Clinical Pastoral Psychotherapy

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A Practitioner's Handbook for Ministry Professionals

Expanded 2nd Edition

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Introduction

The intent in this practitioner's handbook is two-fold. First, we intend to provide a substantive exploration into the definitional parameters of each of the major terms employed in the explication of the nature and function of clinical pastoral psychotherapy. Second, we will provide a quick reference for ministry professionals seeking access to information regarding professional associations, state licensure laws, a glossary of professional terminology, and bibliographic and internet references to the major schools of thought in psychotherapy. Each of the key terms in the handbook, viz., clinical, pastoral, psychotherapy, and ministry, will be defined from both the pastoral and psychological perspectives, thereby establishing and justifying the category of clinical pastoral psychotherapy within a broadly defined concept of professional ministry.

However, in order to be true to the intent of this practitioner's handbook, a roster of professional associations related broadly to this field of psychological and pastoral service will be given with descriptions of each association and its membership and services. Furthermore, there will be a litany of State Licensure Laws given relevant to each state with contact information provided. Where needed and possible, an explication of the range and options of mental health services will be given as well. Also, a substantive Glossary of Terms relevant to and used by those in the general fields of counseling and therapy will be provided. Finally, a bibliography will be provided in the broader field of counseling psychology and pastoral psychotherapy.

I. Clinical Pastoral Psychotherapy

The Convergence of Pastoral Care and Clinical Therapy

John H. Morgan

In the following, we will explore the relationship between pastoral care and clinical therapy, arguing that the creative combining of pastoral care as traditionally understood and practiced within professional ministry with clinical therapy as traditionally understood and practiced within the counseling professionals constitutes a profoundly effective methodology of both care and treatment for individuals who have sought out care and nurture from within their faith community. Pastoral care assumes a worldview and ethos which is faith-based and clinical therapy presumes a professionally trained competency which is science-based. To conjoin a faith-based approach to pastoral care with a science-based use of counseling skills constitutes the perimeters of clinical pastoral psychotherapy. This concept we will explore here.

Establishing the definitional perimeters in any discussion of clinical pastoral psychotherapy requires both courage in the face of opposition and indifference in the face of criticism. As we will see in this enquiry, each of the concepts – clinical, pastoral, and psychotherapy – has a checkered past in its usage within both the medical and clerical professions (Hunter, 2005; Reber, 1985). In order that we might commence with a commonality of term usage, definitions of the various branches of psychological care and treatment are offered here in order that we might at least understand what we mean by the terms being employed. Subsequent to this

discussion, of course, there can be a debate as to the definitions themselves. But for now, these are the terms and these are the definitions we intend to employ in this essay.

Psychotherapy is the analysis and treatment of mental and emotional disorders through the use of psychological insights and techniques, both palliative and curative, designed to deepen the client's self-understanding through personal growth while nurturing the development of skills in interpersonal relationships. *Social Psychotherapy* is the study of interpersonal relationships with particular attention to clinical issues related to interactive dysfunctions including self-image and social skills and the treatment of those dysfunctions. *Social Psychology* is defined by William James, the father of modern psychology, as the "discipline that attempts to understand and explain how the thought, feeling or behavior of individuals are influenced by the actual, imagined or implied presence of others" (Morgan, 2011). *Social Psychiatry* is defined by Harry Stack Sullivan, the father of American psychiatry, as "the study of processes that involve or go on between people. The field of psychiatry," he explains, "is the field of interpersonal relations, under any and all circumstances in which these relations exist" (Morgan, 2010). *Clinical Pastoral Psychotherapy* is the study and treatment of dysfunctions in interpersonal relationships within the context of a spiritual worldview and ethos which provides a faith-based framework for analysis and therapy. Since there is no faith-based science and no science-based faith, we will here explore how a faith-based approach to personal nurture can be conjoined to a science-based understanding of clinical therapy, thereby providing a rational approach to pastoral nurture and therapy treatment for the ministry professional (Morgan, 2012).

CLINICAL AS IN CLINICAL THERAPY PRACTICE

The term *clinical* has a long and respected history within the

healing arts professions, beginning and dominated by the medical community as a term used to indicate a specifically focused interest in empirically-demonstrative symptom-based etiology, diagnostics, and treatment (Amada, 1985). Within the psychological community, both religious and secular, the term has gradually become a central ingredient in discussions relative to treatment plans based upon the presenting symptoms of the client/patient. The American Psychological Association has, for many years, appeared to presume that the term *clinical,* when employed by those professionals engaged in the treatment of emotional and behavioral disorders, was strictly their domain and restricted to the profession of clinical psychology (Milton, 1983). On the other hand, the Association for Clinical Pastoral Education has made the same assumption when dealing with counselors within the faith community (Chiew, 2007). Though both the APA and the ACPE have made significant contributions to the professionalization of the practice of clinical counseling and psychology, it would be far from correct to suggest that either or both professional bodies control the use of the term *clinical* in reference to the treatment of behavioral disorders by professional counselors.

In the following, we will explore the history and development of the field of clinical counseling and psychology and the training pertaining to that professional classification. We will take a close look at what is called assessment and diagnostics by clinicians in the counseling field. Our interest here, of course, is not to offer a full exploration into the history, nature, and function of clinical counseling or the specialized field of clinical psychology. Rather, our attention here is upon the meaning and use of the term *clinical* itself, as recognized and used within the counseling professions – secular and religious – with a particular focus upon the significance of the term in our exploration of *clinical pastoral psychotherapy* (Morgan, 2012). As stated in our opening remarks, our interest is to take a close look at the four terms of relevance in the practice of clinical

pastoral psychotherapy, namely, clinical, pastoral, and psychotherapy as relates to ministry professionals.

For better than a century, clinical psychology in various forms has been practiced and taught (Kendler, 1987). Defined early as the scientific inquiry into the application of psychological insights and understandings, the focus has always been upon the empirical data of behavioral issues in search of assessment and treatment. Though always involved, in some form and at various levels, in research, teaching, consultation, forensic testimony, and programmatic development and administration, the focus has always been upon the "clinical" side of assessment and treatment. The University of Pennsylvania, under the leadership of Lightner Witmer (1867-1956), is credited with the official opening of the first psychological treatment clinic in 1896. However, it was the aftermath of World War II and the radical acceleration of post-traumatic stress (only many decades later officially designated in the Diagnostic and Statistical Manual of the APA as a disorder called "PTSD" for Post-traumatic Stress Disorder) that clinical psychology and psychological clinics became a part of mainstream American medical treatment facilities.

