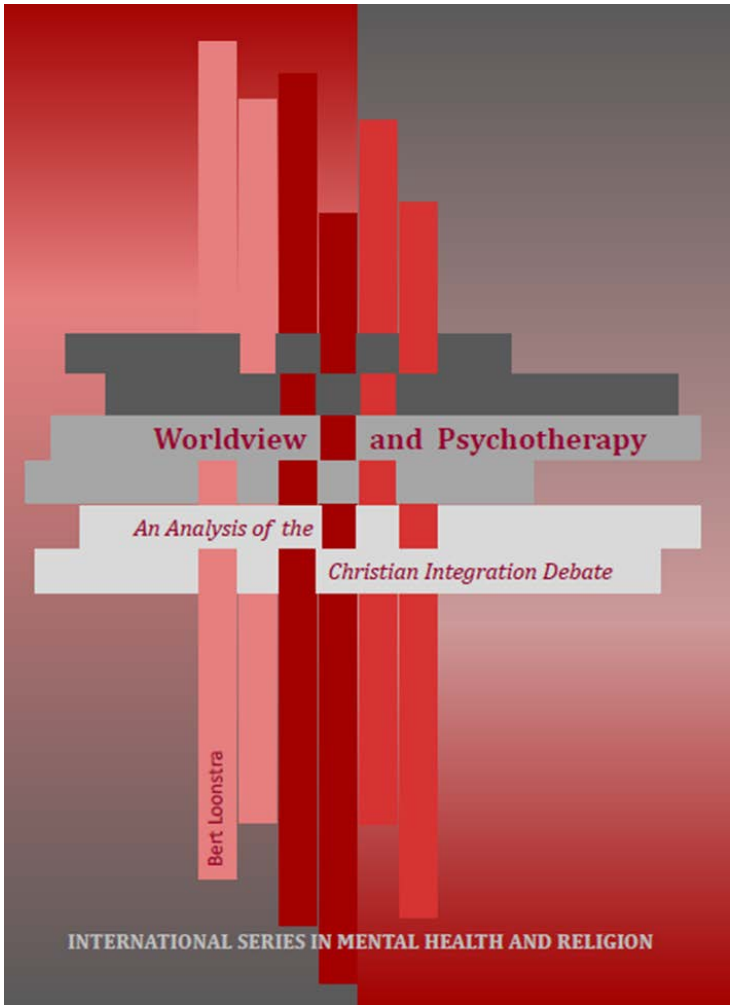
The therapist and the pastor

PhD thesis on worldview and psychotherapy



Two fields of reflection

- Can psychological research be put on a Christian basis? Yes/No
- Can psychotherapeutic practice be put on a Christian basis? Yes/No

Overlap of pastoral and mental health care for Christians

- Why should this happen to me?
- May I choose for myself?
- Is God angry with me?
- Do his promises apply to me?
- Does this come from the devil?
- Whom can I trust after all?
- Is doubting sinful?
- God image, failure, hope, trust, anxiety, meaning, moral choices, guilt feelings

Different perspectives

- In mental health care the main purpose is that faith and mental functioning go together well.

- In pastoral care the main purpose is that people live postively with God.

Difference in view of ‘autonomy’

- Autonomy as independence

  (= ability to look after oneself)

- Autonomy as self-determination

  (= right to make one’s own choices)

Autonomy as the need to stand up for yourself

Pastoral care and group dynamics

- Being part of a community
- Sharing beliefs, values, and norms
- Accepting heteronomy

Psychology:	**Self-acceptance**	**Self-actualization**	**Self-transcendence**
Anthropology:			
Otherness	individuality	autonomy	relationality in respect
Nearness	participation	purposiveness	vision
Temporality	sense of finitude	perceived opportunity	eternity awareness

Integration of Psychology and Anthropology

Cooperation

- Both therapist and pastor guide the counselee.
- They fine tune their activities.

- Complication: 50% does not appreciate the involvement of the own pastor.

Das Fremde

The therapist and the pastor

An introduction to a PhD thesis about *Worldview and Psychotherapy*

[1]In this short presentation I want to introduce some of the content of my thesis which I defended over a year ago at the faculty of humanities of the Free University, Amsterdam. I emphasize the roles of the therapist and the pastor. Toward the end I will make an application to the theme of this congress: the strange, the unfamiliar in me, in you, in God.

