons, 1964, p.320).

However, much more compelling than the pragmatic problems it poses are the moral questions it generates. Functioning as a representative person of a religious tradition provides authority and credibility, even, and especially, when making proclamations in the name of highest authority: "Thus saith the Lord" (Brandsma, Pattison and Muyskens, 1986, p.160). The danger of abuse is obvious. There is the tendency to assume that such authority implies a corresponding responsibility to insure appropriate moral behavior on the part of the recipient of pastoral care, whether parishioner or patient. There is also the temptation to use the power of the role for selfish interests such as the well-being of the collectivity at the expense of the individual or for personal self-aggrandizement.

The ethical issues generated by attempting to act in another's best interests, when you believe by virtue of transcendent truth that you know what their best interests are, are unlimited. Has a pastor acted in a morally appropriate manner if, when a suffering parishioner comes seeking succor, he or she instead provides a sermonette offering biblical solutions to the person's problems? How does a pastoral counselor respond when a client likes to get help or advice but is unwilling to act upon it? How should a chaplain in a medical institution relate to patients who may not share the particular set of ultimate meanings he or

she represents? seeking to assure the salvation of his soul or by comforting him in his illness?

The Problem with Paternalism

Philosophically, the difficulty with paternalism is that it limits the freedom of the individual whose best interest is sought. As a principle, paternalism poses moral questions because it assumes that beneficence should take precedence over autonomy. The distinguishing feature of prima facie duties, as conceptualized by Ross, is that they are self-evident and morally relevant, yet are not applicable without exception. Actual duties are determined by consideration of the competing prima facie duties. Thus the solution to the conflicting claims of beneficence and autonomy, in specific situations, is resolved by rational determination of the relative importance of the respective factors.

In the perception of Immanuel Kant and John Stuart Mill, whose thoughts have been primarily responsible for shaping the notion, the principle of autonomy is the very essence of personal or individual moral agency. Kant's notion of the autonomy of the will is rooted in the rational human will which makes choices based on moral principles one has freely adopted for oneself and which are universalizable. Mill's autonomy of action construes the

principle of utility to indicate that society is served when individuals are permitted to do as they like, without restraint by others, so long as they do not harm others directly. Together these elements inform the commonly accepted understanding that autonomy involves freedom of choice (the right of an individual to decide what he or she wants to do with his or her life) and freedom of action (the right of an individual to do what he or she wants with his or her life so long as it doesn't interfere with another's right to do likewise).

Implicit in this understanding is the fact that others' autonomy is to be respected as well. For Mill, this follows from an appropriate understanding of social liberty and for Kant, it grows out of the conception that others are rational agents acting on their principles and are therefore ends in themselves, having unconditional worth. Though autonomy is a moral imperative for both Mill, who posits that an autonomous agent can not act autonomously to limit his autonomy, and for Kant, who contends that autonomy is a duty, neither regard it as an absolute right in that both acknowledge there are individuals who, either because of incapacity or immaturity, should not and/or cannot be autonomous.

This acknowledgement of limitations on the capacity for autonomy gives rise to the principle of paternalism which asserts that interference with another's autonomy is

appropriate and even required in order to insure the other's good. Dworkin defines it as follows:

> By paternalism, I shall understand roughly the interference with a person's liberty of action, justified by reasons referring exclusively to the welfare, good, happiness, needs, interest, or values of the person being coerced (Dworkin, 1972, p.108).

Thus according to the principle of paternalism it is permissible to impinge on other persons' freedom to do good or to prevent harm to them. Justification for paternalistic intervention is based on a calculation of benefits likely to be derived and harm likely to be inflicted by the intervention. According to some, paternalism is justified only when the evils that would happen to a person if intervention did not occur are greater than the evils inflicted on the person by the interference with his freedom and when it would be appropriate to treat other people in similar circumstances the same way (Beauchamp and Childress, 1979, p.157).

The difficulty arises with the fact that this calculation of risks and benefits is a matter of subjective perception. For adherents of the classic view of human liberty and moral responsibility, informed by the thought of Kant and Mill, freedom is the primary good and is to be relinquished only in extreme circumstances. But Edwards reminds us that this is not the case with everyone:

> Though we may conceive of rational autonomy as the very essence of moral agency, we should not forget that many religious and non-democratic political

> perspectives regard rational autonomy with dismay and insist that *their* ideal moral agents renounce it, or better yet never develop it, for blind, unthinking, inherited or emotionally induced devotion to unquestioned authority (Edwards, 1982c, p.77).

The religious and political perspectives to which Edwards refers would calculate the risk/benefit ratio in a significantly different manner than the classic view of human liberty. In the eyes of these systems, the benefits of accepting paternalistic authority far outweigh the cost in terms of human freedom.

Margaret Pabst Battin's helpful discussion of religious paternalism in Ethics in the Sanctuary, pp.129-175, serves to elucidate the rationale underlying the religious calculation of the risk/benefit ratio. Central to the traditional Christian theological assumptions are afterlife claims: acceptance of and compliance with the set of ultimate meanings and values represented by Christianity results in salvation of an individual's soul; rejection of or noncompliance with that set of meanings and values issues in damnation of the individual's soul. In this traditional belief system these are not trivial claims: salvation, an infinity of an infinitely blissful life, is maximally good both in duration and character, while damnation, an infinity of infinitely severe torment, is maximally bad both in duration and character. Given this traditional bipolar schema, the calculation of the risk/benefit ratio is obvious. The stakes are so high that afterlife outcomes

will become primary in an individual's economy of values; for the rational person, no other value, including autonomy, could possibly outweigh these.

Battin then generalizes Pascal's wager to other-respecting cases to demonstrate the moral obligation to influence other individual's acceptance of the belief set that will insure their salvation. When applied to oneself Pascal's wager is a matter of rational prudence; it makes more sense to choose to believe rather than take the risk to not believe. However, when applied to another, the infinite magnitude of the potential reward and the catastrophic nature of the possible penalty are such that it is morally obligatory to influence another's belief and maximally immoral not to do so when one is in a position to affect the outcome. Thus the traditional set of Christian theological assumptions can be interpreted to justify and even require any measure of paternalistic intervention to insure acceptance of and compliance with the beliefs necessary for salvation, if indeed external intervention can insure this.

> No amount of liberty to act on one's own values or to determine the course of one's life can outweigh the disbenefit of hell - infinitely continuing maximal bad for oneself. Thus, paternalist intervention in religious situations, under the traditional schema, must always be hard paternalism, acting not simply to counter rational impairment but to prevent the greatest of all possible harms. No intervention of any sort, regardless of how deceptive, invasive, coercive, or otherwise seriously morally flawed, would be out of bounds if it were required to save someone's soul (Battin, 1990, p.158).

In light of these considerations, to hell with Freud's criticism of religion as repressive, and Browning's non-moralistic morality be damned! What is important is saving souls from the fire by whatever means possible.

However, as one who accepts the set of ultimate meanings and values that Christianity represents, though not necessarily as popularly presented, I am perplexed by the fact that the principle of paternalism seems to justify behavior that is inconsistent, not only with the values it ostensibly serves, but with ordinary ethical norms as well.

> The paradox the issue of paternalism introduces is that those...tactics that, under ordinary ethical norms and nontheist assumptions, look most reprehensible turn out to be, when the traditional theological assumptions are introduced, those that are morally best (Battin, 1990, p.158).

A bizarre example of this paradox is the evangelistic technique called "flirty fishing" practiced by the Children of God. This methodology of proselytizing was introduced in 1973 when the leader of the Children of God, David Berg or Moses David as he was also known, encouraged his second wife to initiate a relationship, which quickly became sexual, with a man at a London dance school. When the man was "hooked" he was introduced to another of Moses' wives and the original wife was commissioned to catch another "fish." "Flirty fishing" proved to be a rapid, effective method of proselytizing and became a central focus of the group. Battin cited the claim, in Moses David's 1979 newsletter, that:

> Our dear FF'ers are still going strong. God bless'm, having now witnessed to over a quarter-of-a-million souls, loved over 25,000 of them and won nearly 19,000 to the Lord (Battin, 1990, p.136).

David justified the practice on the basis of Old Testament examples of nonmonogamous sexual relationships, from which he extrapolated the principle that sexual activity should be evaluated on the basis of its contribution to the work of God, and their experience that meeting the persons sexual need was an effective means of presenting God's message.

The practice of flirty fishing is, at first glance, morally reprehensible. Yet, given the bipolar schema of traditional Christian theological assumptions, this method of proselytizing can be shown to be morally approved and even recommended on the basis of the principle of paternalism. If, indeed, there are degrees of good and bad, and damnation to hell is the maximally worst thing that could happen to a person, then any means whatsoever are justified, and perhaps even required, to prevent that eventuality. Any measure of intervention, regardless of how invasive, deceptive or manipulative, is warranted to assure an individual's salvation, if salvation is in fact the maximally best thing that could ever happen to a person. To claim that prostitution as a method of proselytizing is inherently "un-Christian" or otherwise intrinsically wrong does not change the calculation of the risk/benefit ratio unless the practice positively precludes the salvation of

the prostitute's patron. Unless this or any other morally questionable practice is absolutely unforgivable, and as such an unconditional bar to salvation, then its wrongness is overridden and its perpetration justified by the incalculable good it accomplishes in leading to the salvation of another.

At this point, the practice of pastoral care is impaled on the horns of the dilemma posed by the principle of paternalism. On the one hand paternalism is an intrinsic part of the role of representing the wisdom, resources and authority of a faith framework. To be identified as a pastoral caregiver or counselor entails both the claim of a set of ultimate meanings and values and the promise of helping efforts consistent with those meanings and values. Yet, on the other hand, the application of the paternalistic principle, in light of the traditional Christian theological beliefs, justifies, and even seems to require, practices that are otherwise regarded as ethically questionable and morally reprehensible. The typical solution to this dilemma, denying the underlying belief system, is unsatisfactory in that it merely rejects the traditional Christian view rather than resolving the moral problem that rises out of it and, in so doing, fails to provide practical help to the practitioner of *cura animarum* who is attempting to provide morally appropriate care.

As a means of examining ethical dilemmas such as this, Battin proposes a typology that distinguishes various levels of doctrinal assertions:

> The typology recognizes four distinct levels or orders of doctrinal assertions: 0-order or base-level doctrines, the fundamental imperatives of a group (often, though not always, stated in scriptural texts); first-order doctrines or teachings, which stipulate ways of putting basic imperatives into practice but which characteristically generate new moral problems in doing so; second-order doctrines or teachings, which establish a position that attempts to resolve the ethical problems presented by first-order doctrines; and third-order doctrines or teachings, which function as excuses for residual moral problems (Battin, 1990, p.108).

The value of this typology is that it offers a way of differentiating the fundamental doctrinal imperatives of a religious group, the practices which the group has developed for implementation of the imperative, and the justifications it offers for difficulties growing out of the practice. Though the practices and justifications may have normative value within the group on par with the fundamental imperative, their derivative nature clearly renders them more accessible to ethical evaluation than the basic doctrines. Thus it provides a means of ethical critique of religious practice that does not require determination of the truth value of basic theological assumptions.

Application of this typology to the Children of God's practice of flirty fishing demonstrates that the 0-order doctrines are the afterlife claims of heaven and hell and evangelistic imperatives such as Matthew 28:19. Flirty

fishing, as a manner of implementing these imperatives, is what Battin identifies as a first-order doctrine. Because its function is to resolve the ethical dilemma generated by the first-order teaching, Berg's position that sexual activity should be evaluated on the basis of its contribution to God's work is a second-order doctrine. The observation that meeting a person's sexual needs is sometimes the only effective means of presenting God's message is clearly a third-order teaching, in that it serves to excuse the residual moral problems.

This delineation serves to separate upper-level teachings and practices from fundamental doctrinal imperatives and thereby render them more accessible to ethical review. When the first, second and third order doctrines which undergird the practice of flirty fishing are submitted to critique, either individually or together, by ordinary ethical theory, with its competing prima facie duties of autonomy and beneficence, they are obviously morally indefensible. The practices they entail--deception, manipulation, and prostitution--are not justified by calculation of the risk/benefit ratio until the O-order doctrines are introduced. It is only in light of the afterlife claims that one could contend the evils prevented from occurring to a person would be greater than the evils of deception, manipulation, coercion and immorality inflicted on them by the practice. Without these claims,

the degree of paternalistic intervention which can be justified is significantly reduced.

The fact that the introduction of O-order imperatives makes what seems to be a morally reprehensible practice seem morally mandatory raises red flags and focuses our attention on the function of these claims in the justification of paternalism. The traditional Christian theological assumptions introduce, into any attempt to assess the benefits of competing prima facie duties, outcome predictions that trump all other considerations. The extreme positive and negative values of the bipolar schema override moral principles that would otherwise be binding.

In Battin's analysis, this is problematic in two respects: these claims are self-interest-gratifying and they are unprovable. The afterlife claims are such that there is a built-in inducement to accept them; as we have seen from Pascal's wager, believing them is a matter of rational prudence. Yet these claims also function as a license for what would otherwise be moral offenses against the person who accepts them. In essence, the proposition is "allow me to abuse you that you may experience great good." This questionable relationship is further exacerbated by the fact that these claims of great good are unprovable. This is not to say that the claims are false, it is only to observe that their truth cannot be objectively validated. They are beliefs and, as such, there is no non-faith based evidence

that can demonstrate them either true or false. Thus in calculating the risk/benefit ratio of paternalistic intervention there is no objective way of determining what the proposed risks and benefits actually are. As it turns out, the trump cards, which supersede all other moral considerations contain self-interested inducements for their acceptance and are unprovable. As such, they "function as a kind of religious blackmail" (Battin, 1990, p.172), coercing individuals to accept them while excusing what would otherwise be considered unethical actions and shielding the perpetrators of those actions from moral scrutiny.

Battin challenges the role that afterlife claims play in the justification of the principle of paternalism by distinguishing between their ethical implications and their epistemological validity:

> It is in the last analysis an ethical issue whether or not such claims should be allowed to function in this way. This is not to say that it is an ethical issue whether such claims are true or false, but rather that given that their truth or falsity cannot be established, it is by default no longer an epistemological question but an ethical question what role these claims should be granted (Battin, 1990, p.172).

The implication, that it is inappropriate to appeal to unprovable premises to countenance unethical behavior, is one that is generally accepted in ordinary morality and should be incorporated into the consideration of ethical

issues in religious experience. Battin offers a methodological principle for doing so:

> Unprovable, off-scale, self-interest-gratifying claims are to be considered suspect when their central function is to excuse violations of moral norms (Battin, 1990, p.172).