Though psychiatry, using the psychopharmacological orientation for treatment of behavioral disorders, was the dominant school of thought and practice, clinical counseling was rapidly becoming a professional phenomenon in its own right (Morgan, 2006). With the iron fist of the American Medical Association controlling the legal rights to prescribe drugs, psychiatry was and still is the power source behind hospital and residential treatment facilities. Even now, clinical psychologists are not authorized to prescribe medication and, thus, there is the perpetual reliance upon the psychiatrist, even if the training has been exclusively or predominately pharmaceutical rather than psychological, for assessment, diagnosis, and treatment of behavioral disorders. However, there has been a trend in the past few decades since the Vietnam War to employ a team approach to

diagnosis and treatment, involving psychiatrists, social workers, and clinical counselors (both religious and secular) in the overall care of the patient/client. It should be pointed out, however, that owing to the spiraling costs in medical care, the team approach has been considered too expensive to be maintained in many treatment facilities.

With the founding of the American Association of Clinical Psychology in 1917, things began to change for the profession of psychology. Within two years, the American Psychological Association, which had been founded by G. Stanley Hall in 1882, moved to develop a section within the APA specifically in clinical psychology, a bold move for such an early date as 1919. Things moved slowly for the APA's new section until World War II when the field became a major component of the APA's structure, called Division 12, and it remains so today with psychological societies and associations all over the English-speaking world and beyond.

Professions being what they are, it was apparent to everyone in the counseling field that a doctoral program was required to elevate the practice of clinical psychology to a recognized sub-specialty within the medical community. The recognition was clear that a distinction, though complimentary, between research and practice, was essential. The old Ph.D. programs based upon research without any emphasis upon application had reigned far too long within the academy. The leader in the new field became the University of Illinois when, in 1965, it approved the inauguration of an applied-oriented rather than a research-oriented Ph.D. in psychology which took its first students in 1968. By 1973, the Doctor of Psychology finally gained official recognition and it was Rutgers University which awarded the first Psy.D. degree in the United States. In the United Kingdom, the Doctor of Clinical Psychology (D.Clin.Psych.) is the recognized doctorate for both research and counseling for clinical psychologists. Today, half of the graduate students majoring in clinical psychology in American institutions are taking the Psy.D.

rather than the Ph.D. Between 1974 and 1990, the number of clinical psychologists increased from 20,000 to 63,000, and the number continues to grow as sub-specializations continue to proliferate (Kendler, 1987).

In the United States, Canada, and the United Kingdom (as well as many other countries), to practice as a clinical psychologist, the professional must hold a license. Pastors trained under the jurisdiction of the Association for Clinical Pastoral Education do not seek licensure as a clinical psychologist on the basis of the pastoral training but some clergy do seek licensure as a clinical psychologist following state laws. Clinicians, whether counselors or psychologists or whether secular or religious, engage in two fundamental processes, namely, assessment and diagnosis. Assessment is usually broken down into four separate but complimenting processes. These include (1) intelligence and achievement tests, (2) personality tests, (3) neuropsychological tests, and (4) clinical observation. Intelligence and achievements tests are designed to measure certain specific kinds of cognitive functions such as IQ tests. Personality tests aim to describe patterns of behavior, thoughts, and feelings and two very popular tests are the Minnesota Multiphasic Personality Inventory (MMPI) and the Rorschach inkblot test. Neuropsychological tests consist of specifically designed tasks used to measure psychological functions known to be linked to a particular brain structure or pathway. Finally, clinical observation is much more subjective and is used by clinical counselors and clinical psychologists, whether secular or religious, as well as a wide range of psychotherapists, in the context of the clinical interview. Such assessment looks at certain areas, such as general appearance and behavior, mood and affect, perception, comprehension, insight, memory, and the content of verbal communication.

Following the assessment process and regardless of which type or types of instruments are used by the clinician, the diagnostic impression is made. In the United States, the *Diagnostic and*

Statistical Manual of Mental Disorders (the DSM version IV-TR) has been developed under the oversight of a blue ribbon committee of the American Psychological Association in consultation with the American Medical Association such that much of the diagnostic nomenclature is medical rather than strictly psychological.

PASTORAL as in Spiritual Care and Nurture

In our discussion of clinical pastoral psychotherapy, we have pointed out that there are four major conceptual terms to be explored, viz., clinical, pastoral, psychotherapy, and ministry professional. When any one of these four terms is used, the other three are implied as *milieu* for our discussion. Here we will focus our primary attention upon what is universally known and recognized as pastoral counseling, namely, that branch of the counseling and psychological professions relevant to the work of clergy – rabbis, priests, pastors, and imams – as well as lay persons exercising their vocation as ministry professionals (Graber, 2004).

In their work as pastoral counselors, these professionals, whether ordained or not, provide therapeutic services to designated faith communities (Jewish, Christian, Muslim), specific constituencies (faith communities, parishes, hospitals, prisons, colleges, etc.), as well as the general public. Because of the specialized nature of this delivery of therapeutic services, a pastoral counselor is at liberty to integrate both traditional psychological schools of thought with specific faith-based worldviews which are drawn from religious training such as provided by seminaries. Psychological data as perceived by pastoral counselors may, therefore, imply spirituality issues informed by the traditional religious texts of the specific faith-community being served, such as the Torah, the New Testament, and the Qur'an (Hunter, 2005).

The generally recognized distinguishing characteristic of the pastoral counselor vis-à-vis non-faith-based counselor is that the

pastoral counselor is expected to draw upon the faith tradition of the patient or client seeking help from the pastoral counselor (Chiew, 2007). The pastoral counselor, therefore, is accountable to both the client and the faith community in drawing from the faith tradition's understanding of the nature of the human person and the way in which that specific tradition understands healing, nurture, emotional health, and spiritual well-being. The pastoral counselor is, then, at liberty, indeed, expected to draw from the tradition images and concepts which are understood to be provocative, insightful, and helpful in assisting the client seeking help from the counselor. Unlike secular-oriented non-faith-based counseling, pastoral counseling focuses precisely upon the nature of the human condition as articulated and expounded by the faith community of the client and counselor alike.