First, what did I investigate? I scrutinized two American journals from their first year of publication until now on the subject of worldview and psychotherapy. It concerns the *Journal of Psychology and Theology*, issuing from 1973 onward, and the *Journal of Psychology and Christianity,* issuing from 1982 and its forerunner *CAPS Bulletin,* from 1975, CAPS standing for Christian Association for Psychological Studies. The authors who contributed to both journals appeared to have a keen eye for worldview presuppositions in all scientific inquiry and therapeutic practice. Every scientific theory is value laden, while underdetermined by facts, and every practical method all the same. That is, if no Christian suppositions underlie academic and practical work, then there are some of another kind, like: positivistic, naturalistic, or humanistic ones.

This being commonly recognized in the journals mentioned, two interesting questions have been raised, and answered differently. [2] The first question is: Can psychological research be put on a specifically Christian basis, and in that way be improved and become more useful to us Christians? Yes, it can, some say. No, it can't, others declare. The optimists, as I call them, think they can take the Bible as data source and from that point of departure they try to develop psychology in a Christian way. The pessimists deny this. I will not elaborate on this topic now.

Presently, I focus on the second question, concerning the relationship between therapy and pastoral care. Can psychotherapy be put on a specifically Christian basis by being merged with pastoral care, in order to produce a Christian psychotherapy? It is my contention that the two should be distinguished. In a few words I will try to explain why. It has to do with authority and autonomy.

Let me first sketch the overlap between pastoral care and metal health care. [3]Christians with mental problems have questions about meaning of life. Why has this happened to me? May I choose for myself? Is God angry with me? Do his promises apply to me? Does this come from the devil? Whom can I trust after all? My doubting and being in low spirits, aren't these internal conditions sinful? Questions can be raised relating to the God image, own failure, hope, trust, anxiety, meaning, moral choices, guilt feelings. Both pastors and therapists meet with these problems.

In treatment conversations there should be room for faith questions and faith experience. However, in another way than in pastoral care. [4]In mental health care the main purpose is

that faith and mental functioning go together well. Conflicts that have to do with psyche and faith should be detected. The patient should find out to what degree his or her deepest beliefs can be helping and healing. Negative basic assumptions should be criticized from these beliefs. In short, the primary frame of reference for therapy is healthy mental functioning. On the other side, the primary framework of pastoral care is not mental functioning but God's reality as it is experienced and confessed within the normative tradition of the faith community. In pastoral care, too, there is a testing of faith problems and religious opinions. But this is not a testing related to a view of positive mental functioning but to a view of living positively with God.

However, are we not breaking apart here what belongs together? We cannot split up human functioning in a mental part and a religious part, can we? I think we agree on that. But why, as a Christian caregiver, are you not allowed to put the patient's functioning to the test of the patient's living with God? Why could you not be both caregiver and pastor for someone seeking help? Maybe you are a pastoral worker or an elder in your own community. And practice learns that in Christion oriented mental care the conversation can be about interpreting biblical texts and testing negative God images by reflecting on what the Bible says. Being freed from obsessions means accepting and internalizing other values than the ones one was obsessed with. In a Christian view these other values are derived from the Gospel.

This all may be true but it does not take away the principal difference between mental care and pastoral care. Partly this is a matter of expertise. A pastor has other skills than a mental caregiver. But above all it is a matter of competence. Competence has to do with skills, indeed, but also with authority. As a caregiver you are not authorized in that capacity to address faith statements to a patient belonging to a faith community. I will work that out soon, when I reflect on the own character of both practices. I keep saying that Christian inspired psychotherapy is different from soul care as we understand it in the Christian tradition. The difference is in the way of testing faith experience.

Where does this difference lie? In the difference between heteronomy and autonomy. [5] The term 'autonomy' is ambiguous, therefore we have to maneuver cautiously. It has meanings between independence, ability to look after oneself, and self-determination as the right to make one's own choices. One should have in mind that the former is a condition for the latter. No self-determination without independence. A secular mental caregiver will be inclined to interpret autonomy as self-determination as the highest purpose of being human. On the go he or she works with the patient on being independent. A Christian caregiver will deny self-determination as highest purpose. We do not dispose of our own lives, we belong to God. He has created us. He has a destination for our lives. We are heteronomous, we don't make our own laws as the word 'autonomy' may be interpreted, but subject to God's will. Such a caregiver will work on autonomy as ability to look after oneself, independence.