Though this principle is inconclusive in that it will neither yield a conclusion in a specific case nor demonstrate once and for all that recourse to faith assumptions as justification for paternalistic intervention is either appropriate or inappropriate, it is helpful in that it points us primarily to the upper-level doctrines of Battin's typology when calculating the risk/benefit ratio of paternalistic intervention. This frees the pastoral caregiver from the paradoxical demands of an extreme paternalism to function as the representative of the traditions of the Christian faith insofar as justified within the framework of accepted ethical norms. Though this does not eliminate the responsibility of determining the appropriate limits of paternalistic intervention it does define the parameters of consideration for the calculation of risk and benefit in a more accessible and verifiable manner. Furthermore, I would suggest that consideration of accepted ethical norms will prove fruitful in defining the parameters of paternalism in such a way as to permit attainment of Browning's ideal of "sensitive moral inquiry without becoming moralistic," a non-moralistic morality.

The Parameters of an Appropriate Paternalism

As we have seen, adherence to the traditional Christian belief system, with its bipolar schema of afterlife outcomes, sanctions a degree of paternalism that quickly becomes problematic in that it excuses, and even mandates, violation of commonly accepted standards of ethical behavior. Battin's typology is helpful in that it provides a means of evaluating the ethical implications of theological beliefs without reference to their epistemological validity by focusing on derivative statements that are subject to scrutiny within the calculus of accepted ethical theory. The ensuing necessity of balancing the respective claims of the prima facie duties of autonomy and paternalistic beneficence, rather than overriding one or the other on the basis of unverifiable assertions, yields insight that serves as a means of evaluating and justifying appropriate paternalism.

Mark Komrad, in a helpful article "A Defense of Medical Paternalism," made a significant contribution to this end by recasting autonomy and paternalism as "two inversely varying parameters along a spectrum of independence" rather than mutually exclusive contrapositives. Our analysis of the prima facie duties of autonomy and beneficence demonstrates that both are intended to serve the good of the same individual. Thus autonomy and paternalism wax and wane reciprocally in the interests of the individual; they are

first cousins "since both are related to the same good of the same person" (Komrad, 1988, p.148).

Komrad's conclusion, that appropriate paternalism, in a medical setting, is "designed solely to maximize...autonomy" is, when extended, somewhat of a non sequitur inasmuch as demonstrating that both autonomy and paternalism serve the good of the same moral agent does not entail that paternalism should necessarily serve autonomy. By definition paternalism is designed to maximize the good of the individual, even when that good is at the expense of that individual's autonomy. What Komrad has done, is, behind the smokescreen of inversely varying parameters on a spectrum of independence, sneak the notion of autonomy as the pre-eminent moral value in through the back door. As Edwards has pointed out, this perspective is not compatible with certain religious and political ideation. Specifically, for those groups whose theological assumptions include afterlife outcomes, no amount of autonomy to determine the course of one's life or act on one's values can outweigh the potential benefit or harm of those outcomes. Paternalism, in such a system, must serve the ultimate good entailed by the theological assumptions, not autonomy. But, the question is how?

It is precisely at this juncture that Komrad's conception, if not his conclusion, is helpful. Autonomy and paternalism are not inimical contrapositives, but rather

collaborators in assuring an agent's good. In this process, it can be demonstrated that there are times when autonomy should submit to paternalism and paternalism should serve autonomy. Regarding the former, the necessity of autonomy submitting to paternalism is central to the conceptualization of profession with its motto of *credat emptor* rather than *caveat emptor*. Komrad cites, as examples of the latter, Mill's argument that the State is justified to intervene paternalistically to prevent one from selling himself into slavery i.e. paternalism preserving autonomy; the paternalistic dimension of the physician-patient relationship, which should aim to restore autonomy; and the paternalism which parents express toward their children in order to develop autonomy within them. The salient feature of each of these examples is that, in seeking to serve the ultimate good of individuals, paternalistic intervention works to maximize autonomy.

It appears that this notion of paternalism maximizing autonomy as a means of serving an individual's ultimate good is potentially both theoretically consistent with the demand of faithfulness to the theological assumptions of the traditional Christian faith and pragmatically helpful in defining the parameters of appropriate paternalistic intervention. Biblical and philosophical justification can be cited to demonstrate that, even in the traditional belief system with its afterlife outcomes, autonomy is a primary

value that should be preserved and maximized. Christ modeled this numerous times in articulating the citizenship requirements of the kingdom he was establishing while respecting the autonomy of individuals in terms of their compliance or noncompliance (Matthew 23:37; Mark 10:17-23; John 6:60-71). Obviously, in Jesus' calculation of the risk/benefit ratio, afterlife outcomes did not warrant coercive, paternalistic intervention at the expense of individual freedom of choice. One profound theological reconciliation of autonomy with the religious values of salvation, devotion, and service to God is that God offers salvation and desires devotion and service only if it is freely accepted or given. Roger Williams insisted that "Forced worship stinks in God's nostrils." (Cited in Edwards, 1982a, p.259).

Bergin espoused this perspective with his proposal of the open and explicit use of religious values in conjunction with respect for differing values and the individual's freedom to choose.

> It would be honest and ethical to acknowledge that we are implementing our own value systems via our professional work and to be more explicit about what we believe while also respecting the value systems of others (Bergin, 1980, p.101).

In an attempt to be explicit about what he believes, Bergin compared, in tabular form, his value system, which he termed "Theistic Values," with the values that he understands to inform much of psychotherapeutic practice, which he

identified as "Clinical-Humanistic Values." Commenting upon this comparison, O'Brien (1984) noted that human dignity, the acknowledgement of people as free and responsible agents i.e. autonomy, is acceptable as a core value for counseling by practitioners representing a broad spectrum of differing value systems. Though this core value occupies a different place in theistic and clinical-humanistic values, it is shared by both. Whereas in the latter, human dignity expressed in autonomy is supreme, in theistic values God is supreme, ranking above the core value of human dignity. Nevertheless, O'Brien's understanding of the theistic hierarchy of values is that "the dignity of persons comes above the value counselors might place in clients' accepting counselors' values" (O'Brien, 1984, p.29). Thus philosophically, as well as biblically, autonomy is an important value that should be preserved and maximized.

The practical helpfulness of this notion of paternalism maximizing autonomy in defining the parameters of appropriate paternalistic intervention in pastoral counseling is elucidated by the application of role theory to pastoral care. Role theory emphasizes that within human society there is a vast panoply of role exchanges, with most individuals functioning in a multiplicity of roles that entail different and sometimes conflicting privileges, responsibilities and expectations. Successful societal

functioning requires clarification and appropriate performance of respective roles.

Brandsma, Pattison, and Muyskens (1986) applied role theory to helping relationships to explicate the diversity of functions, opportunities and responsibilities in the task of providing pastoral care. Their helpful schema, which we will take to be illustrative rather than exhaustive and definitive, delineates three pastoral caregivers: the parish pastor, the pastoral psychotherapist, and the Christian psychotherapist. Brandsma et al. acknowledge the complexity of the role of parish pastor by distinguishing within it four categories of function:

> In the *pastor* role he or she "shepherds the flock," counsels, comforts, engages in the liturgy, and deals in moral distinctions and obligations. This role is often more community oriented and liturgy based. The *preacher* role is more narrow in time and place, but can be a very potent role; it involves aspects of being a teacher, an expositor, or a persuader. A *teacher* role has greater flexibility in strategies to be employed than the preacher and has greater opportunity for reciprocal interaction, but not as much potency...The *denominational counselor* role is the pastor who provides counseling services to parishioners, usually voluntarily negotiated and involving no fee. (Brandsma, Pattison, and Muyskens, 1986, p.157).

The pastoral psychotherapist is identified by the fact that his professional behavior is informed primarily by Christian theology and tradition and secondarily by psychotherapeutic tradition, whereas the Christian psychotherapist's professional behavior is predicated primarily on psychotherapeutic tradition and secondarily on Christian

theology and tradition. The pastoral psychotherapist is closely associated with the pastoral role while the Christian psychotherapist functions more like a secular therapist yet identifies himself as a Christian. Thus, in Brandsma et al.'s analysis, there are six different roles in which pastoral caregivers can function, each of which involves different responsibilities, privileges, and expectations. Their evaluation suggests that these six functions can be placed on a continuum from the pastor role to the Christian psychotherapist role and understood to entail diminishing degrees of paternal responsibility. As we saw in Parsons' analysis, the pastor qua shepherd of the flock has a greater responsibility for the inculcation of the theological and moral tradition of the faith than, as does the pastor qua preacher, than the pastor in the role of denominational counselor. By the same token, the role of pastoral psychotherapist is understood to entail less responsibility for the shaping of moral vision than the pastor role, but more than the role of Christian psychotherapist. This differentiation of paternal responsibility is a function of the respective role that the pastoral practitioner fills. The pastor qua pastor is the "father of the family," responsible for the maintenance of the cultural and theological tradition which he or she represents and from which he or she derives his or her authority. When he or she fulfills the role of

denominational counselor, his or her authority is still rooted in his or her theological tradition and training, yet his or her responsibility is significantly different. Rather than serving as the moral standardbearer of the collective group, his or her role is "structurally speaking, far more closely analogous to the sense in which good parents take an individualized interest in and responsibility for the...welfare of their children" (Parsons, 1964, p.317). Inasmuch as the pastoral psychotherapist is closely related to the pastoral tradition, it is expected that his or her therapeutic methodology would employ the moral framework of religious tradition as a context for dealing with life's challenges moreso than that of the Christian psychotherapist whose authority derives from psychotherapeutic training rather than religious affiliation.

Thus the respective responsibilities implicit in these various roles help define the interface of autonomy and paternalism in the fulfillment of them, both for the practitioner and for the recipient of care. It is understood that the core value of human dignity would inform the practice of pastoral care, in all of the various functions, in such a way that the paternalism expressed in each role would be appropriate to the responsibilities of that role and would be designed to maximize the autonomy of the care receiver so as to facilitate his or her best

interests. For example, in the role of pastor, the responsibility of the caregiver as moral standardbearer of the covenant community is to provide leadership that bears witness to the set of ultimate meanings and values upon which the corporate life of the group is grounded. The image of shepherd, which is often applied to this role, is very instructive as to the nature of this leadership in that, rather than driving a herd, a shepherd leads a flock; he or her walks out in front and his or her sheep follow. Hence, the paternalism that is appropriate and essential for this role is that of providing direction for the living of life in a manner consistent with the moral and ethical framework entailed by the theological assumptions of that particular expression of the covenant community. The autonomy of the individual is respected, even in this very paternal function, in that the responsibility of the pastor is to provide that direction, not ensure that others accept and follow it.

It might be argued that the pastor is indeed responsible to ensure that others accept and follow the direction he or her provides inasmuch as his or her function includes the discipline of members of the collectivity and that this discipline, necessary for the maintenance of the traditions of the community, precludes the autonomy of the individuals within. Yet, if shepherds lead and sheep follow, then the autonomy of the individual is expressed in

choosing to become and remain a part of that particular community of faith, thus accepting the implications of membership, including discipline.

By this analysis the elders of The Collinsville Church of Christ overstepped the boundary of appropriate paternalism in the infamous case of Marian Guinn. Guinn was a divorcee, with four small children, whom the church assisted extensively in the reestablishment of her life. When she later became involved in an affair with a prominent local businessman, the elders of the church took steps to exercise what they understood to be appropriate discipline based on Matthew 18:15-17, informing her of their intent to give public notice of her behavior and withdraw fellowship from her unless she repented. Guinn responded by withdrawing her membership from the church, only to be informed by the elders that, in the absence of a New Testament precedent, she could not do so and that they would, therefore, proceed with their plans. Subsequent litigation was decided in Guinn's favor by the Oklahoma Supreme Court on the basis that, though a religious group could discipline a current member in a manner consistent with its theological presuppositions, it could not discipline a member who had withdrawn (Battin, 1990, pp.60-73). This ruling supports the position that paternalistic intervention, as expressed in discipline, is not incompatible with individual autonomy implied by membership.

The further argument that the theological implications of some belief systems are, in themselves or in their presentation, so coercive as to preclude freedom of choice in regard to membership will be considered in the presentation of a stage model of intervention.

That paternalism, as here described, maximizes autonomy is demonstrable in two respects. First, the pastor, as representative of a faith tradition that claims maximally good afterlife outcomes for those who accept it and maximally bad outcomes for those who do not, nevertheless respects the right of individuals to choose. Second, implicit in our understanding of the pastoral role is the assumption that an individual serving as representative of a particular faith tradition does so out of conviction that the belief system he espouses contains truth for living. We expect that he believes acceptance of and compliance with the truth he represents will provide greater meaning and purpose in life. In the words of Jesus, "You shall know the truth and the truth shall make you free" (John 8:32). Therefore, in paternalistically maintaining and espousing the theological presuppositions he represents, the pastor maximizes autonomy because those beliefs will issue in freedom. Whether or not that is indeed the case is an unverifiable epistemological question, but we can conclude that the pastoral role of shepherding the flock entails an

appropriate paternalistic dimension that is designed to maximize an individual's autonomy while seeking his good.

Paternalism in Pastoral Counseling

The continuum defined by Brandsma et al. suggests that the paternal dimension involved in pastoral care diminishes as one moves from the role of pastor as shepherd into counseling functions. As we have seen, this analysis delineates three specific pastoral counseling roles: denominational counselor, pastoral psychotherapist, and Christian psychotherapist, each of which justifies an increasingly narrower parameter of paternalistic intervention.

The responsibility of the pastor qua denominational counselor is different than that of the pastor qua shepherd in that the focus of the counseling role is on the idiosyncratic personal experience of the individual congregant rather than the maintenance of the moral and theological tradition of the collectivity. Parsons distinguishes between

> ...the minister's primary responsibilities as leader of a congregation and the kinds of permissiveness and support which are indicated in a role that is trying to deal with the complex interweaving of religious problems with the personality structure of the individual (Parsons, 1964, p.318).

In the counseling role, implementation of a context which facilitates resolution of the presenting problem takes

precedence over paternal exhortation to proper participation in ritual, proper affirmation of belief or proper moral conduct. Has a pastor acted in a morally appropriate manner if, when a parishioner comes seeking succor, he or she instead provides a sermonette offering biblical solutions to the person's problems? Application of role theory to the question would seem to indicate that he or she has not, that the responsibility of the counselor role does not warrant the degree of paternalism that a sermon manifests. How does a pastoral counselor respond when a client likes to get help or advice but is unwilling to carry it out? Brandsma et al.'s assertion that "a fundamental moral requirement of the therapist is to keep his or her roles and role boundaries straight" yields helpful insight (Brandsma, Pattison and Muyskens, 1986, p.162). Inasmuch as the responsibilities of the counseling role focus on the creation of a context conducive to resolution of presenting problems, the counselor is freed from paternalistic concern for assuring proper conduct.