Because pastoral counseling is a specialized model of traditional psychotherapy, the use of religious resources such as prayer, spiritual direction, and biblical guidance are recognized and accepted as legitimate components of the healing and nurturing process. Depending upon the tradition – Jewish, Christian, Muslim – and the subset with each tradition – Hassidism, Conservative, Reform, Reconstructionist Judaism, Evangelical Protestant, Fundamentalism, Mainline Protestant, Roman Catholic, Orthodox Christian, and Sunni, Shiite, Sufi Muslim – there is a wide range of viable mechanisms for providing psychotherapy as a pastoral counselor. Obviously, for example within the Christian tradition, a Roman Catholic client would feel more comfortable with the counselor referencing the *lectio divina* whereas a Pentecostal Christian would prefer referencing the sayings of Jesus from a King James Version of the New Testament. Because pastoral counselors are recognized as mental health professionals, whether certified and licensed or not (depending on state laws), the client will more often than not seek guidance and nurture from a pastoral counselor within his or her own faith tradition,

knowing and expecting that the counseling received will be true to the fundamental teachings of the client's tradition.

Before we pursue a closer scrutiny of this therapeutic service, we should point out that pastoral counseling implies what is recognized throughout the professional world as clinical pastoral education. The various professional associations using this term are many (Hunter, 2005). Clinical pastoral education, usually simply referred to as "CPE," is education based upon a multicultural and interfaith perception of mental health and emotional nurture validating and employing faith-based insights drawn from the appropriate religious tradition. Whether employed by ordained or lay persons, CPE is the training normally assumed by the client of the pastoral counselor being consulted. This training consists of over 1,200 hours of supervised clinical experience which means providing therapy to individuals, groups, and families including over 200 hours of direct supervision by a training professional in the field. CPE training is provided in a variety of venues, including counseling centers and hospital chaplaincy programs, and the amount of time and effort spent in gaining this training is at the highest professional levels of didactic instruction and practicum experience.

There are over 3,000 pastoral counselors serving in various venues in the United States and these professionals, some functioning with only a master's degree while many have a doctorate, either a Doctor of Ministry in Pastoral Care and Counseling or increasingly common the Doctor of Psychology. The Psy.D. has become more commonly recognized as the preferred credential for secular practice and increasingly practiced within faith-based institutions as well. Many pastoral counselors, if not most, have at least one CPE Unit of training consisting of 400 hours of supervision, and serve in hospitals, prisons, parishes, schools, and private and public counseling centers treating a wide range of emotional disorders affecting individuals and families.

Though clergy of all traditions have for hundreds of years offered advice and counsel to members of their faith communities, the gradual integration of traditional religious values with modern psychological methods leading to the emergence of a pastoral psychotherapeutic approach to spiritual nurture dates only from the 1930s when the Rev. Norman Vincent Peale and Smile Blanton, MD, created the Blanton-Peale Institute in New York City. The Rev. Anton Boisen, considered the father of the clinical pastoral education movement, pressed for an integration of faith and mental health and this movement of thought has grown rapidly throughout the United States and Canada and now throughout the world with CPE centers all over Africa, Europe, and Asia. Though predominantly fostered and practiced by Christians and Jews, pastoral care and counseling is now becoming increasingly accepted and employed by members of the Muslim community, particularly under the leadership of Dr. Muhammad Hatim and Dr. Ibrahim Abdul-Malik, both members of the Islamic faculty at the Graduate Theological Foundation in Indiana.

PSYCHOTHERAPY AS IN THE CLASSICAL SCHOOLS OF THOUGHT

Pastoral counselors are a breed unto themselves as they come in all flavors, from the highly trained post-ordination psychotherapist credentials of advanced learning in the field to the lowly parish pastor who made it through divinity school to ordination with possibly a single CPE unit of training, if that. Our compassion is for both types and all those in between. Pastors involved in counseling, whether depth analysis or crisis triage, have our sympathy and support, first, because few in their faith community understand their training and, second, even fewer understand the pressures of the profession itself.

What is Psychotherapy? The answer to this question is easy and it is not; it is simple and it is certainly complex. It might be fair here

to offer a working definition of this field of health care practice and to suggest the perimeters of its value and function (Amada, 1985). We will, therefore, offer a brief definition of the practice of psychotherapy which pastors and counselors can easily identify for professional practice. Thanks to the generosity of Arthur S. Reber and the publishers of the *Dictionary of Psychology*, by Penguin Books, we have ready access to the authoritative definition (Reber, 1985). Of course, we will not be hamstrung by this definition, but we will commence with it. Reber says, "In the most inclusive sense, the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional or behavioral disorder can be called *psychotherapy*." In this general sense of the term, it is neutral with regard to the theory that may underlie it, the actual procedures and techniques entailed, and the form and duration of the treatment. There may, however, be legal and professional issues involved in the actual practice of what is called psychotherapy, and in the technical literature the term is properly used only when it is carried out by someone with recognized training and using accepted techniques (Zeig, 1987). The term is often used in shortened form as therapy, particularly when modifiers are appended to identify the form of therapy or the theoretical orientation of the therapist using it.

Psychotherapy is, as a professional practice, an interpersonal and relational *intervention* used by trained professionals in the treatment of clients who are experiencing difficulty in daily life. The focus is usually upon issues related to well-being and the attempt to reduce personal senses of dissatisfaction with one's life (Hall and Lindzey, 1957; Hjelle and Ziegler, 1976; Reist, 1985). Practitioners of psychotherapy use a wide variety of techniques devised by theorists in the field dealing with problematic issues of life's daily functions. Such simple things as improving dialogue skills, communication development, and behavioral modification are employed in such treatment. The goal is the improvement and enhancement of mental health on the part of the client/patient.

Contemporary practices in psychotherapeutic counseling have reached far beyond their early modality of treatment which, by and large, were limited to a conversational style of patient/client/counselor relationship. Today such modes of interaction as writing, artistic expression, drama, therapeutic touch and even aroma-therapy are commonly used. We will limit ourselves here, however, to the classic mode of encounter, viz., conversation. This structured and highly orchestrated therapeutic encounter between therapist and client/patient dates from the earliest beginnings of psychotherapy in the late 19th century. Whereas formerly psychotherapy was thought to be limited to behavioral crises and counseling limited to the more mundane behavioral adjustments needed for a well-directed life, that line of distinction has all but vanished these days with psychotherapy being used as both the term for and practice of intensive counseling encounter (Morgan, 2011). Yet, whereas counseling has not frequently been thought of in terms of the medical model, interventionist psychotherapy is most commonly so characterized. Again, however, given the rise of clinical pastoral education, which is most commonly practiced and taught in a medical setting, even that line of distinction has more or less vanished.