This does seem to involve a clear distinction, indeed. But there is a snake in the grass. The distinction between independence and self-determination has a highly theoretical character. In practice aiming at independence has a dynamic toward self-determination. In all meanings autonomy is standing up for yourself, deciding or concluding yourself what is right. The ultimate measure is in yourself. Even if you recognize heteronomy under God, it is you who recognize God as the higher authority. That choice is with you. The caregiver says: eventually it is up to you. On the contrary the pastor says – I formulate it dryly, in a pastoral setting it may be expressed more empathically and nuancedly – : God demands this from you. He has the right to have your recognition. Do you feel something of the tension? Put briefly: the caregiver does accept the dynamic of independence toward self-determination, the pastor is inclined to do not.

Within a Christian oriented mental health care the dynamic from independence toward self-determination should not be abandoned. Why not? Because we live in a complex society. Life is not neatly arranged anymore. We cannot contend ourselves with repeating old answers to new questions. Everyone is finding his or her own way, developing his or her own abilities, having his or her own experiences and challenges, on which he or she has to react. Anyone else can give some advice in subareas, but nobody else can overlook the entire life of the person in question, and for that reason no one can weigh all relevant factors but you. It is your own business. Patients should be helped to regain autonomy and control, being independent toward eventually making their own choices and decisions.

On the other hand, the pastor has other interests. [6] The pastor pursues that members of his or her community function well and feel fine as parts of that community. If you participate in a community, you have shared beliefs, values and norms. These are protected by the competent authority. The pastor is part of this authority. Therefore, he/she tries to enhance the members in these shared views. To be sure, a wise pastor allows space to everybody to articulate and practice those beliefs in his or her own way, but a community has a heteronomous gist. There is a group norm that each member has to meet.

Those specific purposes of the caregiver and the traditional pastor make it inevitable that there is a potential tension between the two. This tension can be transformed into a fruitful polarity, however, if the caregiver accounts for the group dynamics that the patient is subject to, and the pastor has a keen eye for the need of individual emancipation. The secular caregiver should bear in mind that nearly every individual belongs to groups. Another point is that traditional groups have norms and values that are more compelling to the members than modern groups. In modern groups people have the individual choice to participate to the group or to withdraw from it. Think of associations, peer groups, groups of colleagues. In traditional groups one participates by birth. Think of families, village communities, churches.

In my thesis I developed a model that could help mental caregivers to account for the group dynamics their patients are subject to, in order to integrate that aspect in their treatment.[7]

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Integration of Psychology and Anthropology

There is much to say about this figure, but I confine myself to a few remarks. By the anthropological notions of otherness and nearness I try to account for both the uniqueness of each person and the belonging of each person to larger entities. Temporality is an additional notion we cannot but involve. The three psychological notions of self-acceptance, self-actualization and self-transcendence are meant to stress the modern sense of subjectivity or awareness of the self. All these notions have to be done justice, both in the work of the therapist and of the pastor.

For patients belonging to traditional groups such as a church this state of affairs could lead to the recommendation of a structure in which the therapist and the pastor could cooperate. [8] This means that in the ideal situation both the therapist and the pastor guide the counselee, and that they fine tune their activities in regular treatment consultations, if possible in the presence of the patient.

But here a complication arises. As I have been told by professionals in a Christian mental health institution, 50% of Christian patients do not appreciate the involvement of the own pastor. They want to have treatment for their distress without being noticed as a patient by the communal pastor. How to explain this? It must be the appeal of the group to be a normal participant of the community. By being a mental patient one member feels different, not responding to the group norm, and tries to hide his or her abnormality. Here the theme of the strange appears, in a social context. It leads to feelings of shame. Of course, if the patient does not want to draw the pastor into the treatment, this is decisive, but it is not ideal. Apparently the patient's autonomy is not that far developed that he or she has the courage to admit his or her personal problem. And the social environment is not that safe as to offer an accepting atmosphere. It should be a sign of progress, if there comes a point when the patient allows the pastor to enter his or her life. For a human being is not only an individual. One is also a member of social units that share essentials in mutual acceptance.