Browning's distinction between pastoral care as moral inquiry and pastoral counseling further serves to determine the parameters of appropriate paternalism:

> Pastoral care as moral inquiry attempts to keep moral concerns uppermost in conversations and deliberations with individuals and members of a church. On the other hand, pastoral counseling to some extent brackets moral issues and focuses more specifically on emotional-dynamic issues that block persons from living the kind of life they hope for and believe in (Browning, 1976, p.106).

The responsibility of the counseling role, that of assisting individuals with the resolution of problematic life issues, sometimes entails "bracketing" moral concerns to a degree commensurate with the presenting problem. For instance, in the case of a young, unmarried woman, experiencing significant grief and depression over her choice to abort an unplanned pregnancy, who asks the pastoral counselor "What the Bible says about abortion?", it is appropriate for the counselor to "bracket" the ethical issues of premarital sexual activity and abortion while attending to the woman's grief. In response to a man angry regarding his wife's infidelity, the counseling role dictates focus on the man's emotional state prior to consideration of doctrinal issues of divorce and remarriage. In other words, not only does the role of pastor qua counselor justify a lesser degree of paternalism than pastor qua shepherd, but within the role of pastoral counselor the caregiver will be presented with different problematic life issues which will entail different degrees of paternalism.

Young and Griffith suggest that pastoral counseling encompasses at least three different types of activity, which they label as religious counseling, pastoral mental health work and pastoral psychotherapy (Young and Griffith, 1989). Each appropriately deals with a different type of problem: religious counseling with disturbed relations and spiritual-emotional crises, pastoral mental health work with

difficulties in psychological and religious growth, and pastoral psychotherapy with mental disorders as defined in the DSM-III-R. Each activity obviously requires different training and takes place in a different context as well. As one moves across the spectrum of presenting problems from faith issues to major disturbances involving potential consideration of unconscious conflicts and resistances, the nature of appropriate care with its corresponding paternal dimension changes. Of the three activities delineated, religious counseling most clearly involves the notion of moral guidance historically associated with *cura animarum* while pastoral psychotherapy requires the more specialized treatment of theologically informed psychodynamic therapy, which would entail a greater degree of "bracketing moral issues."

Indeed, the necessity of minimizing the paternalistic dimension in some helping situations led to Parsons' concern that the exigencies of the pastoral leadership role constituted such a formidable barrier to effective implementation of the permissive and supportive components of the therapeutic role that the development of a profession of spiritual counselors was necessary. The role we have described as "pastoral psychotherapist" fulfills Parsons' recommendation, while "Christian psychotherapist" takes the differentiation he envisioned a step farther than he discussed. Inasmuch as the authority of these pastoral

caregivers is derived partially, as in the case of the pastoral psychotherapist, or primarily, as in the case of the Christian psychotherapist, from psychotherapeutic training rather than from theological tradition, as in the case of the parish pastor, their roles indicate a proportionately diminished degree of paternal responsibility for maintenance and enforcement of the moral aspects of the belief system. In their practice of the cure of souls they have both greater freedom and greater responsibility to bracket these issues in order to focus on the emotional and dynamic aspects of those whom they help.

The bracketing of moral issues in no way implies the elimination of them, but is rather to be seen as an essential aspect of the therapeutic process. As discussed previously, Talcott Parsons' understanding of societal roles recognizes both a value and a task dimension in any given role. Illness is conceptualized as the status of subscribing to the values entailed by a role but being incapacitated from performing the tasks. Treatment of illness involves a "sanctioned retreat" from the expectations of societal roles that is intended to facilitate a reorganization of resources which eventuates in restored capacity to function.

Browning underscores the temporary and transitory nature of this sanctioned retreat by comparing it with Turner's "liminal phase." In The Ritual Process, Victor

Turner demonstrated that primitive therapeutic rituals consist of three phases: the separation phase in which individuals are detached from societal roles and their accompanying cultural conditions; the liminal phase, from the Latin *limen* meaning threshold, in which people are on the threshold neither here nor there, but betwixt and between, an undifferentiated phase of transition; and the aggregation phase that consummates the passage and reincorporates the persons into societal roles with their customary norms and ethical standards. The point of the comparison is that the therapeutic relationship with its bracketing of moral concerns, like the liminal phase, is a temporary component of a larger process that serves a social order and its value system.

As we have seen, the tendency in the twentieth century has been to divorce therapy from values and thereby make the liminal phase an end in itself:

> What appears to have happened is that with the increasing specialization of society and culture...what was in tribal society principally a set of transitional qualities "betwixt and between" defined states of culture and society has become itself an institutionalized state (Turner, 1969, p.107).

Browning's contention is that any therapy which focuses on the restoration of the capacity to act, without addressing the value system that action will serve, contributes to the institutionalization of liminality and thereby to moral confusion. His argument is that if there is no moral world

from which to retreat and to which to return, then emotional and mental incapacity will be followed by moral confusion which, in turn, engenders emotional incapacity (Browning, 1976, p.37). So, though the therapeutic roles of the pastoral psychotherapist and the Christian psychotherapist entail the bracketing of moral issues and therefore justify limited paternal intervention, they must be understood as temporary and transitional tools that ultimately serve the moral framework of the theological tradition that distinguishes them. This recognition of therapeutic phases suggests a stage model for pastoral counseling that further clarifies how the notion of paternalism maximizing autonomy serves the ultimate good of individuals.

Paternalism in a Stage Model of Pastoral Counseling

Mill's linkage of full autonomy and maturity prompted Komrad to postulate degrees of autonomy that fluctuate with time and situation. Mill's conception of maturity as capability of growth certainly seems parallel to Parsons' understanding of health as capacity to function. Komrad draws the conclusion that the sick role is always a state of diminished autonomy that, in light of his understanding of paternalism and autonomy as two inversely varying parameters along a spectrum of independence, warrants paternalistic intervention (Komrad, 1988).

At first glance this appears to be incompatible with the aforereached conclusion that the sanctioned retreat entails the bracketing of moral issues and thereby minimizes the parameters of appropriate paternalistic intervention in the therapeutic role. However, careful consideration reveals that no inconsistency exists between these two conclusions in that the paternalism which Komrad warrants in the sick role aims to protect and restore the patient's autonomy, while the paternalism which Browning, Parsons and Turner limit in the therapeutic role enforces the moral and ethical implications of theological assumptions. Thus maximizing the former and minimizing the latter serve the same end of protecting the individual's freedom. This confirms the conclusion that appropriate paternalistic intervention in pastoral counseling is that which maximizes autonomy.

O'Brien (1984) demonstrates how this can operate in practice with his stage conception of counseling that both preserves client freedom and permits value consideration. Following the example of Carkhuff (1969), Egan (1982), and others he defines the first stage of therapy as being primarily relational in nature. The goal of this stage is problem clarification and the fundamental qualities underlying it are respect for clients and genuineness in counselors. Basically, this stage employs Rogerian client-centered techniques and unconditional positive regard to

build a therapeutic milieu that is facilitative of improvement in the client.

Appropriate paternalism in this first stage is that which maximizes the client's autonomy by respecting his freedom in regard to the counselor. People in distress are often desperate for some way out and are especially vulnerable to solutions and values proposed by helpers (O'Brien, 1984). It is not unusual for a patient to demand that the therapist take over for him, reassure him, and make decisions for him (Breggin, 1971). Refusal to assume paternal responsibility for the client is paternalistic, in that it is action in the best interest of the client despite his wishes, but it is paternalism that maximizes autonomy. Graber's discussion of "The Paradox of Autonomy" is helpful at this point in that it demonstrates that to respect the client's autonomy expressed in the request to "take over for him" compromises the client's future autonomy. Thus to paternalistically violate present autonomy actually maximizes the client's autonomy by enhancing it in the future (Graber, Beasley, and Eaddy, 1985, pp.48-49).

Graber's discussion also demonstrates that this first stage of pastoral counseling is, alone, inadequate.

> Pastoral care must never be considered as simply a matter of implementing forgiveness even though forgiveness is an essential part of all care. Pastoral care should never be understood simply as a matter of "loosening people up," helping them to become "more open" or more "spontaneous and flexible," "removing their guilt," or making them "more loving" (Browning, 1976, p.103).

Though these relational and affectual dimensions are necessary, they are not sufficient. The expectation is that affirmation of the client's dignity will stimulate the client's self determination which ushers in O'Brien's second stage of the counseling relationship. Having been relieved of distress, the client will begin to develop new perspectives, explore root causes for his problems, and set goals. The counseling relationship enters the realm of moral inquiry of which Browning spoke.

Even in this stage, and especially in the beginnings of it, the pastoral counselor should be very sensitive to the difficulty troubled people have in inquiring into and adhering to their perceptions of what is of value. The Judeo-Christian theological heritage informs us of the captivity of the will and psychological science has sensitized us to this dimension of the human experience. People have great difficulty in following the dictates and values of their consciences. This difficulty is exacerbated by the inequity of power in the counseling relationship.

> A therapeutic encounter involving a Christian therapist and Christian patient begins with a large number of shared beliefs and values. The therapist is in an ideal situation to work with the patient from within the patient's belief and value system. The great moral danger, however, of all therapeutic relationships is that the greater power of the professional in the unequal professional-patient relationship is misused. Paternalistic beneficence can replace or be used as a shortcut to autonomy and love...Motivated by concern for the patient's best interest, both well-meaning or manipulative therapists may impose on the patient, whether willingly or through

> counter-transference, values or beliefs that arise from their own belief framework, and not that of the patient....*If so, the patient has not been treated with proper moral regard* (Brandsma, Pattison, and Muyskens, 1986, p.169).

This danger demands that, even in the task of shaping moral vision, pastoral caregivers function so as to respect and guard the autonomy of the agent. Christ's model of presenting the claims of truth in a manner conducive to freedom of choice should be the strongest of cautions, to the pastor in his role of moral standardbearer, against presenting the theological implications of the Christian tradition in a way that could be construed as coercive or manipulative. In the role of pastoral counseling, the task of moral inquiry requires paternal intervention that supports the self-determination of the client.

Martin Lakin, author of Ethical Issues in the Psychotherapies, p.63, asserts that engaging a client in a discussion of values entails a special type of teaching-guiding relationship that should not push prescriptive choices on the client and suggests that the best way to avoid doing so is through an essentially Socratic dialogue. Gustafson echoes this perspective in arguing for the necessity of ministers functioning in the role of moral counselors:

> Contrary to a prescriptive role, I imagine that of a moral counselor to be one in which the minister finally honors the conscience of the individual, but by asking relevant ethical questions and providing relevant information, the individual can

> come to an ethically considered judgment about a course of action (Gustafson, 1984, p.19).

He suggests that questions which clarify the circumstances that occasioned the moral dilemma and which elicit the relevant ethical issues, moral outlook of the principal agents, and religious convictions that inform their practical reasoning are especially helpful in the process.

Williamson's consideration of value orientations in the counseling of students in the university setting employed the model of teacher, also identified by Lakin, to demonstrate how a counselor can participate in moral inquiry without imposing his perspectives on the client. In contrast to persuading the client in the right direction or arguing for the right value orientation, the counselor assists the client in applying the techniques of analysis, clarification, and understanding to the particular value issue. He suggests that in the course of this process, it is acceptable for the counselor, as a teacher, to introduce his own value system as an approach to the particular problem.

> In counseling about values, as in the case of vocational and educational counseling, we limit ourselves to helping a student understand the options open to him...and their implications for him. At that point...the student is free to make his own choice from these or other options...But I have long held that the exercising of such a right does not preclude "direct" assistance from counselors, or anyone else, prior to and after choices have been made (Williamson, 1958, p.528).

I maintain that the insights afforded by the notion of a paternalism which maximizes autonomy in serving the ultimate good of the individual, applied to a stage model of counseling within the respective roles of pastoral counseling, will enable physicians of the soul to remain faithful to the moral framework of their faith in our pluralistic milieu without becoming moralistic.

CHAPTER IV

INFORMED CONSENT IN PASTORAL COUNSELING

C. S. Lewis penned a playful, yet serious, epitaph that exposes a tendency which presents one of the most serious challenges confronting the helping professions in general and pastoral counseling in particular.

> Erected by her sorrowing brothers
> In memory of Martha Clay.
> Here lies one who lived for others;
> Now she has peace. And so have they.
> (Lewis, 1965)

The tendency, endemic to those who profess to help others, is to promise one thing and provide another. The challenge is to, indeed, provide what is promised. Martha thought she was serving her brothers; they apparently thought she was a pest. In attempting to meet her brothers' needs as she perceived them, it appears that she, in their opinion, did not provide what she promised. Despite Martha's commitment to care for others, it can be concluded that her efforts, at least from her brothers' perspective, actually served someone and/or something else.

In another form, this is one of the most pressing and problematic issues facing the helping professions today. The concern is that the Martha Clays of our world, those who ostensibly live to serve others, will either misunderstand their brothers' needs or, even worse, under the guise of meeting others' needs actually serve their own ends. These issues are especially challenging for providers of pastoral counseling in that they are distinguished by their commitment to an ultimate set of meanings and values. How do pastoral counselors balance their responsibility to serve both the implications of their theological presuppositions as they see them and the needs of their individual clients? Does the moral and ethical framework of their faith tradition put them in a position to "really know" their clients' needs, despite what their clients think their needs are? What will keep the professed altruism of the caregivers from collapsing into self-serving egoism, as in the case of Martha Clay?

Consideration of the questions "Who is right about what Martha's brothers need?", "Who decides what constitutes appropriate care?", "What protects the clients?" have, in the last half of the twentieth-century, taken place in reference to the doctrine of informed consent. Since its initial appearance, in lawsuits related to health care delivery, in the 1950's, this notion has generated

significant discussion and controversy within the medical profession (Meisel and Roth, 1981). Its proponents claim

> The most axiomatic action-guiding principle in contemporary medical and legal ethics is that of informed voluntary consent. The principle is advanced as a morally acceptable way of structuring power relationships within the medical setting (Edwards, 1982b, p.189).

While its opponents contend

> ...that it is a myth and a fiction - that patients do not understand, cannot understand, and do not want to be told (Meisel and Roth, 1981).

Despite its controversial nature, the notion of informed consent addresses significant ethical issues for helping professionals in general and pastoral counselors in particular. I will briefly examine the history and nature of the doctrine, demonstrate its contribution to an ethical framework from which pastoral counseling can function, and discuss the particular challenges the doctrine presents to those activities of pastoral care which derive some dimension of their authority from the psychotherapeutic tradition.