These variances in terminology and usage have created something of a problem for pastors who both wish to be trained in and to offer psychotherapeutic counseling to their pastoral constituencies and yet wish to avoid any appearance of treading on the medical profession's rightful domain. The use of such terms as counselor, therapist, client, patient, clinical, etc. has often created ambiguities in the minds of both the practitioner and the client/patient. There are no set rules, though some have tried to establish them (Chan, 2005). There are, however, state laws affecting the use of such terms as counselor and psychologist which pastoral counselors would be wise to explore before launching out into this cauldron of psycho-medical and psycho-clinical practice. Let us agree here that we will use

psychotherapy and its variants to apply to pastoral counseling and we will use the term *client* rather than *patient* to refer to the recipient of such psychotherapy. For pastoral counselors preferring to use the term "counselor" to describe what they do, we will honor that and, also, for psychotherapists who prefer to consider the recipients of their professional skills patients rather than clients, we will honor that position as well. For our purposes, however, we will say psychotherapists when referring to pastoral counselors and clients when referring to their patients.

Needless to say, since the time of Sigmund Freud (Jones, 1957), there have emerged several rather distinctly identifiable systems or schools of psychotherapy. We will not consider any of these in detail except as relates to the classical traditions explicated elsewhere in my book entitled, *Beginning with Freud: The Classical Schools of Psychotherapy* (Morgan, 2010). As we know, Freud was a trained medical neurologist and was early on interested in the seemingly non-biogenic behavioral disorders and this interest led him to develop and utilize such analytical techniques such as dream interpretation, free association, the concept of transference, and the tripartite id/ego/superego construct of the human psyche. Regardless of one's own ideological bias or professional preference, few would dispute the fact that Freud is the Father of the Movement known as psychoanalysis and its contingent, psychotherapy (Lundin, 1985). Under the broader concept of psychodynamics, many schools of thought were spawned by Freud's pioneering work with some staying close to his theoretical moorings as neo-Freudians while others moved farther afield such as the post-Freudians. However, all schools of psychodynamics engaged in psychotherapeutic application address themselves necessarily and inevitably to the whole concept of the psyche's conscious/subconscious/unconscious reality (Monte, 1987).

Of course, not all psychologists and those engaged in the behavioral sciences choose to use Freud as a launching pad. The

behaviorism of B. F. Skinner and others evolved a behavioral therapy which has become quite popular in certain circles which uses such concepts as operant conditioning, classical conditioning, and social learning theory. And, eventually, such ideological positions as existential philosophy came into play in the development of certain schools of psychotherapeutic treatment such as Viktor Frankl's logotherapy. Extending existentialism to psychotherapy was the work of Carl Rogers and Abraham Maslow. Their work, of course, led to the rather popular *person-centered* school of psychotherapy and from that came Fritz Perls' gestalt therapy and Eric Berne's Transactional Analysis, all falling into a rather lumpy collection of what is passionately labeled humanistic psychotherapy today. Other and diminishingly important schools of thought were spawned by this rash of post-Freudian and even post-Sartrean existentialist thought into such things as cognitive therapy following Aaron Beck, and postmodernist trends known as narrative therapy, coherence therapy, transpersonal psychology, feminist therapy (as a separate school of its own!), somatic psychology, expressive therapy and, for want of a better descriptive term, brief therapy. This plethora of schools has been both extensively attacked and defended, and we need not repeat that agenda here (Kendler, 1987).

MINISTRY PROFESSIONALS AS IN FAITH-COMMUNITY PRACTITIONERS

Defining *ministry* is like trying to define love, we all know it when we see it but words either fail us or plague us with too few or too many and, when we are done, there is still some question as to whether or not we have done the word justice. Ministry, when coupled with *professional*, creates an even broader problem and challenge. We know what a physician is and what an attorney is but when it comes to being a minister, there is a wide range of what it might or might not mean. To solve the problem by using the word

clergy is really no solution at all since many ministry professionals are not, and do not desire to be, clergy in the traditional sense of the word. Here, we will explore the narrow and broad usage of the terms ministry and professional and, after exhausting the traditional meanings, we will explore the contemporary usages and viability of the now more commonly used term, *ministry professional*. For ease of use, we have throughout this inquiry suggested that the concept "ministry professional" does not imply ordination but does require the practitioner to both embrace and represent an identifiable worldview and ethos representative of a faith-based understanding of the world and the individual's rightful place in it (Morgan, 2005). The practitioner need not be personally committed to the faith-based theology of the community but must both understand it and empathize with the individual within it who has sought pastoral care and clinical therapy from the ministry professional. An intentional duplicity might be operative here in the phenomenological sense insofar as the ministry professional as clinical therapist is able to understand the worldview and ethos of the individual's faith-based community, thereby drawing from and offering nurture and insight into the individual's psychological state based on that understanding, without the therapist subscribing to it personally.

Professions have generally arisen and become elevated naturally from lower trades and occupations through a slow process of maturation. They have established themselves, put down roots, created approved procedures and qualifications, obtained legal and political recognition and so have grown in size, power and sophistication through time, often from modest beginnings. While all professions enjoy high social status, certain professions, such as law, medicine, and ministry, have the highest status, regard and esteem conferred upon them by society at large. This high social status, regard, and esteem arise primarily from the wider, deeper and higher social function of their work as compared with other lower ranking professions. Their work is regarded as more vital to society as a

whole and thus of having a special and very valuable nature. By contrast, certain secondary professions, while also enjoying high standing in society, yet the value of their work is seen as less vital to society and thus they enjoy a correspondingly lower status. The distinctions between *primary* and *secondary* professions are less clear in the United States than in European and other industrialized nations, and, therefore, for our discussion here, we will treat only of physicians, lawyers, and the clergy in all subsequent references to professions.