The Doctrine of Informed Consent

Informed consent is rooted in the age-old history of the relationship between doctor and patient (Eth and Robb, 1986). Its development as a doctrine has grown out of the interplay of the disciplines of medicine, law, and philosophy. The antecedents of our contemporary concept of informed consent can be found as far back as the late-

eighteenth century. Meisel, Roth, and Lidz (1982) cite the case of *Slater v. Baker and Stapleton*, in which the court ruled that the physicians in question had acted improperly by their usage of an innovative means of treating a fracture because they did so without obtaining the patient's consent:

> It appears from the evidence of the surgeons that it was improper to disunite the callous without consent; this is the usage and law of surgeons....It is reasonable that a patient should be told what is about to be done, that he may take courage and put himself in such a situation as to enable him to undergo the operation (Meisel, Roth, and Lidz, 1982, p.193).

The rise of interest in informed consent issues in the latter half of the twentieth century can be seen as stemming from the complex social issues of post-war America including the bureaucratization of society, concern for individual liberty and social equality, and development of a powerful technological and impersonal health care (Faden and Beauchamp, 1986, pp.86-88). The shocking revelations of the Nuremburg trials provided additional impetus for the formal development of the doctrine of informed consent. The atrocities committed by Nazi physicians during World War II motivated the institutionalization of informed voluntary consent in United States case law as a means of protecting people subject to scientific and medical procedures (VanDeVeer, 1986, pp.167-175). Beauchamp and Childress (1979, p.62) claim that, since the Nuremberg trials, the issue of informed consent has received more attention than any other issue in biomedical research and practice. The

primary contributions to the development of the doctrine have been made in the fields of moral philosophy and law.

Most philosophers would agree that the principle of autonomy is one of the supporting principles, if not the primary justificatory basis, for the doctrine of informed consent. The central ingredient of this concept, as shaped by Kant and Mill, is self-directed action based on a rational principle accepted by the agent (Beauchamp and Childress, 1979, p.58). The word "autonomy" was first used in reference to Greek city-states whose citizens had the right to make their own laws in contrast to those city-states whose laws were imposed by conquering forces (Eth and Robb, 1986). In moral philosophy, then, autonomy has come to be applied to individual's self-governance, freedom to control one's own actions and destiny without external constraint or internal personal limitation that prevents choice. The corresponding prima facie duty is, therefore, the responsibility to respect and/or promote autonomy. Inasmuch as this is a prima facie duty, rather than an actual duty, it may be overridden by competing claims such as beneficence or justice. However, some moral philosophers go so far as assigning priority value to autonomy, viewing it as a core attribute necessary for full status of personhood (Eth and Robb, 1986). In arguing that autonomy is *a* moral value rather than *the* moral value, Faden and Beauchamp nevertheless assert that:

> ...we would be well advised not to depress the value of autonomy relative to the other principles in our framework. Autonomy is almost certainly the most important value "discovered" in medical and research ethics in the last two decades, and it is the single most important moral value for informed consent...Autonomy gives us respect, moral entitlement, and protection against invasions by others. Few matters of morals could be more important (Faden and Beauchamp, 1986, p.18).

Because, in light of the principle of autonomy, a person has the right to be self-governing and free from external constraint, respect for autonomy demands that a helping professional acquire the consent of a patient or client before applying treatment or performing a procedure upon him.

The contribution of the discipline of law to the development of the doctrine of informed consent is derived primarily from case law dealing with issues of liability in the physician-patient therapeutic relationship. The first principle of jurisprudence on which the informed consent doctrine is legally based is that of patient self-determination (Miller, 1980). The landmark case of *Schloendorff v. Society of New York Hospital*, established the legal requirement of patient consent to medical care from the right of self-determination implicit in the civil law of battery. Technically, battery is nonconsensual touching and Justice Benjamin Cardoza ruled by extension that to perform a procedure on a patient which the patient has not authorized is to commit battery:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages (Eth and Robb, 1986, p.88).

This opinion that a legally competent person has the right to determine what is to be done with his body was reiterated in the decision of *Natanson v. Kline*:

> Anglo-American law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment (Beauchamp and Childress, 1979, p.65).

The judgment in this case, decided by the Kansas Supreme Court in 1960, was predicated on negligence rather than battery and was the first to use the particular term "informed consent."

The second principle of jurisprudence which has served as a source for the doctrine of informed consent is the concept of the fiduciary relationship (Miller, 1980; Eth and Robb, 1986; Battin, 1990). The fiduciary principle is a dimension of professional ethics that identifies the responsibility of the professional to the client within the context of the professional relationship. In light of the asymmetric nature of professional-client dyads, the principle specifies that the professional, in whom the client has placed a special trust, must act in good faith for the best interests of the client, even when the interests of the professional conflict with those of the

client. Despite the fact that a professional's knowledge and power would enable him to take advantage of a client, for his own benefit, within the professional relationship, the fiduciary principle prohibits him from doing so.

The courts have decreed that the inequity of power in the physician-patient relationship, "the special knowledge and training of the physician" and "the ignorance and helplessness of the patient regarding his own physical condition," qualify it as a fiduciary relationship (Miller, 1980, p.2100). Such a relationship imposes on the physician the responsibility to give the patient knowledge about the patient's condition and the recommended treatment that will diminish the asymmetry in the relationship and thereby enable the patient to act independently. Hence, quoting from *Sard v. Hardy*, Miller defines the doctrine of informed consent as:

> ...the duty of a physician, before treating a patient, to explain the procedure to the patient and to warn him of any material risks or dangers inherent in or collateral to the therapy, so as to enable the patient to make an intelligent and informed choice about whether or not to undergo such treatment (Miller, 1980, pp.2100-2101).

Beauchamp and Childress' (1979, p.67) analysis of this doctrine indicates that there are four elements which are necessary in order for informed consent to be considered valid, the first of which focuses on the disclosure of information. The question of the amount and nature of information which must be communicated to a patient to

satisfy the requirement of informed consent has generated three standards of disclosure: the Professional Practice standard, the Reasonable Person standard, and the Subjective standard (Faden and Beauchamp, 1986, pp.30-34).

The Professional Practice standard defines the practitioner's duty to disclose information in terms of the prevailing practice of medical professionals in that or a similar community. Adherence to the customary professional standard of disclosure was the basis for determining liability in the eighteenth-century *Slater v. Baker and Stapleton* case and, parallel with standards of negligence in practice, continued to be virtually the exclusive interpretation of the informed consent requirement until the early 1970's (Meisel, Roth, and Lidz, 1982).

The cases of *Canterbury v. Spence* and *Cobbs v. Grant* rejected the Professional Practice standard because of the difficulty in determining an actual professional standard in a given community, the possibility of the perpetuation of inferior care through shared ignorance or collusion on the part of medical practitioners, its inconsistency with an individual's right of self-determination, and the fact that the decision as to which risks are relevant to a patient's acceptance or rejection of treatment is not a medical decision and therefore should not be judged by a medical standard (Miller, 1980). These courts adopted a standard for determining the scope of disclosure that focused on the

information about risks, consequences, and alternatives that a reasonable person would need to know in order to make a decision about treatment (Faden and Beauchamp, 1986, pp.32-33). The Reasonable Person standard requires the physician to divulge any information that would be material to a reasonable person's decision and in so doing shifts the determination of pertinence of information from the physician to the patient. In trial situations, this shift is reflected in jury, rather than expert testimony, determination of pertinent information.

The Subjective standard takes this shift one step farther in that it requires disclosure of information that is material to the specific, individual patient rather than to the hypothetical reasonable person. The responsibility of the physician, according to this perspective, is to make a reasonable attempt to ascertain how much and what information the particular patient needs to make an informed decision and then to provide it.

Whereas Beauchamp and Childress (1979, p.72) and Miller (1980) understand the Reasonable Person standard as the prevalent criterion, Faden and Beauchamp (1986, p.31) contend that the Professional Practice standard continues to be predominant in informed consent law. The Subjective standard is proposed, for the most part, in legal commentary (Faden and Beauchamp, p.33). As we shall see in subsequent discussion, the Subjective standard of informed consent is

most appropriate for the pastoral counseling context in that the communication it entails enables counselors to serve the needs of their clients while at the same time clarifying their belief system. Such communication allows counselors to both honor the autonomy of their clients while remaining faithful to the implications of their faith framework.

The second and third elements of valid informed consent, competency and understanding, are related in that they deal with the patient's reception of the information provided. Competence is a measure of the individual's ability to understand the information disclosed and to employ it in deliberation, while understanding is a measure of the individual's actual apprehension of the information. In determining the validity of informed consent, a patient is presumed to have the capacity to understand the information disclosed to the extent that a hypothetical reasonable person would understand it, unless the patient is afflicted with a condition, physical or mental, that would preclude him from understanding it to that extent (Meisel et al., 1982). The existence of such a condition would render that patient incompetent and eliminate the possibility of valid informed consent. The notion of competence is very difficult to define in light of the possibility of limited or intermittent competence (Beauchamp and Childress, 1979, pp.67-70) and the lack of a widely accepted and clearly defined test for competence (Roth, Meisel, and Lidz, 1982).

Understanding is an equally elusive concept given the obvious difficulty in assuring that imparted information has actually been understood. The courts have assumed that a competent agent, who has been provided with adequate information, will understand it as long as the hypothetical reasonable person would have understood it (Meisel, Roth, and Lidz, 1982). In essence disclosure of information to a competent individual constitutes understanding.

The final element of a valid informed consent is that it must be voluntary, i.e. free from coercion or undue influence. Acknowledging the practical improbability of absolute independence from influence by others, especially in medical care and research contexts, Faden and Beauchamp (1986) cast this criterion in terms of "substantial noncontrol" by coercion, persuasion, or manipulation. However, it is important to realize that the absence of these controlling influences, in and of itself, does not guarantee voluntary choice or consent. Meisel and Roth cite a study of mothers who admitted their children to a hospital to be subjects in a research protocol offering no benefits to the children to demonstrate that for voluntary choice or consent to be a reality options for choice must exist. The fact that only three of 140 refused to admit their children is misleading given the recurrent statement, "I have no choice." (Meisel and Roth, 1981, p.2476). It appears obvious that the mothers did not "voluntarily" admit their

children to the research protocol, in the sense that they would have made the same choice given other alternatives, but rather were compelled by the absence of such alternatives.

In summary, the doctrine of informed consent entails that valid informed voluntary consent has taken place when information is disclosed by a helping professional to a competent person, so that the person understands the information and voluntarily makes a decision to accept or refuse the recommended procedure (Meisel and Roth, 1981).

Difficulties with the Doctrine of Informed Consent

As we saw in the discussion of paternalism, the difficulty with and controversy surrounding the doctrine of informed consent grow out of conflict between the principles of autonomy and beneficence. Katz called this "a conflict between two visions;" on the one hand a "vision of human beings as autonomous persons" and, on the other, "deference to paternalism, another powerful vision of man's interaction with man" (Katz, 1977). The controversy between patients' or clients' right to self-determination of treatment and physicians' professional judgments as to the best interests of the patient has given rise to the claim that

> a patient autonomy-rights model based in rationalist philosophy and liberal political theory, has been used to subvert values intrinsic to medicine, that it has done so without adequately establishing the merits of its case, and that the attempted replacement of the historic

> medical value system by an ill-fitting alternative (Clements and Sider, 1982, p.151).

In addition to the claim that informed consent is philosophically unfounded, it has been argued that, in actual practice, informed consent is virtually impossible to attain, for reasons ranging from patients' understanding of medical information (Edwards and Graber, 1982, pp.120-122) to the very nature of the doctor-patient relationship:

> Indeed, I doubt if any physician caring for any patient can ever get really informed consent from the patient; the patient-physician relationship is, or should be, so strong as to make the likelihood of free consent about the same as that of prisoners (Spiro, 1975, p.1135)

Numerous empirical studies have been conducted which, ostensibly, demonstrate that the majority of patients do not want to be informed of potential risks of therapeutic procedures, do not really understand informed consent information, and do not actually utilize such information in decisions regarding acceptance or rejection of therapeutic procedures (Meisel and Roth, 1981). Based on these, practitioners object that the ideal of informed consent would require physicians to give their patients a medical school education which would take too much of the doctors' time and in the process frighten patients away from receiving needed treatment. Furthermore, it has been contended that the ideal of rational autonomy which underlies the notion of valid informed consent is an ideal

that is rarely fully achieved by anyone (Graber and Edwards, 1988, pp.120-122,112).

These difficulties are further exacerbated in the mental health realm by virtue of the fact that the presenting problem entails some measure of impairment of the part of the patient that controls knowing and willing (Edwards, 1982b). The elements of competency and voluntariness, implicit in the notion of valid informed consent, are particularly vexing in psychological settings (Eth and Robb, 1986). Competency is difficult to determine because of the episodic nature of mental illness as well as the absence of consensus regarding appropriate criteria for competence. Voluntariness is equally difficult to ascertain in that the problems which motivated the client to seek psychiatric or psychological help may preclude the possibility of free choice. As we have seen, people in distress are often desperate for some way out and are especially vulnerable to solutions proposed by helpers (O'Brien, 1984).

> The concern over voluntariness is underscored when the patient is suffering from a serious psychiatric disorder. In addition to the direct effects of the mental impairment on cognition, affect, and personality, there are significant secondary consequences of chronic hospitalization. Institutionalization can promote the iatrogenic effects of low self-esteem, inertia, and diminished effectiveness in decision-making (Eth and Robb, 1986).

Responses to concerns about informed consent are as varied as the objections themselves. Proponents of the

doctrine recognize that to demand the achievement of full rational autonomy before allowing a person to take part in decisions regarding their medical treatment would effectively eliminate everyone from such participation. Though no one, it would seem, always makes choices based on principles that are part of a comprehensive, coherent, and consistent life-plan and that have been applied to the situation through rational deliberation, this, in and of itself, does not seem to alleviate the caregiver from the responsibility, implied by the principle of autonomy, of respecting the patient by providing information about available treatment options, including the risks, benefits, and potential side effects of each (Edwards and Graber, 1988, pp.112-120). Alan Meisel and Loren Roth reviewed representative empirical studies in an attempt to validate the common criticisms of informed consent and discovered that the empirical literature offers little support for either proponents or opponents of informed consent.

> It is our conclusion, unhappily, that while much information has been generated about informed consent, a large proportion of it is of questionable utility in answering the questions raised in the debate about informed consent as a result of serious conceptual and methodological flaws in the studies (Meisel and Roth, 1981, p.2473).