Nevertheless, all professions involve technical, specialized and highly skilled training and work. Training for this work involves obtaining degrees and professional qualifications in order to gain entry into the profession, and without which entry to the profession is barred. This is sometimes called occupational closure. Therefore, all professions can be seen to involve some degree of credentialing; indeed, in modern times this credentialing aspect of professions is increasing all the time, such as through professional upgrading of skills and *payment by results* by which the true merit of a professional person is deemed – rightly or wrongly – to be measured by the number of skill update courses they have recently attended.

Additionally, all professions have a high measure of control over their own affairs and, therefore, tend to be self-regulating or institutionally autonomous. Furthermore and invariably, strong national professional organizations exercise a great deal of power over their domain of service such that, for example, the American Medical Association has established national governance over the issuance of prescription drugs. Unless a health professional is a member of the AMA in good standing and holds a medical degree, he or she is forbidden to issue prescriptions. Also, all professions have control over their own knowledge base sometimes called "epistemological autonomy." Therefore, professional training programs, schools, and institutions establish the curriculum as determined by the professional association to be necessary for mem-

and professional functioning with that body.

All professions have also evolved their own "codes of practice," both to maintain the overall integrity and high status of the profession itself, through regulating the behavior of its members, and to protect the public or client-base which they serve. Codes of practice need to be reviewed and policed, and breaches of discipline punished, ultimately by expulsion from the elite group of the profession. Such is the highest sanction imposed for persons found guilty of professional misconduct in the legal, medical, and clerical worlds. Each professional body will have spelled out in detail over years of experience precisely how to proceed in such cases, with law, medicine, and ministry each functioning according to its own rules. The higher the ethical standards, the more circumscribed the procedure. Thus all professions have overseeing regulatory bodies to judge the conduct or misdemeanors of members, which are regarded as a serious matter. These bodies often also serve to protect and justify to outsiders the rights and privileges of the profession, and to defend it in times of public scrutiny or criticism.

Not surprisingly, all primary professions such as law, medicine, and ministry enjoy various privileges and rights associated with high office and these are both granted by the wider society and demanded by the profession itself. Hence also these rights and responsibilities can be reviewed or forfeited if codes of practice are breached. To that end, all professions have evolved strict guidelines and protocols concerning the behavior of members, within which accepted rules apply and if they are broken, then various sanctions and punishments come into effect to moderate such conduct.

These primary professions are necessarily hierarchical and have a graded structure; they are finely stratified by rank, age, experience and qualifications, etc. This inevitably generates a deeply conformist culture within which behavior patterns like cronyism tend to be commonplace, in devious attempts to curry favor and gain advancement within the hierarchy. Each of the primary professions

of law, medicine, and ministry has its own unique system of gradations and, within each specialization, further refined stratification of status determiners. Among the clergy, the denomination itself has its own hierarchy alongside the profession itself. Within this context of hierarchical gradations, there is also generated a fierce internal competition at all levels, acute rank awareness and a struggle between individuals to gain advancement within the promotional structure of the profession. Within the professions of law and medicine, this is recognized, acknowledged within the closed ethos of the professions, and fostered to the extent that competition is perceived to be good for the practice.

However, within the profession of ministry there is a bold and naïve denial of such competition and a systematic avoidance of addressing it and formalizing it. Clergy compete for status, position, assignments, recognition, etc., all the while insisting that they do not. This denial is usually couched in "sacramental" language about the avoidance of pride, the nurturing of humility, etc. Yet, at the end of the day, the actions of clergy bespeak a natural desire for success and advancement, even over and at the expense of one's peers. A negative but unavoidable feature of this competition is the generation of a culture of whispers, rumors, and people being either in or out of favor and being continually judged as to their competence and merit. This in turn generates strong social tensions within the profession and helps to sustain a climate of suspicion, and petty jealousies. Though this quite clearly exists within each of the primary professions, there is always a loud and brash disclaimer of it, particularly among the clergy, even in the midst of its all-consuming presence.

Conclusion

Clinical pastoral psychotherapy constitutes the practice of pastoral care conjoined with clinical therapy on the part of the ministry professional. A faith-based approach to pastoral care and a

science-based use of clinical therapy allows the ministry professional to both honor the integrity of the science of psychotherapeutic psychology while providing a context within which the worldview and ethos of the patient is allowed to function as a foil for emotional security. Whether the practitioner embraces the faith-based worldview and ethos of the individual patient or not is irrelevant so long as the practitioner allows for the viability of the patient's faith to offer security and nurture. The clinical therapy, then, operates within the worldview but employing strictly science-based methodologies of assessment and modalities of treatment. By so doing, the clinical pastoral psychotherapist has honored both the faith of the patient and the science of the profession.

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II. Pastoral Essays

The Case Study Approach to Pastoral Care

Anthony R. DeMieri

Case Study #1 of 5: Ted

Introductory Statement

This first case study illustrates the complexity of a diagnosis of Borderline Personality Disorder with co/occurring Substance Abuse Disorder and Mood Disorder NOS. This case also demonstrates the added complexity of family dysfunction. This writer will focus primarily upon the family dysfunction aspect as it applies to, and is affected by, the psychiatric and substance abuse disorders.

Demography

Ted is a 58-year-old African American male who is currently unemployed and lives in supportive housing for individuals with chronic medical conditions. He is separated from his spouse and has two sons, Henry and Harry, ages two and three, respectively. The two children are currently in foster care custody. Ted is in frequent contact with two of his relatives, namely: his mother (87 years old) and his only brother (42 years old). Ted has lived in New Jersey since childhood. He has an 11th grade education and no history of holding down steady employment for over 12 years.

Mode of Referral

Ted was referred to the parenting program from an ACS worker who believed that he would benefit from a nurturing fatherhood program. Ted followed the mandate and is currently in full compliance with the ACS mandate.

History of Presenting Complaint

Ted experiences severe anxiety and depression resulting from his familial situation, which involves potentially losing visitation rights to see his two sons. Ted described himself as being a product of the "broken" foster care system, and he adamantly mentioned that he does not want to see his sons becoming like him in life. Ted disclosed that he often used substances to cope with immense pain. He is currently in an outpatient substance abuse treatment center for cocaine and marijuana usage. Ted complains that he believes the court is going to take away his rights to see his sons. He mentioned that nobody is on his side and that the system is working against him. He described his situation in life as a "stacked deck" which he had to deal with ever since he was a child. At one point during group session Ted mentioned that he has nothing to live for anymore. Ted's substance abuse counselor at the outpatient facility reported that Ted exhibits attention-seeking behavior. In this regard, it was reported that Ted exaggerates his attempts at ending his life for the attention of others.

Ted mentioned that seeing his children brings him great satisfaction and that he doesn't want them to be exposed to "the system" and become another statistic of the broken foster care system. Further, Ted maintained that the child's mother tells lies to the court about him, and that the mother states that Ted did not take care of the apartment or the children. He maintains that the mother of his children was the one who is guilty of neglect. Ted is currently able to

see his children once per month during supervised visitation. The mother of the children is allowed to see them every week under supervised visitation. Ted claims that his chronic medical illness also contributes to the anxiety and mentioned that his wife made the accusations that she now has the chronic medical illness as a result of intimacy with Ted. Ted claimed that he informed his wife about his medical condition before intimacy. He mentioned that he could cope with having the medical condition, but he could not cope with losing visitation rights to see his children.

There are many attributions to Ted's discomfort, which include: his wife, ACS, the courts, his health condition, and his current living situation. The impact of Ted's psychological distress is his inability to think rationally and clearly about how to communicate in court to the judge, and his inability to communicate with his wife and attorney. Ted's psychological reaction may also be a major factor in attributing to the possibility to him losing visitation rights if he is deemed to be a danger to his children. Ted has very poor coping skills.

Clinical Interventions

Upon learning from the group instructor about Ted's comment about not having anything to live for anymore, this writer contacted Ted's substance abuse counselor, who confirmed that Ted has a tendency to exaggerate his emotional reactions. This writer alerted the relevant staff to the situation, and then met with Ted for individual counseling. When asked further about his comment of not having anything to live for anymore, Ted mentioned that he made the comment out of anger and had no intention of harming himself. He mentioned that he doesn't know how to handle with his excessive stress and speaks "off the cuff" at times. This writer and Ted drafted and reviewed a safety plan, which consisted of two columns and six rows, with the two headings: "Activities that I can do when I am

feeling overwhelmed" and "phone contact numbers of supportive people." Some activities that Ted listed which assist him at alleviating his stress include: (1) walks in the park concentrating on his breaths, (2) having a cup of hot water with lemon, (3) listening to relaxing jazz music (4) conversing with his mother over a meal (5) conversing with his sister over a meal. Some people that Ted listed as emergency contact numbers included: (1) his mother, (2) his brother, (3) his substance abuse program (4) the fatherhood program, and (5) the emergency room/911.

The goal of the safety plan was to provide additional reassurance to Ted that he is not alone, and that there are other people he can go to when he needs help. Ted's anxiety decreased considerably after creating this chart and he mentioned that he felt less tense because he can now see visually that he's not alone in the world.

Prior to the outburst during group session, Ted went to family court two days prior with support staff. Despite having a positive report from the judge on his overall compliance, Ted believed that he was trapped and that everything went sour. This writer reminded Ted that support staff accompanied him to family court and gave a good report, and that the judge read the supportive letter that was provided to the court. The judge ruled that he will not remove vitiation rights, or modify visitation rights so as to interfere with the current arrangements. The supportive letter demonstrated Ted's attempts to overcome many of the challenges in his life, that he had been attending the program consistently, and attempts to participate often in the program during group activities. Ted was resistant to hearing good news and attempted to downplay what the support staff reported. After speaking further with Ted and reassuring him that the support staff went to many prior court hearings and was very seasoned in his field, Ted felt more relaxed and understood that all was not as gloomy as he initially conceived. Another valuable clinical strategy that was used was reminding Ted of his unique and positive qualities, and all of the support that he had. Ted was

essentially trapped within a narcissistic state-of-mind which requires a reexamination of motivation, intention, goals, values, emotion, and logic.

This writer provided Ted with the vivid imagery example of someone wearing dark sunglasses and who is not aware of peripheral vision. By this point, this writer explained to Ted that on every field of his vision he has the support of the parenting program, of his mother and brother, of his outpatient program, and of his peer group members. This extra comfort was crucial for Ted. Ted also described the importance of spirituality in his life, and mentioned that going to church provides him with a safe haven where he feels relaxed and alone with God. However, Ted thereafter maintained that he experiences a rush of inner turmoil on a daily basis. The social worker, upon constructing the treatment plan, included the spiritual dimension, which was important to Ted.

Ted was able to speak to an attorney who answered his legal questions and alleviated some anxiety that was caused by the complexities of the legal system. The support staff will be available to accompany Ted to his next court date, which will offer Ted additional moral support. The treatment plan included extensive counseling for anxiety and depression, and a referral for offsite additional counseling, preferably dialectical behavioral therapy (DBT) for borderline personality disorder. Ted is currently enrolled in an outpatient intensive substance abuse program. In addition, Ted sees a psychiatrist for psychopharmacological treatment. All of these support structures provide Ted with the treatment necessary to alleviate his presenting psychopathology.

Family Psychiatric History

Ted reported that his mother has a history of alcoholism. Ted also reported that depression is prominent in his family history.

Mental State Examination

Appearance, behavior, eye contact, and rapport: During the session Ted appeared anxious, depressed and avoided direct eye contact. Ted was dressed in a sweater with denim jeans and sneakers- all of which looked relatively clean.

Speech: Ted spoke at a rate faster than average, high volume and anxious intonation.

Thought form: Ted's thought form was coherent despite at times seemingly suspicious content.

Thought Content: Ted's thought did contain paranoid ideations and ruminatory in nature.

Perception: Ted's perception was observed as normal: no evidence of delusions or hallucinations

Mood: Depressed elevated, angry fearful

Affect: High range of intensity and mobility

Insight: Ted had poor insight into his mental condition and frame of mind.