However, their observation that the doctrine of informed consent is not refuted by the empirical uncertainty as to its feasibility because "positions based on values suffer none from the lack of useful data" is most helpful

because it directs our attention to the value realm as the appropriate sphere for the consideration and justification or refutation of the practice.

It is at this point that the work of Beauchamp and McCullough in "The Management of Medical Information: Legal and Moral Requirements of Informed Voluntary Consent" is most helpful. They acknowledge that the legal doctrine of informed consent is committed to both of the competing moral objectives of protecting autonomy and protecting from harm, i.e. patients' rights of self-determination and physicians' professional judgments. Furthermore, they posit that though there is no *a priori* inconsistency between these two principles, neither is there a single or final solution to the conflicts between them. Their conclusion is that helping professionals must utilize both models of autonomy and beneficence in the management of information according to three guidelines they develop:

> First, patients whose decisional capacities are substantially intact (and who qualify as autonomous) should be treated primarily in accordance with the autonomy model and a subjective standard of disclosure of information that emphasizes relatively complete disclosure. Second, patients whose decisional capacities are substantially impaired by such conditions as severe or profound mental retardation, advanced dementia, emergency situations, and the like (and whose autonomy is substantially reduced) should be treated primarily in accordance with the beneficence model, with its characteristic emphases on harms, goods, and the careful monitoring of information (Beauchamp and McCullough, 1988, p.139).

Their third guideline is especially relevant for mental health care in general and pastoral counseling in particular because it addresses those individuals who are borderline:

> For patients whose decisional capacities are basically intact yet whose emotional state may temporarily retard the exercise of sound judgment, the physician must determine the proper balance between the demands of the autonomy model and those of the beneficence model (Beauchamp and McCullough, 1988, p.140).

These guidelines assist practitioners in the implementation of informed consent by acknowledging and balancing its dual moral and legal objectives.

Informed Consent Applied to Pastoral Counseling

Applied to pastoral counseling, the doctrine of informed consent proves helpful in the construction of an ethical framework that supports and directs its practice. Pastoral counselors are, as we have seen, distinguished by their commitment to a set of ultimate meanings and values and the help they offer is an expression of the moral and ethical implications of that theological tradition. This attempt, to function as representative persons of the resources and authority of a faith framework, gives rise to questions as to how the practitioner serves both the implications of the ultimate meanings he or she espouses and the best interests of his or her clients. Informed consent helps to answer them.

One of the implications of the doctrine of informed consent for the practice of pastoral counseling is that the practitioner will inform his or her clients of the nature of the treatment being offered, specifically that it is shaped by a particular theological orientation. By dealing with the issues presented by those seeking his or her help in reference to the moral and ethical implications of his or her faith tradition, the pastoral counselor is faithful to the ultimate values he or she espouses. He or she is also acting in the best interests of his or her client, as the counselor understands them, in that those interests are served by the theological truth he or she represents. Furthermore, the client is served inasmuch as his or her autonomy is not only respected but maximized as he or she is informed of the philosophical and theological presuppositions of the counselor. The client is thereby enabled to evaluate the counsel he or she receives, in light of the presuppositions which shape it, and to make informed, voluntary choices as to its implementation.

The doctrine of informed consent also helps to free the pastoral counselor from the demands of a paternalism which, based on claims of transcendent truth, would argue that if the pastoral counselor is indeed a representative of truth, then he or she "really knows" what the needs of his client are and solutions to those needs, regardless of the perceptions of the client. In other words, it could be

argued that Martha really was taking care of her brothers, despite the fact they thought she was a pest, because she knew best what they really needed. Battin's typology enables us to evaluate this claim in light of ordinary ethical theory by virtue of its elimination of unverifiable O-order imperatives. The pastoral counselor may "really know" what is best but, ethically, he is neither required nor justified to impose that on the client. Informed consent, with its philosophical basis of respect for autonomy and its legal basis of fiduciary responsibility, requires that the counselor inform the client of the proposed treatment, i.e., his perception of what is best, and respect the right of the individual to respond as he or she chooses, even if what he or she chooses seems to be wrong to the counselor. The criterion of voluntariness in valid consent demands that the manner in which this is presented safeguard autonomy, as in the stage model of paternalistic intervention considered previously.

The doctrine of informed consent serves to protect both the pastoral counselor and the counselee within the asymmetry of the professional relationship. This inequity of power, exacerbated by the paternal dimension inherent in the pastoral role, presents the possibility of self-serving activity on the part of the professional. Informed consent guards against this by demanding that the nature of the proffered care is clearly specified and that the care that

is promised is indeed provided. Though these factors would be a feature of any ethically valid therapy, this challenge is particularly relevant to those pastoral counselors who derive some measure of their authority from psychotherapeutic tradition. Of the five categories of contemporary practitioners of pastoral care we have identified, this would primarily be true of secularly-trained psychotherapists who identify themselves as Christians and specialists in pastoral counseling, identified by Brandsma et al. as Christian psychotherapists and pastoral psychotherapists. Inasmuch as these categories of pastoral counselors generally function in "private practice" and insofar as their theological orientation is not obvious through association with a congregation or denomination, it becomes all the more incumbent upon them to clarify the nature of the care they offer their clients. For example, what is the ethical responsibility of the Christian psychotherapist, whose understanding of the ethical implications of his or her faith precluded homosexuality as a morally acceptable lifestyle choice, to the homosexual seeking his or her help for situational anxiety and depression? Or what is the responsibility of the pastoral psychotherapist to the homosexual who is struggling with his sexual identity and seeking help from a specifically Christian perspective?

Informed Consent and Christian Psychotherapists

Despite the fact that VanDeVeer acknowledges:

> We do not expect a physician, nurse, clinical psychologist, social worker, genetic counselor, dentist, or teacher to operate on the principle of *caveat emptor* (let the buyer beware), even though we directly or indirectly purchase their services (VanDeVeer, 1986, p.164)

he nevertheless recognizes that paternalistic policies create situations in which recipients of service or care do not want to be helped in the manner offered. Given this realization, Cross and Kahn suggested that it might be important to issue a caveat to potential consumers of counseling services. Their rationale is that because there is no such thing as value-free therapy, therapy is a powerful mechanism for changing clients' values and a shared moral and religious value system cannot be assumed. Therefore it is advisable, if not essential, for clients to be aware of their counselor's value systems and for counselors to be explicit about their value systems (Cross and Kahn, 1983).

These considerations are especially germane for Christian psychotherapists whose authority is derived primarily from psychotherapeutic training. Motivated both to rediscover the distinctive theological basis of pastoral counseling and to satisfy secular educational and licensing requirements, these individuals, for the most part theological conservatives, have trained in secular programs and integrated their faith into their clinical practices.

The Christian psychotherapist functions much more like a secular psychotherapist than any of the other categories of pastoral counselors we have identified, generally in the context of an independent private practice.

In considering the responsibility of the Christian psychotherapist to be explicit about his or her value orientation, the Professional Practice standard, previously discussed, indicates that the professional controls the decision as to what information about his value orientation is relevant for disclosure and, if such disclosure is appropriate, when in the professional relationship it takes place.

However, when applied to the psychotherapeutic context, the doctrine of informed consent seems to indicate that such a position violates the philosophical principle of respect for autonomy by giving the professional unilateral control of the counseling relationship and maintaining asymmetry in the relationship.

> Counselors are faced with a decision concerning whether to overtly communicate the values inherent in their own methods and goals or to allow those values to operate in an implicit, unacknowledged fashion. The use of a covert rather than an overt value statement gives the counselor dominance in the counseling relationship and the power to define and accomplish the goals for the counseling that he or she deems appropriate (Lewis and Walsh, 1980, p.309).

The purpose of informed consent is to ameliorate this power inequity and make the client a partner in the therapeutic process. In light of this it seems that a more explicit

value statement than that recommended by the Professional Practice standard is necessary to avoid undue professional control of and enhance client responsibility for the therapeutic process.

Moreover, the concept of a fiduciary relationship, implicit within the doctrine of informed consent, imposes a burden on the practitioner for any misrepresentation or nondisclosure of treatment. The development of the informed consent doctrine since *Natanson v. Kline* regards the provision of information as the responsibility of the professional and, in the medical context, failure to inform adequately has been judged negligent nondisclosure (Eth and Robb, 1986). Inasmuch as the fiduciary principle applies most directly to the purpose for which the individual has consulted the professional, in the case of the pastoral counselor it is imperative that the treatment offered is consistent with the aims or interests for which the client has sought the services of the professional.

> What the fiduciary principle requires is that the (religious professional) not treat those who come as prey, even in the most subtle ways, or use them either for self-interested ends or other institutional goals, but instead remain worthy of trust (Battin, 1990, p.119).

For a Christian psychotherapist to define and accomplish goals for counseling based upon the moral and ethical framework of his faith tradition without the knowledge and participation of his client is unethical in that such behavior primarily serves the faith tradition of the

psychotherapist. Unless such goals motivated the client in his selection of therapists, the imposition of them is a violation of the fiduciary relationship and the trust it entails by treating the client as a means to the end prescribed by the faith tradition.

Consideration of the concept of the materiality of information, central to the Reasonable Person standard of disclosure, further suggests the importance of overt acknowledgement of values on the part of the counselor. "Material information" is that information which any reasonable person would need to know about risks, consequences, and alternatives in order to make a decision to accept or forgo treatment. Investigations of the impact of initial value similarity or dissimilarity between the counselor and client upon the counseling outcome indicates that value considerations are indeed a material issue. Beutler and his colleagues discovered that a client's attitude toward his therapist's values is strongly related to the development of trust and attraction (Beutler, Pollack, and Jobe, 1978) and that when client's and therapist's values are sufficiently similar that the therapist's attitudes are acceptable to the client, positive results are more likely to occur in the counseling from the client's point of view (Beutler, Jobe, and Elkins, 1974). Especially important to what, from the client's point of view are positive results, is client-counselor similarity on

religious values (Beutler, Jobe, and Elkins, 1974; Welkowitz, Cohen, and Ortmeyer, 1967) and values specifically relevant to the issues of the counseling (Lewis and Walsh, 1980). However, there is some indication that a too-great initial value similarity between client and counselor might produce a very close relationship but not produce maximum therapeutic benefit (Beutler, Elkins, and Jobe, 1975; Beutler, Pollack, and Jobe, 1978). This is germane given the discovery that successful clients change their initial values to approximate those of their counselor (Beutler, Jobe, and Elkins, 1974; Welkowitz, Cohen, and Ortmeyer, 1967).

Worthington and Gascoyne (1985) conclude from these studies that clients who share the value systems of Christian psychotherapists have a "head-start" on the process, in that the consequent trust is conducive to the development of relational dynamics facilitative of personal growth and change. Clients can profit from counseling with a professional whose value system is dissimilar from theirs so long as the dissimilarity does not preclude mutual acceptance of the client and counselor. But, this dissimilarity, in light of the discovery that conservative clients tend to be more tolerant of liberal counselors than liberal clients are of conservative counselors (Lewis and Walsh, 1980: Godwin and Crouch, 1989), dictates that disclosure of value orientation is indeed material to the

counseling process and outcome and is therefore recommended by the doctrine of informed consent.

> If non-Christian clients were to attend counseling with these Christian counselors, the likelihood of value change of the client would be great. This would perhaps make ethically desirable some statement of the explicit values of the counselor and of the risk to the client of value change (Worthington and Gascoyne, 1985, p.38).

Given the ethical importance of explicit disclosure of value orientation, many practical questions remain about how this may be accomplished without compromising the effectiveness of psychotherapeutic treatment. Is it essential for Christian psychotherapists to present themselves as such? If they do not, at what point in the counseling process are the value dimensions most constructively introduced? What degree of disclosure, concerning which issues, is required?

It would appear that there are no clearcut answers to these and related questions. On the one hand, it could be argued that the importance of value dimensions to the counseling process dictates that orientation be established from the outset, as through their public presentation of themselves. On the other hand, this would possibly preclude the maximization of therapeutic benefit that results from some measure of disparity on such issues. Perhaps the initial interview is the appropriate time to clarify belief systems, yet as the stage approach to therapy suggests, the client may be distressed to the degree that, at this

juncture in the relationship, he is particularly vulnerable to paternalistic influence. Considerations like these prompted Faden and Beauchamp's assertion that disclosure standards which specify a quantum of information are misleading and that a subjective standard predicated on client-counselor communication is more helpful:

> The key to effective communication is to invite active participation by patients or subjects in the context of an informational exchange. Ordinarily, the professional soliciting consent has but a narrow window from which to view the values and informational needs of others. Professionals would do well to end their traditional preoccupation with disclosure and instead ask questions, elicit the concerns and interests of the patient or subject, and establish a climate that encourages the patient or subject to ask questions. This is the most promising course to ensure that the patient or subject will receive information that is personally material--that is, the kind of description that will permit the subject or patient, on the basis of his or her personal values, desires, and beliefs, to act with substantial autonomy (Faden and Beauchamp, 1986, p.307).

It would appear that adoption of this approach would enable Christian psychotherapists to satisfy the ethical demands of the doctrine of informed consent, honor the autonomy of his clients, and maximize the therapeutic potential of his relationships while remaining faithful to the moral and ethical implications of his faith commitment.

Informed Consent and Pastoral Psychotherapists

The challenge that informed consent presents to pastoral psychotherapists is the flip side of the coin from

that presented to Christian psychotherapists. As we saw in the case of Martha Clay, there is an endemic tendency on the part of those who live for others to promise one thing and provide another. The challenge of informed consent to Christian psychotherapists is to promise what they will in fact provide, to be explicit about the nature of the service they offer. The challenge of informed consent to pastoral psychotherapists, on the other hand is to provide what they have promised, to in fact offer service consistent with their explicit claim of care and counseling that is shaped by a particular faith tradition.

As we have seen, the specialty of pastoral counseling was a product of a pragmatic reality and a particular cultural context. The demands and multiple roles of the parish structure presented situations in which time and training constraints and the exigencies of leadership prevented the pastor from functioning as the primary religious therapeutic agent. The emergence of the pastoral psychotherapist to fill this need was nurtured by the post World War II psychologicalization of society, which served to inform and shape the discipline after the accepted therapeutic practice. Thus, the challenge for pastoral psychotherapists is to show that they are providing the distinctive care they claim.

> Pastoral care and counseling must be able to show what is "Christian" and "pastoral" about what the minister-or the pastoral specialist-does when he offers his services. And pastoral care must be

> able to show that what it has borrowed from other disciplines will not corrupt the essential thrust of its own unique perspective (Browning, 1976, p.19).

Studies indicate that clients seeking help from pastoral counselors do so primarily because of the faith tradition they represent. Of the respondents to a question regarding the importance of the religious background of a counselor, 60% indicated that shared religious beliefs gave them confidence that the counselor would be more trustworthy or understanding (Endicott, Greenawalt, Nee, and Jasmine, 1983). King found that 89% of conservative Christians, dissatisfied with available counseling services, were concerned that their faith would be in some way misunderstood or eroded (King, 1978). Worthington similarly concluded that "Christians prefer likeminded counselors and distrust secular counselors. They generally fear having their values changed and misunderstood or being misdiagnosed because of their beliefs" (Worthington, 1986). Motivated by these concerns and the desire to avoid the stigma of "mental illness," very few of the clients of pastoral counseling centers would seek help from a private psychiatrist, a community health center, or a psychiatric clinic (Endicott et al., 1983). These findings, in light of the fiduciary principle implicit in the doctrine of informed consent, underscore the importance of Browning's concern. Inasmuch as the client consults the pastoral psychotherapist specifically because of the pastoral dimension of the care

offered, it is ethically essential that the therapist provide what is promised.

Unfortunately, this is a particularly difficult challenge for pastoral psychotherapy to meet. The seeds of this difficulty are found in the very conceptualization of pastoral psychotherapy as a distinct discipline. Talcott Parsons' sociology provided the most compelling justification for the development of pastoral counseling as a specialty with its recognition of the incongruity of collectivity leadership and therapeutic agency. Parsons' solution was to create distance between practitioners of pastoral counseling and responsibility for maintenance of the faith tradition that would facilitate implementation of the permissive and supportive components of the therapeutic role.

> That a profession of spiritual counselors in this sense should be a specialized group clearly separated from the parish ministry...seems to me to be strongly indicated. I would even suggest the possibility of going a step beyond this, namely to the point where such a group should be independent of at least formal denominational affiliation....It would certainly greatly facilitate the impression of the genuineness of the "disinterestedness" of the counselor, namely, by removing the suspicion that he was simply an agent of the denominational authorities, not sincerely concerned with his client's personal religious problems, but only commissioned to bring him back into the fold by whatever pressures were necessary (Parsons, 1964, p.321).

The problem is that the distance from and disinterestedness in the moral dimensions of the faith that Parsons posits

seems to undermine the distinctiveness of the contribution the pastoral counselor has to offer. Browning asks

> But if, by definition, the specialized counselor should enjoy some distance (qua counselor) from the direct concerns of moral inquiry, what then makes his counseling pastoral? What does he bring that cannot be brought by the social worker, the psychologist, the psychoanalyst? (Browning, 1976, p.110-111).

The difficult challenge, then, is to create sufficient distance to facilitate the therapeutic role without creating such distance that the distinctive components of the role are lost.

One distinctive aspect of pastoral care that is jeopardized by the development of private counseling practice and the attendant fee-for-service model is the availability of care. Howard Clinebell, the first president of the AAPC, concurred with Seward Hiltner's position that deprivation of pastoral services on financial grounds is unthinkable to anyone who represents the church and suggested service provided on an ability-to-pay basis as a solution for pastoral psychotherapists (Hiltner, 1964; Clinebell, 1964).

Clinebell acknowledged these difficulties, inherent in the very conceptualization of the role of the pastoral psychotherapist, in his enumeration of the dangers facing the discipline:

> A danger which is very real is that the pastoral counseling specialist will lose his distinctive ministerial identity and substitute the model of the psychotherapist. If this happens, the label

> "pastoral" will be inappropriate and a new, non-church-related profession will have been created (Clinebell, 1964, p.23).

Oates rather pessimistically predicted that the danger Clinebell envisioned was inevitable. His contention was that the very establishment of a professional association of pastoral counselors would engender this loss of ministerial identity and adoption of psychotherapeutic identity: "This is the direction this kind of thing will go. It can go no other" (Oates, 1961, p.49).

Unfortunately, more than one voice suggests that Oates' pessimism was prophetic and that pastoral psychotherapy has gone the way of Martha Clay. Browning laments that

> The majority of those who make up American Association of Pastoral Counselors...are becoming more and more preoccupied with issues relating to counseling techniques and less and less interested as professionals in issues related to ethics, theology, and the philosophy of religion.... Pastoral counseling specialists...generally seem unaware that their counseling should proceed in a fairly clear value context (Browning, 1976, p.113).

Smith (1990) makes the more pointed observation that the practice of most pastoral counselors, characterized by private practice, fee-for-service, and secular diagnostic systems, is indistinguishable from that of other psychotherapeutic professionals. Larry Graham, a Fellow of the AAPC, makes it clear in "The Institutionalization of Pastoral Counseling" that this is, at least, his goal for the AAPC. He takes it as a sign that the pastoral psychotherapy has come of age that it was linked, by Robert

Bellah et al. in Habits of the Heart, with other types of therapy in contributing to a dangerous overemphasis on individualism in American culture and looks forward to the day in the near future when pastoral counseling becomes

> ...functionally autonomous in relation to the church and society, maintaining important ties but proceeding about its business with little internal relationship to either of those social structures (Graham, 1988, p.8).

Pastoral psychotherapy might be winning in the battle in gaining public recognition and esteem for thoroughly professional therapeutic approaches, but it is losing the war in that the care it offers no longer seems to be uniquely Christian (Farnsworth, 1980).

Farnsworth's contention is that pastoral psychotherapy has been secularized by its acceptance of the culture of professionalism. Professionalization, such as pastoral psychotherapy has undergone, is more than specialization of work; it is acculturation involving both "the shaping of the lives of professional counselors and psychotherapists by a comprehensive set of moral values and ethical behaviors dictated by the mental health profession" and the socialization of the "worldview and activity of the public to the profession's own ends" (Farnsworth, 1980. p. 116).

There are two primary dimensions in the conceptualization of professionalism, one cognitive and the other normative. The cognitive dimension centers on objectively legitimized competence in an area of esoteric

but useful knowledge based on extensive education of an exceptional nature (Moore, 1970). Professionals profess to know better than others the nature of certain matters and because of this knowledge they claim the exclusive right to practice the art they know. The normative dimension promises service orientation that justifies self-regulation. Professionals profess to serve the interest of the client and the community, if necessary, at the expense of their own interests.

The normative dimension of professionalization is particularly problematic in that it presents the professional with an internal tension between the needs of his clients for care and his own need for income. Adam Smith's observation in The Wealth of Nations that

> People of the same trade seldom meet together even for merriment and diversion, but the conversation ends in conspiracy against the public, or in some contrivance to raise prices (Smith, 1902)

crystalized into the accusation that the principal function of professionals is to develop and control a market for their expertise and in so doing advance their interests (Larson, 1977; Lieberman, 1970).

Awareness of this tension apparently informed Hiltner's suspicion of issuing special credentials to pastoral counselors: "The suspicion is strong that he who wants to be endorsed about something he ought to be doing anyhow has motives not clear to the naked eye" (Hiltner,1961, p.47)

and gave rise to Oates' question "To what extent does the financial motive engender the desire for such an association?" (Oates, 1961, p.48). Hiltner and Oates were concerned that the founders of the specialty of pastoral counseling were unduly motivated by potentially lucrative private practices based on the fee-for-service model.

History indicates that their concerns were well-founded. Despite the original intention to make pastoral psychotherapy available regardless of income, the reality is that it, like other private psychotherapeutic services, primarily serves middle and upper class individuals (Pattison, 1978; Endicott et al., 1983; Smith, 1990). Pastoral psychotherapy's adoption of secular psychotherapeutic methodology for practice determines both the class of client and type of problem with which private practice pastoral counselors will deal; fee-for-service virtually guarantees they will see very few clients who are poor or who are suffering from the most acute psychological problems (Smith, 1990). Smith's analysis of the situation confirms the observation that in winning the battle of professional respectability, pastoral psychotherapy has lost the war of remaining faithful to the historic mandate of the faith:

> At a minimum, the church has, throughout its history, understood its services to be available to the poor and suffering-even if this availability has often been expressed in condescending ways. When the profession which embodies the counseling function of the church is

> established is such a way that the least of these tend to be excluded from receiving help, or the help they receive is less than that given to those who are richer or who are suffering less, the church has betrayed its mission (Smith, 1990, p.105).

Pastoral psychotherapy is not providing what it promises, either in the content or the extent of the care it offers. The doctrine of informed consent with its fiduciary principle suggests that it is ethically imperative for those who identify themselves as pastoral counseling specialists practice *cura animarum* in a manner consistent with the values that inform their faith. In regard to the content of pastoral psychotherapists' practice, this will entail rediscovery of their spiritual heritage. On the twentieth anniversary of the founding of the AAPC, its first president was asked to envision the future of the organization and of pastoral counseling. Clinebell's address maintained:

> We must strengthen our sense of pastoral identity by deepening our theological roots, broadening our spiritual growth methodologies, and developing our unique theological contribution to the healing arts. Our self-understanding must reflect our awareness of the grounding of *all* we do in a rich religious heritage and in the ongoing life of the caring community of faith. The response of the pastoral counseling movement to our society's spiritual crisis should be a *more explicit, robust, and imaginative theological thrust in all that we do* (Clinebell, 1983, p.182).

In regard to the extent of pastoral psychotherapists' practice, a primary criterion of truly pastoral counseling should be its availability to "the least of these" (Smith, 1990; Hiltner, 1964; Clinebell, 1964). This will entail the

acknowledgement on the part of pastoral psychotherapy as a discipline that at least some of its practitioners will function from a model of remuneration more akin to that of the traditional parish minister than that of the psychotherapeutic fee-for-service. The implication for the larger community of faith is the responsibility to provide support for pastoral counselors so that they can take on the historical task of the church to care for those most in need. Of ordained ministers, only pastoral psychotherapists have adopted a fee-for-service model.

CHAPTER V

COMPETENCE IN PASTORAL COUNSELING

Procrustes, the mythological innkeeper of ancient Greece, offered only one bed of fixed length on which all his guests were forced to lie. He cut off the feet of those who were too long for his bed and stretched the bodies of those who were too short for it. The result each time was an exact fit to the bed.

Pastoral counselors are distinguished by their commitment to an ultimate set of meanings and values; pastoral counseling is pastoral precisely because it involves the guidance of persons toward a life lived out in accordance with those ultimate meanings and values. It is primarily from the faith tradition which he or she represents that the pastoral counselor derives his or her authority and his or her claim to competence in helping. The problem is some would claim that such an approach to *cura animarum* is Procrustean in that it begins with a set of metaphysical assumptions and forces everyone and everything

into its framework without regard for, what appears to be, existential reality.

As a result of twentieth-century developments in the psychological sciences, pastoral counselors, particularly parish pastors and the lay counseling movement, have been confronted with questions such as: "To what extent do the theological assumptions of the pastoral counselor, with their moral and ethical framework, equip him or her to deal with people's problems?" and "Is a pastoral counselor ever morally obligated to refer and, if so, to whom?" The proliferation of secular practitioners of the cure of souls has challenged the competence of religious functionaries to fulfill their historical role of assisting people in their problems with living.

As would be expected, responses to these questions have spanned the spectrum of opinion. Televangelist Jimmy Swaggart told the nine million viewers in his audience that psychotherapy is the "rot of hell," that there can be no professional Christian counseling, and that pastors and lay people are the best source of counsel (Collins, 1987). Jay Adams asserted basically the same perspective, though somewhat less polemically, in Competent to Counsel:

> Given the qualities mentioned in Romans 15:14 and Colossians 3:16, plus the proper convictions about counseling, any Christian worker may become a helpful counselor in the place where God has called him to serve. That the work of counseling should be carried on preeminently by ministers and other Christians whose gifts, training and calling especially qualify and require them to pursue the

> work, I do not doubt....He should see no need, therefore, to defer to a self-appointed caste of men called psychiatrists who have pontifically declared that their province necessarily extends beyond his own (Adams, 1970, p.268).

In contrast, Ben Zion Bergman, in supporting the notion of clergy malpractice, argues that the secularization of certain areas of the clergy function remove those areas from the purely ecclesiastical domain and make them subject to scrutiny by prevailing standards. The fact that counseling has become a secular professional function imposes the duty of compliance with the accepted standards of that professional community upon the pastoral counselor, despite the fact that his functioning in that area may proceed from different suppositions and with different techniques than the non-clerical practitioner. The implication is that the competence of the pastoral counselor, and his responsibility to refer, are determined by reference to secular, psychological standards rather than by reference to the theological assumptions of the faith framework he or she represents.

> This is understandably a change from the traditional role of the clergy, who by reason of the special sanctity attached to their person and function and by virtue of being viewed as one in a specially intimate relationship with God, have tended to regard themselves and be regarded by others as a source of final authority. The mere force of tradition, however, is inadequate to withstand the modern realities created by greater scientific knowledge. No one would seriously consider allowing barbers today to act as healers through bloodletting, although that was once their traditional function. While that example is more

> extreme than our clergy counselor case, the two are analogous (Bergman, 1986, p.60-61).

In attempting to determine, within this spectrum of opinion, an ethically appropriate position regarding the question of pastoral counselor competence, I will review clergy counseling and referral practices, consider criteria of competence, and propose a methodology that solves the problem of the Procrustean bed.

Clergy Counseling and Referral Practices

Historically, the longstanding tradition of clergy ministering to the needs of emotionally troubled individuals is an expression of the treatment of health problems with religious techniques that has been a universal feature in every culture (McNeill, 1951; Clebsch and Jaeckle, 1964; Parsons, 1964). Though it might be expected that demands for pastoral counseling would decrease with the increased availability of alternative professional mental health services, this does not appear to be the case (Virkler, 1979). The 1961 report of the Joint Commission on Mental Health and Illness cited a nation-wide survey which showed that 42% of those who sought professional help for psychological distress first turned to a member of the clergy; ministers were the most sought-out resource for help (Gurin, Veroff, and Feld, 1960; Mollica, Streets, Boscarino, and Redlich, 1986; Larson, Hohmann, Kessler, Meador, Boyd, and McSherry, 1988; Lau and Steele, 1990). When the study

was replicated approximately two decades later, it was discovered that 39% went first to clergy, still more than any other mental health professional (Veroff, Kulka, and Douwan, 1981; Meylink and Gorush, 1988).

Rather than decreasing, the demand for pastoral counseling has been growing rapidly such that pastors today spend a significantly larger percentage of their time counseling than did their counterparts in previous decades, and pastoral counseling has become the primary clergy therapeutic activity (Virkler, 1979; Favazza, 1982; Mollica et. al., 1986; Lau and Steele, 1990). While the typical minister spends between 4 and 10 hours a week in counseling activities, approximately 10 to 20% of their work week, 65% of one study population reported spending 20% of their time counseling while another 28% reported 40% of their time spent in such situations (Lowe, 1986; Domino, 1990; Wylie, 1984).