Diagnostic Formulation

1. DSM IV

301. 83 Borderline Personality Disorder
296.90 Mood Disorder Not Otherwise Specified
304.30 Cannabis Dependence

304.20 Cocaine Dependence
GAF= 43

Explanation

Ted has been taking medication to manage his symptoms for Borderline Personality Disorder and Mood Disorder NOS. Despite taking his medications, numerous external stressors (ACS, court related matters, wife) have exacerbated anxiety, paranoia and depression. Ted's ability to make rational decisions is sharply affected by his co-occurring personality and mood disorder, and further affected by his cannabis and cocaine dependency. Ted displays the following symptoms of BPD as listed in the DSM-IV: (1) frantic efforts to avoid real or imagined abandonment, (2) a pattern of unstable and intense interpersonal relationships characterized by alternate between extremes of idealization and devaluation, (3) identity disturbance: markedly and persistently unstable self-image or sense of self, (4) impulsivity in at least two areas that are potentially self-damaging (substance abuse and sex), and (5) recurrent suicidal behavior, gestures, or threatens, or self-mutilating behavior, (6) chronic feelings of emptiness, and (7) inappropriate, intense anger or difficulty controlling anger, and (8) transient, stress-related paranoid ideation or severe dissociative symptoms.

Ted meets the criteria for Mood Disorder Not Otherwise Specified, as stated in the DSM-IV: This category includes disorders with mood symptoms that do not meet the criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bipolar Disorder Not Otherwise Specified (i.e., acute agitation).

Ted meets the criteria for Cannabis and Cocaine Dependence, as stated in the DSM-IV:

(1) tolerance, (2) withdrawal, (3) the substance is often taken in larger

amounts or over a long period of time than was intended, (4) there is persistent desire or unsuccessful efforts to cut down or control substance use, (5) important social, occupational, or recreational activities are given up or reduced because of substance use, and (6) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problems that is likely to have been caused or exacerbated by the substance.

Analysis via Classical Schools of Psychotherapy

Jung: Ted essentially believes he has lost his manhood; no feeling of being a man; lost generativity.

Adler: Ted clearly illustrates an inferiority complex.

Freud: Ted has a displaced libido – extensive wild libidinal energy from the borderline condition.

Rogers: Ted demonstrates no defined self-concept; needs to take ownership of his self-identity.

Erikson: Ted needs to rectify the very early stages of his development; he is stuck at age three.

Frankl: Ted experienced trauma in his early life but has meaning in his life, namely his two sons.
Maslow: Ted is struggling to sustain himself within the hierarchical order of needs.

Sullivan: Ted's borderline condition emerged from his inability to come to terms with inherent contradictions in his upbringing and in society- the push-pull tension is extraordinarily elevated.

CASE STUDY #2 OF 5: TOM

Introductory Statement

This second case study illustrates the complexity of Depression NOS with co/occurring Cannabis Abuse. This writer will focus primarily upon the family dysfunction aspect as it applies to, and is affected by, the psychiatric and substance abuse disorders.

Demography

Tom is a 45-year-old Caucasian male who is currently employed as a facility maintenance worker and lives with his three children (Tabitha (5 years old), Tim (10 years old) and Tasha (12 years old).) Tom's first marriage ended in divorce due to familial disagreements. Tom reports that he is very close to his family, and was raised with a strong Irish heritage wherein he has many cousins who live in Brooklyn and in Ireland. Tom had prior involvement with the justice system for trespassing. Despite his prior involvement in the justice system, Tom remains committed to being an active part within the life of his children. He currently lives in Staten Island with his family [wife and three children] in a three-bedroom apartment.

Mode of Referral

Tom was referred for counseling by a friend who previously attended group counseling sessions. At the time of his enrollment, Tom was unemployed and actively seeking employment.

History of Presenting Complaint

Tom had the attitude upon entering the parenting program and job training program that he had numerous brushes with the legal system

over matters to which he had little control. He declared that he needed money to take care of his children and committed a non-violent trespass to make ends meet for which he is currently serving probation. Tom believed that he had justification for his actions upon entering the program. He maintained that the economy was bad and asserted that he was barely able to provide a roof for his children. Tom complained of feeling sad throughout the day, but that his family ties kept him invigorated- it provided him with a reason to live and to believe. Tom also maintained that it was acceptable to do whatever was necessary to provide for his family, even if it meant battling against the grain of the law.

The impact of Tom's psychological distress is his inability to think clearly about the consequences for his actions- and/or how his actions affect other people. Tom noted that he had a high tolerance for stress- but maintains that he occasionally resorts to using marijuana to alleviate tension, at least once or twice per week.

Clinical Interventions

Tom possessed the natural protectiveness of a concerned father for his children and family. Despite his numerous conflicts with the legal system, which displayed irresponsible behavior, Tom instinctively believed that had many admirable traits for a father. Tom needed to be cognizant of his actions upon others and the effects it has on his children. One of the goals that we explored as part of the clinical intervention was weighting the pros and cons of Tom's actions of trespassing. The intervention utilized elements from the Thinking for a Change component of the curriculum, namely to think through thoughts, emotions and consequences. For instance: if Tom broke the law to provide for his family would this be worth the price if he gets caught, ends up incarcerated, and will therefore be unable to spend time with his children.

Upon the first individual session Tom was in denial that his

actions were wrong and used his own code of morality to determine the greater good. This writer encouraged Tom to present his views exactly as they were such that we can arrive at his thoughts and feelings. As this writer and Tom met for further individual sessions, and after participating in the fatherhood group, Tom gradually came to understand the impact his actions has on others and how finding an honest job would be the best approach, especially for building his credit and providing him with medical benefits. Tom initially focused on the fast solution to his financial woes, which he further understood to be most dangerous and irresponsible. Further, we discussed and arrived at the conclusion that Tom's marijuana use could be a dangerous mix if a neighbor smelled the fumes and notified Children Protective Services. Tom initially insisted that he doesn't smoke around the children, but he later came around to understand that he should not smoke in the household. This writer was able to refer Tom to a substance abuse specialist who was able to help him overcome the temptations to use marijuana when he found himself in overwhelming situations. The treatment plan included extensive counseling for depression, and a referral for offsite additional counseling to help with substance abusing behaviors. Tom initially presented features of antisocial personality disorder, but after extensive individual counseling sessions and group sessions, this writer realized that Tom could benefit from CBT, which proved to be very helpful.

Family Psychiatric History

Tom reported that marijuana use was prominent in his family history. No prior family history of mental illness was reported.

Mental State Examination

Appearance, behavior, eye contact and rapport: Tom appeared

overly relaxed and depressed. Tom was dressed in a clean pair of jeans and a designer tee shirt.

Speech: Tom spoke at an average rate and soft volume.

Thought form: Tom's thought form was coherent.

Thought Content: The content of Tom's thought pattern, although coherent, did seem depressive.