Although it might be expected that much of the counseling done by clergy would pertain to spiritual issues, the literature suggests that pastoral counselors are consulted for basically the same concerns as other mental health professionals (Domino, 1990). The most frequently presented problems seem to be marital problems, spiritual issues, depression, anxiety, and guilt, with family problems comprising about one-half of the counseling caseload (Virkler, 1979; Lowe, 1986; Meylink and Gorsuch, 1988).

Individuals seem most reluctant to discuss sexual issues with pastors, apparently confirming the concerns of Jung and Parsons (Jung, 1932; Parsons, 1964; Virkler, 1979; Lowe, 1986). Furthermore, data from the Epidemiologic Catchment Area Study by the National Institute of Mental Health indicates that major psychiatric disorder, in most diagnostic categories, is as prevalent among those who seek help from clergy as from other mental health professionals, suggesting that pastors are frequently presented with major and life-altering affective and anxiety disorders (Larson et al., 1988; Lau and Steele, 1990). The fact that pastoral counselors are likely to deal with people whose emotional needs cannot be met by simple advice-giving is corroborated by a study of MMPI profiles of parishioners seeking pastoral counseling which indicated a significant number were in extreme or even disabling emotional pain due to psychological disturbances across the spectrum of emotional disorders (Wagner and Dobbins, 1967).

Faced with this broad range of presenting problems, most pastors feel underprepared, if not inadequate, for the task of pastoral counseling (Worthington, 1986).

> Most evangelical pastors (88%) believe that some of their church members have marriage, family, and personal problems beyond the professional capability and/or time the pastor has available to help alleviate the problems (King, 1978, p.279).

Some of these felt limitations are simply a function of the situation of parish clergy; the multiple demands of the role

for preaching, teaching, administration, visitation, and other expressions of pastoral care often leave little time and/or emotional resource for ongoing, in-depth counseling (Oglesby, 1987). Additionally, we have seen that the leadership responsibilities of the covenant community preclude the pastor from being able to provide a maximally helpful therapeutic context, as seems to be the case with sexual issues. The role of moral standardbearer creates the perception that the pastor would be less than understanding of struggles in such areas (Parsons, 1964; Virkler, 1979; Lowe, 1986). Furthermore, the severity of emotional disturbance discovered in those seeking help from the parish minister caused Wagner and Dobbins, himself a pastor, to question "the competency of the average clergyman to meet these demands" (Wagner and Dobbins, 1967, p.84).

An equally significant dimension of the limitations clergy feel in their counseling role is related to the training they have or more accurately, have not, received. A 1981 survey of 76 Protestant seminaries in the United States found that only 53% required at least one course in pastoral care and counseling, indicating "that 47% are doing little or nothing in preparing their students for the almost inevitable role of counseling which will be thrust upon them" (Linebaugh and DiVivo, 1981). This corresponds with Virkler's (1979) discovery that 27% of his respondents had no seminary courses in counseling, while approximately 60%

had two or less courses and reported no opportunity in their training to counsel real cases and receive professional supervision; most seminary instruction in pastoral counseling appears to be cognitive, providing suggested methods of dealing with a variety of presenting problems. It is not surprising then that 63% of the subjects in one study evaluated their seminary counseling training as somewhat or significantly deficient in preparing them for the counseling responsibilities of their pastoral role; 50% in another study indicated that they were not adequately trained to counsel, and at least 50% in a third study expressed a moderate or high need for additional training in twelve of the fourteen most frequently presented problems: Marital Problems, Salvation Concerns, Depression, Guilt, Anxiety, Parent-Child Problems, Premarital Issues, Adolescent Concerns, Alcohol/Drug Abuse, Anger, Job Related Concerns, Sexual Concerns and Physical Problems. The only areas in which the majority did not express a significant need for additional training were Salvation Concerns and Premarital Issues (Virkler, 1979; Wylie, 1984; and Lowe, 1986).

This lack of training would appear to compromise the clergy's ability to provide positive therapeutic assistance, as demonstrated by their incapacity to recognize the nature and degree of morbidity evidenced by symptoms of psychopathology (Domino, 1990). Holmes and Howard's

administration of their Recognition of Suicide Scale, which presents signs of suicide ideation and risk, to physicians, mental health professionals, ministers, and college students yielded what they labeled the "disturbing result" that clergy are not better able to recognize the signs of suicide lethality than educated laypersons and substantially less well than other mental health professionals (Holmes and Howard, 1980). Domino extended this study to the assessment of the clergy's knowledge of psychopathology more broadly defined with his Knowledge of Abnormal Psychology test which contained fifteen content areas: nomenclature and taxonomy, dynamic theories and principles, behavior therapy theories and principles, childhood disturbances, neurotic behavior, personality disorders, alcohol and drug abuse, psychophysiological aspects, schizophrenia, affective disorders, organic disorders, psychological assessment, psychotherapy, mental retardation, and sexual functioning. As predicted, the results revealed a continuum of knowledge with doctoral Clinical Psychologists scoring highest and doctoral students in Clinical Psychology and Counseling Psychology, undergraduate students in Abnormal Psychology and Introductory Psychology scoring progressively lower, with clergy scoring lowest of all. Domino's modest conclusion is that "the results strongly support the notion that clergy, as a group, are not well trained in basic psychopathological principles" (Domino, 1990, p.38).

Given their admitted inadequacy in training and their demonstrated lack of knowledge of psychopathological principles, it might be expected that, inasmuch as pastoral counselors are presented with a diversity of problems that most mental health professionals do not feel equipped to handle without referrals to specialized counseling services, they would make extensive use of referral resources. The literature, however, demonstrates that this is not the case: clergy report referring between 0 and 10% of those who seek their help to other mental health professionals; this referral rate is consistent in nearly every study done on referral practices of ministers (Lowe, 1986; Virkler, 1979; Abramczyk, 1981; Gilbert, 1981; Worthington, 1986; Meylink and Gorsuch, 1988). Several variables appear to affect both the counseling and referral practices of ministers including organizational variables such as the size, socioeconomic status, race and geographic location of a congregation and individual variables such as church membership status and severity of the presenting problem (Lau and Steele, 1990). But the two factors which most strongly impact the clergy's perception and practice of their counseling role are theological position and counseling training (Clark and Thomas, 1979; Lowe, 1986).

> Differences on the theological dimension relate to factors which include perceptions of counseling as a moralizing and religious effort. Conservative clergy tend to place more of a religious emphasis in their counseling than liberal clergy. They also see their roles as being restricted by the

> expectations of their parishioners to a greater extent than do liberal clergy. Finally, conservatives are more likely than liberals to view their counseling roles as having a character of moral absolutism from which they express evaluations regarding the "morality" of their clients' behavior (Clark and Thomas, 1979, p.55).

Abramczyk's survey (1981) of United Methodist Church ministers, who are generally theologically somewhat more liberal, reported these pastors as describing their counseling style as Rogerian, using support, reflection of feeling and content, clarification, attending behaviors and avoiding advice giving. In contrast, Virkler's surveys (1979, 1980) of theologically conservative pastors found them utilizing a much more directive approach; 50% stated that they usually told counselees what changes they needed to make in the first two sessions, 85% stated that they often give advice. Conservative clergy make greater use of sacramental methods in counseling such as prayer and reading of scripture (Virkler, 1979; Clark and Thomas, 1979; Lowe, 1986). Theological orientation affects referral practice as well; theologically liberal pastors refer more and counsel less than conservative pastors (Gilbert, 1981; Mollica et al., 1986; Worthington, 1986).

The second variable which influences pastoral counseling practice is educational level, specifically counseling training. Clergy with more training in counseling see counseling involvement as a more worthwhile and important part of their work (Clark and Thomas, 1979).

Ministers with more formal academic and counseling training make more use of non-directive methods than those who have had less training and refer more frequently to other mental health professionals (Lowe, 1986; Meylink and Gorusch, 1988). In summarizing their empirical study of the pastoral mental health involvement model, Lau and Steele (1990) suggested that one of the conclusions their data yielded was

> ...that training in mental health is extremely important if clergy's potential is to be fully utilized in the mental health network. Moreover, they also suggest that an increase in the clergy's knowledge of and familiarity with mental health resources will probably promote clergy's mental health activities, particularly their tendency to refer (Lau and Steele, 1990, p.268).

Criteria of Competence

This picture of inadequate training and knowledge of psychopathological principles has given rise to considerable discussion of the professional role of pastoral counselors, and of the clergy in particular, in dealing with emotionally disturbed people (Wagner and Dobbins, 1967; Larson, 1968; Tiedeman, 1982; Favazza, 1982; Quackenbos, Privette, and Klentz, 1986; Mollica et al., 1986; Larson, Pattison, Blazer, Omran, Kaplan, 1986; Meylink and Gorsuch, 1988; Larson, Hohmann, Kessler, Meador, Boyd, and McSherry, 1988; Domino, 1990; Lau and Steele, 1990). Larson's study (1968) of the clergyman's role in the psychotherapeutic process demonstrated a significant disagreement between clergymen and psychiatrists concerning diagnosis of disturbed

individuals, as well as appropriate involvement in the therapeutic process and referral policy on the part of clergy. Clergymen were asked to diagnose twelve case histories (male and female hallucinators, simple schizophrenics, paranoid schizophrenics, normal distress, erotomanics, and homosexual panics), in terms of degree to which an emotional disturbance was implied (none, mild, moderate, or severe); to specify the extent to which he or she could become involved in the therapeutic process (handle alone, major assistance, minor assistance, or referral only); and to indicate to whom referral should be made in the event that referral was necessary (no one, other clergy, physician, psychiatrist, or other). Psychiatrists were asked to diagnose the case histories as well and specify, from a psychiatric point of view, how they thought a pastoral counselor should respond when confronted with a person manifesting the described symptoms. Regarding degree of emotional disturbance described in the case studies, clergy and psychiatric diagnoses differed in eleven of the twelve cases with psychiatrists consistently ascribing a greater degree of disturbance. Regarding involvement of the clergy in the therapeutic process, nine of the twelve comparisons showed significant differences with the clergymen consistently describing a greater role for themselves than the psychiatrists envisioned for the clergy. Regarding referral policies, eleven of the twelve

comparisons showed significant differences. In essence, Larson found pastoral counselors to believe that their role was to provide major assistance to the person who sought them out for help while psychiatrists thought it much more appropriate for the clergy to provide only limited assistance and to serve primarily as a referral source for other mental health professionals.

Tiedeman (1982) reports in "Chaplain and Psychiatrist as Ally-Rivals" that the same dynamic is operative in the institutional context ostensibly characterized by interdisciplinary collaboration. A categorization of cases requiring mental, as well as physical, health care identifies four features that define them as requiring such treatment: physiological disorders of psychogenic origin, despair, confusion, and bizarre behavior. In Tiedeman's analysis, the chaplain envisions a role for himself in three of the four cases, two of which involve collaboration with the psychiatrist, while the psychiatrist argues for his inclusion and the chaplain's exclusion in all four cases, maintaining "that chaplains see many patients whom they have no business seeing and who should be handled by psychiatrists but are not" (Tiedeman, 1982, p.198).

Given what we know about pastoral counselors' typical training and limited knowledge of psychopathological principles, my conjecture is that most people would agree with Tiedeman's psychiatrist. The problem is that closer

examination reveals that the criteria employed to evaluate competence involve assumptions which predetermine what the criteria are designed to evaluate. For example, Domino's (1990) development and administration of the Knowledge of Abnormal Psychology test demonstrated the clergy, as a group, are not well trained in basic psychopathological principles thereby creating questions about the therapeutic competence of pastoral counselors. The assumption is that an objectively legitimized mastery of a body of esoteric information is an appropriate criterion for determining therapeutic competence.

As we shall see, it has been demonstrated that knowledge of psychopathology per se is not necessarily determinative of, and may very well be detrimental to, psychotherapeutic competence. But for the moment, let us accept the assumption that objectively legitimized mastery of esoteric knowledge is an appropriate criterion for competence, the question then becomes *what* knowledge? It is significant that, among other categories, Domino tested for knowledge of dynamic theories and principles and behavior therapy theories and principles. These are theoretical constructs that entail significantly different and, what appear to be, mutually exclusive conceptualizations of the etiology and treatment of emotional disturbances. The inference drawn regarding an instrument such as the KAP is that it tests for knowledge that is demonstrably helpful in

its application to the psychotherapeutic process. However, the inclusion of both dynamic theory and behavior therapy theory clearly indicates that this is not the case. If, then, we are not dealing with knowledge that has been demonstrated as helpful in psychotherapeutic care but rather with information that theoretically is of value, the question of basis for inclusion in an instrument becomes even more critical. If the assumption had been that the moral implications of a faith tradition are of value in caring for distressed individuals, the instrument developed could very well have been the Knowledge of Applied Theology test that evaluated understanding of the eschatological implications of the kenotic dimension of Pauline christology rather than the taxonomy and nomenclature of psychopathological disorders. If indeed the appropriate criterion for determining therapeutic competence is objectively legitimized mastery of esoteric knowledge, then Jay Adams' claim that every Christian can be competent to counsel through knowledge of biblical principle and its application to life situations contains as much veridicality as the claim that knowledge of psychopathological principles makes one competent to counsel. The objection that psychopathological principle is more relevant to emotional disturbance than biblical principle is specious in its circularity. The obvious point is that the difficulty in employing knowledge as a criterion for determining

competence lies in the fact that the decision as to what body of knowledge is relevant, apart from empirical verification, is predicated upon assumptions which, in effect, are judgments of competence and incompetence.

The claim of empirical verification for the relevance of psychopathological principles turns out to be no more definitive in determining therapeutic competence than does the claim of the relevance of biblical principle. After reviewing the empirical research regarding religious counseling, Worthington reached the conclusion that

> ...pastors may lack confidence in their counseling skills and may not always be facilitative, but their parishioners seem to be as satisfied as are clients of other professional counselors (Worthington, 1986, p.424).

Battin (1990, p.253) went a step farther with the observation that some 80% of the people who have consulted clergy describe them as "helpful" or "very helpful," more than any other profession.

There is a considerable body of research which confirms that training in psychopathological principles and therapeutic methodology does not enhance the skill of the helping person and may even reduce it. Carkhuff (1968) found extensive evidence to indicate that people with little or no training in psychotherapeutic technique can effect significant constructive change in clients they see, hospitalized neuropsychiatric patients as well as outpatient neuropsychiatric patients, situationally distressed people

otherwise normal, and children. Evaluation of forty-two studies comparing the effectiveness of professional and paraprofessional helpers demonstrates that paraprofessionals achieve clinical outcomes equal to or significantly better than those obtained by professionals (Durlack, 1979). Furthermore, it has been found that students in graduate psychology programs exhibit a drop in their level of facilitative functioning over the course of their training, with the greatest loss occurring between the first and second year (Carkhuff, Kratochvil, and Friel, 1968) and that though some of this loss is recouped through functioning, "there are direct suggestions that they may never again function at the level of those conditions related to constructive change with which they entered graduate school" (Carkhuff, 1968, p.121; Carkhuff and Berenson, 1967). The hypothesis is that this diminution in facilitative skill results from the focus of graduate training programs on highly elaborate and highly cognitive systems of psychopathology rather than on the skills that simply enable people to help other people (Carkhuff, 1968).

> The provocative conclusion from these... investigations is that professionals do not possess demonstrably superior therapeutic skills, compared with paraprofessionals. Moreover, professional mental health education, training, and experience are not necessary prerequisites for an effective helping person (Durlack, 1979, p.85).

Carkhuff's analysis is that the positive differential effects of the paraprofessional or lay counselor are

attributable to several factors which characterize his care in contrast to the professional's: a) the increased ability to enter the milieu of the distressed; b) an ability to establish peer-like relationships with the needy person; c) the ability to take an active part in the client's total life situation; d) the ability to empathize more effectively with the client's style of life; e) the ability to teach the client, from within the client's frame of reference, more successful actions; and f) the ability to provide clients with a more effective transition to more effective levels of functioning within the social system. With less training and expertise to rely on, the paraprofessional focuses on "being with" and listening to the client (Carkhuff, 1968). It is obvious that these factors, in varying degrees, particularly characterize the care offered by pastoral counselors in their role of representative persons of the wisdom, resources, and authority of a community of faith.

Legal Consideration of the Criteria of Competence

Our consideration of appropriate criteria for assessing the therapeutic competence of pastoral counselors indicates that such a determination inevitably entails value dimensions and theoretical assumptions. This was exactly the conclusion the California Supreme Court reached in regard to the landmark case *Nally v. Grace Community Church*,

one of the first, and certainly the most publicized, clergy malpractice suit.

Ken Nally, a twenty-four year old seminary student and member of Grace Community Church of the Valley, the largest Protestant congregation in Los Angeles County, committed suicide while in the care of the church's pastoral counseling staff for emotional problems (Ericsson, 1986; Young and Griffith, 1986; Battin, 1990). His parents filed a wrongful death action suit, one year later in March, 1980, alleging three counts of clergy malpractice, negligence, and outrageous conduct (Battin,1990; Ericsson, 1986). The allegation in the first count was that, knowing Nally was severely depressed and had suicidal tendencies requiring professional psychiatric and psychological care, the pastoral counselors at the church had counseled him to pray, read the Bible, listen to taped sermons, and counsel with church counselors. They discouraged him and effectively prevented him from seeking the needed professional help. The second count charged negligence on the part of the church in their training, selection, and hiring of counselors, as well as the counselors' unavailability to Nally in time of need. The third count alleged that the defendants had ridiculed the Catholic religion of Nally's past and promulgated a perspective that exacerbated his preexisting feelings of guilt, anxiety, and depression (Ericsson, 1986).

Samuel E. Ericsson, the chief defense counsel, based his defense on First Amendment considerations of the separation of church and state contending that the very notion of "clergy malpractice" entails consideration of spiritual and doctrinal matters that the judicial system can neither competently nor constitutionally deal with. Central to his argument was the claim that psychotherapy and pastoral counseling are predicated upon different metaphysical and epistemological assumptions:

> The religious and spiritual counseling of the Church cannot be subsumed under an essentially medical model of psychotherapy, and treated as giving rise to quasi-medical duties to diagnose psychiatric problems and refer persons to psychiatrists. To be sure, both psychiatry and religion may deal with human emotions and human problems, but that no more makes a religion a subspecies of psychiatry than psychiatry is a branch of religion....They are different disciplines that operate on different premises (Battin, 1990, p.234).

Assessing the competence of a pastoral counselor would put the court in the position of making judgments regarding the veracity and efficacy of the underlying metaphysical presuppositions. Moreover, the imposition of a duty to refer upon the religious counselor, as in the medical field, seems to be barred by the nature of the pastoral role, in that a dimension of it is nurturing and protecting the faith of those in his or her care. Inasmuch as there may not be a professional mental health worker supportive of the particular doctrinal stance held, the creation of a duty to refer would force the pastoral counselor to violate his or

her mandate by referring a troubled person to a professional whose perspective could very well be inimical to his or her faith (Ericsson, 1986). The case was brought to a close in 1989 when the United States Supreme Court declined to hear it, upholding the ruling of the California Supreme Court that development of a standard of care for clergy counselors would encounter First Amendment problems and that the state is unprepared to evaluate the quality of religious counselors' work (Young and Griffith, 1989).

Ethical Consideration of the Question of Competence

The difficulty with which we are presented at this point is that there seems to be no way of defining criteria for competence given that such criteria entail implicit metaphysical assumptions; any system then becomes self-insulated against criticism. Battin's typology of orders of doctrinal assertions is helpful in defeating this circularity and demonstrating how ethical critique can be accomplished. Her analysis of the Nally case suggests that the legal determination does not entail that the case is immune to ethical argument.

> Quite the contrary, where the walls of legal separation of church and state must remain highest if freedom of religion is to be preserved, ethical scrutiny-which carries only moral force, not the coercive power of the state becomes most appropriate. The supreme court dismissed *Nally* at least in part, as its majority opinion clearly shows, out of a refusal to create a new duty to refer for nontherapist counselors, including but not limited to pastoral counselors. It feared

> that the creation of a legal duty to refer might "stifle all gratuitous or religious counseling" for fear of the liability to which such counseling would expose clergy or others. But moral criticism does not impose legal liability; thus, gratuitous and religious counseling can be protected from the litigiousness prevalent in other areas of professional activity while still exposing it to the kind of criticism it sometimes fully deserves (Battin, 1990, p.251-252).

Ethical scrutiny of the practice of pastoral counseling in the light of Battin's typology reinforces the court's decision that the philosophical and theological presuppositions which inform it are O-level imperatives whose truth or falsity need not be considered. However, this does not excuse upper-level, developed practices from moral scrutiny. Inasmuch as all forms of pastoral counseling are idiosyncratic and distinctive, from Adams' competent-to-counsel to Hiltner's eductive approach, these developed practices are vulnerable to the claims of ordinary and professional ethics despite the fact that their roots are in a set of transcendent meanings and values. Thus, coercive practices such as Swaggart's "rot of hell" statements which submit an individual seeking professional help, Christian or not, to censure by the community or aggressively paternalistic advice-giving to a distressed individual in the initial stage of counseling, or deceptive practices which present selected anecdotal information about successful treatment without base-rated data and acknowledgement of failed cases are morally indefensible. Battin's analysis of the counseling offered by Grace

Community Church to Ken Nally in light of the accepted professional standards for dealing with suicidal individuals suggests that their practice was certainly ethically questionable.

I would conclude that though the faith framework they represent does indeed equip pastoral counselors to assist troubled people with their problems, there are situations in which practitioners of the cure of souls are morally obligated to refer. I would further contend a significant dimension of the difficulty that this involves grows out of the Procrustean approach to care that typifies most mental health professionals, not just pastoral counselors.

G. K. Chesterton offered an engaging and insightful analysis of insanity that is fruitful for this issue. He suggested that "the madman is not the man who has lost his reason. The madman is the man who has lost everything except his reason" (Chesterton, 1959, p.19). Chesterton observed that perhaps the most sinister quality of one in the heart or on the edge of mental disorder is a clarity of detail and logical perspicuity that offers lucid explanations, which are satisfactory in a purely rational sense, for delusions which defy reality. Argue with someone in a mental institution and you will probably lose the argument.

> ...the insane explanation, if not conclusive, is at least unanswerable; this may be observed specially in the two or three commonest kinds of madness. If a man says (for instance) that men

> have a conspiracy against him, you cannot dispute it except by saying that all the men deny that they are conspirators; which is exactly what conspirators would do. His explanation covers the facts as much as yours. Or if a man says that he is the rightful king of England, it is no complete answer to say that the existing authorities call him mad; for if he were the king of England that might be the wisest thing for the existing authorities to do (Chesterton, 1959, p.19).

Though the insane explanation appears to be blatantly false, it is, nonetheless, difficult to refute. Chesterton explains this by the analogy of a circle; a small circle is as infinite as a large circle only not as large. An insane explanation is just as complete as a sane one but it is not as large, though lucid and logically consistent it is not large enough to accommodate reality. Though Chesterton's definition of madness is probably somewhat inadequate in that it doesn't consider the ideal of comprehensive in its understanding of rationality, his image of a circle drawn too small serves to focus attention on a central difficulty in assessing competence in mental health care.

Seigler and Osmond's work on the differentiation of interpretive models suggests that this same tendency characterizes conceptualizations of mental illness:

> ...the numerous theories put forth to explain it are of all sorts: biochemical, interactional, legal, moral, and so forth. These theories resemble, in a curious way, the productions of the schizophrenic patients on whose behalf they are constructed; they tend to be self-involved, and while they often display much internal consistency, they lack any comprehensible relation to each other (Seigler and Osmond, 1966, p.1193).

To bring some order to this confusing plethora of theories, Siegler and Osmond developed a set of dimensions by which these theories could be analyzed and compared and generated six models, medical, moral, psychoanalytic, systemic, conspiratorial, and societal, which accommodated all the major theoretical differences. After carefully delineating these models they proceeded in a rather curious fashion, first recognizing that each of them, in one way or another, corresponds to reality:

> ...they can all be considered to be "true": schizophrenia is indeed an illness, the behavior of patients can be radically altered with sanctioning systems, schizophrenics do have unusual family histories, the families of schizophrenics demonstrably interact differently from non-schizophrenic families, lower class people are over-represented in mental hospitals, and the civil rights of mental patients are undoubtedly violated from time to time. It is no accident, then, that all these models exist; they all represent aspects of the truth (Siegler and Osmond, 1966, p.1201).

Yet, despite their recognition that each of these models embodies elements necessary for the conceptualization and care of mental disturbance, the conclusions that Siegler and Osmond drew were that practitioners need to be aware of the model that underlies their particular program of care and to develop strategies appropriate to their particular model. They cautioned practitioners from deriving strategies from other models, even if such strategies appeared helpful or necessary for their patient. Rather than suggesting a creative synthesis, as would be suggested by the rational

ideal of comprehensiveness, which embodies the elements of reality represented by each of the models they delineated, Siegler and Osmond recommended reductionistic consistency. In essence, they encouraged those who care for the mentally disturbed to do exactly what the mentally disturbed do, develop a self-involved system which displays internal consistency at the expense of comprehensible relation to the larger reality. The size of the circle is of little relevance as long as it is neatly drawn. People can be made to fit the Procrustean bed as long as it is constructed consistently.

The challenge presented to the Procrustes of the helping professions, pastoral and secular alike, is to adjust their bed to fit their guests rather than vice versa. The relevant literature demonstrates clearly that neither the pastoral counselor (King, 1978; Abramczyk, 1981; Gilbert, 1981; Cross and Khan, 1983; Lowe, 1986; Worthington, 1986; Larson et al., 1988; Domino, 1990; Lau and Steele, 1990) nor the psychotherapist (Carkhuff and Berenson, 1967; Carkhuff, 1968; Carkhuff, Kratochvil, and Freil, 1968; Pattison, 1978; Durlack, 1979; Quackenbos et al., 1986; Larson et al., 1986; Young and Griffith, 1989) possesses all the skills and insights necessary to address the emotional needs people in the twentieth century present, suggesting a definite need for linkage between the Couch and the Cloth. An alternative means, to the reductionistic

consistency of circles drawn too small, of dealing with the intertheoretical difficulty this would entail, would be a "multiple criterion" approach that seeks bridging laws as a means of interrelating the insights of the various theories, Such an approach would not require religious agreement in order to tap the possibilities of psychotherapeutic-pastoral synergism, but rather mutual respect for respective competence.

Dean (1986) suggests that the multiaxial classificatory scheme of the DSM-III could serve just such a function because it reflects an inclusive notion of personhood that regards all aspects of a person's life as important.

> It provides a conceptual bridge between psychiatric and pastoral practice when psychiatry is practiced on the DSM-III holistic conceptual foundation and pastoral responses are based on the biblical doctrine of personhood. The DSM-III and the biblical doctrine of personhood view individuals from a multivariant perspective focused on the whole person (Dean, 1986, p.307).

A perspective of this nature would allow professionals from different disciplines to acknowledge one another's competence in dealing with different dimensions of the careseeker's life and experience. In their consideration of spiritual issues in mental health care, Dombeck and Karl offer a concrete example of such a rapprochement in the following case study:

> Mr. B is a 38-year-old professional man who has been in therapy for several years. His therapy can be described as successful because, in the past five years, he has redirected his energies in productive, successful, and satisfactory ways. He

> has terminated certain destructive relationships in his life, and started and maintained relationships satisfactory to himself. He is on the verge of achieving a cherished goal: to become an ordained minister. He is at present working through angry feelings he has about God and the church coming from past experiences with church-related people. The fact that the therapist is not ordained places her in a position neutral enough to give the client freedom to express his anger, although it is very clear that he does not use the therapist as a spiritual counselor. The role distinction became apparent when he realized that he needed spiritual counsel from an ordained pastor. His need baffled him precisely because he felt positively about the therapy. He said to the therapist, "In a sense with you, I talk about my relationship with God and the church as if it were any other relationship. With a pastor there would be another dimension. I would confess my anger, and something would happen. Then I could continue my work with you." (Dombeck and Karl, 1987, p.189)

It would seem that Mr. B would be best served if both the therapist and the pastor would recognize that Mr. B's growth into wholeness involves issues in different dimensions of his experience and, though they are each certainly competent to help with some of them, neither of them is able to deal with all of them. Mr. B needed the sanctioned retreat of the therapeutic context to process his anger with the church but he needs the ritual relationship with the representative person from the faith community to receive forgiveness and move on. It is obvious that if practitioners of the cure of souls, both secular and pastoral, would shift their focus, from their Procrustean beds to the multifaceted guests they serve, synergism could

replace between the disciplines and people could be better helped. In Dean's words:

> The latent or overt hostility between psychiatrists and clergy need no longer continue. Psychiatrists and clergy may cooperate on a goal of holistic assessment and care designed to alleviate pain, facilitate growth, and redeem individuals created in God's image....The question for psychiatrists and clergy should not be, "Who's in charge?" but, "How can we work together for the good of the person in need?" (Dean, 1987, p.307).

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