Perception: Tom's perception was observed as normal: no evidence of delusions or hallucinations

Mood: Depressed and calm

Affect: Limited range of intensity and mobility

Insight: Tom had fair insight into his mental condition and frame of mind.

Diagnostic Formulation

1. DSM IV

311 Depression Disorder Not Otherwise Specified
305.20 Cannabis Abuse
GAF= 71

Explanation

Tom meets the DSM-IV criteria for Depressive Disorder Not Otherwise Specified, namely: (1) minor depressive disorder: episodes of at least 2 weeks of depressive symptoms but with fewer than the

five items required for Major Depressive Disorder, and (2) Recurrent brief depressive disorder: depressive episodes lasting from two days up to two weeks, occurring at least once a month for 12 months.

Tom also meets the DSM-IV criteria for Cannabis Abuse, specifically: (1) recurrent substance abuse resulting in failure to fulfill major role obligations at work, school, or home, and (2) continued substance abuse use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Analysis via Classical Schools of Psychotherapy [For Discussion]:

Jung: Tom has a strong conceptual schema of his animus that provides him with justification for irresponsible actions; he blends his understanding of manhood with his personal history/cultural heritage.

Adler: Tom can begin to heal his inferiority complex (which he hides by walking on tip-toes) through practical achievements and encouragement, developing the inner core belief that he has value and can contribute to the world through hard work.

Freud: Tom's history demonstrates that he is at war between his ID, EGO and Superego; his ID seems to win, which places him in dangerous circumstances.

Rogers: Tom needs to take ownership of his self-identity.

Erikson: Tom needs to rectify the early stages of his development: specifically the stage of industry vs. inferiority.

Frankl: Tom has many resilient capacities and a strong reason to live to which he has full awareness: his family. This should be the focal point of the fabric that provides him strength for his life journey.

Maslow: Tom is struggling on the hierarchical ladder of needs.

Sullivan: Tom's condition stemmed from the inability to come to terms with inherent contradictions in his upbringing (closeness) and in society (distance).

CASE STUDY #3 OF 5: SAM

Introductory Statement

The third case study illustrates the complexity of a diagnosis of Bipolar I Disorder with co-occurring Poly Substance Abuse. This case also demonstrates the added complexity of family dysfunction. This writer will focus primarily upon the family dysfunction aspect-as it applies to, and is affected by, the psychiatric and substance abuse disorder.

Demography

Sam is a 35-year-old Hispanic male who was recently released from incarceration and is currently living with his older sister in a four-bedroom apartment in the Bronx. Sam is separated from his spouse, Georgina, and has one eight-year-old son, Patrick, who is currently residing with Sam's cousin in Queens. Sam and his wife have been separated for over five years and they rarely communicate. Sam's cousin currently has custody of Patrick due to Sam's recent incarceration. Sam spoke to his son from prison on a weekly basis and looks forward to seeing him upon return from incarceration. Sam is close with his sister and extended family but is not on speaking terms with his mother or father. Sam is a Queens native since childhood and reported to have friends and relatives within the community. Sam was incarcerated for petit larceny of merchandise from a warehouse.

Sam's prior charges included sale of narcotics, cocaine.

Mode of Referral

Sam was referred to counseling groups from his parole officer. Sam complied with the stipulations of his mandates and will complete a substance abuse program in addition to the parenting program.

History of Presenting Compliant

Sam experiences mood disturbances and symptoms of trauma, which has been occurring for over 20 years thus far. Sam was diagnosed with a mood disorder when he was in his late teens. He reported to have used drugs (cocaine and alcohol) since he was 11 years old to cope with an unbearable family life. Sam mentioned during the fatherhood groups that he essentially had no active support from his parents growing up; reportedly, they would use drugs in his presence and would encourage active drug use. Sam mentioned that he would smoke marijuana with his father when he was a youngster. His parents showed no support or encouragement for his schooling. Sam maintained that he did well on his own for a while and was able to graduate high school. He mentioned to his counselor that he would be interested in enrolling in the fatherhood program to better understand how to be a nurturing father for his eight-year-old son, Patrick. Since his incarceration, Sam has been sober from cocaine, marijuana and alcohol use. Sam mentioned that he tried his best not to let his past influence how he raises his son; he maintained that he is cognizant of his past actions which stemmed from a highly dysfunctional family environment. He asserted that he needed to acquire wisdom on how to go about spending quality time with his child, how to better communicate with his child, how to communicate with the child's mother, how to properly discipline his child, and how to be an active part of his child's life. Further, Sam maintained to the

group that he thinks he knows what the right thing is to do- but sometimes he doesn't know how to go about doing it. Fortunately, Sam mentioned that his mood disorder is under control from the psychiatric medication, which he claims has helped him tremendously and changed his life despite some minor side effects. Sam would also like to use the fatherhood program to assist him in family court to help him get back full rights to his child after he finds gainful employment and is able to support himself. He also would like the social worker to assist him with securing housing and for providing further individual counseling support.

Clinical Interventions

Sam had many clinical needs and was a strong candidate for the fatherhood program. This writer drafted a Treatment Plan which was designed to assist Sam with seven major objectives: (1) ensuring that Sam continues to receive necessary medical and psychiatric services, (2) ensuring that Sam speaks to a substance abuse counselor for support, (3) providing Sam with individual counseling support which supplements the psychiatric services, (4) assisting Sam with parenting skills through group and individual counseling, (5) assisting Sam towards navigating family court, (6) assisting Sam towards finding gainful employment and (7) assisting Sam towards securing safe and affordable housing. Sam reported to currently taking lithium to manage his bipolar disorder, which allows him to function in the world. He has a strong relationship with his psychiatrist who has been a positive influence in Sam's life. This writer and the fatherhood staff provided additional individual counseling, which aimed to support Sam and help him make constructive decisions regarding his parenting choices. Further, individual counseling sessions were structured to foster within Sam a positive self-esteem and self-efficacy. Of great importance was the clinician's helping Sam understand his strengths, and to help him learn how to feel

comfortable walking in his own shoes. This required a revisiting of experiences that occurred in the past- through group counseling; Sam appreciated being able to speak about his life experiences with the support of the group. Sam arrived at the conclusion that he is in control of his life at this point with all of the additional support, psychiatric assistance, and structure. He is also scheduled for outpatient substance abuse treatment three evenings per week. Sam reported that his substance abuse counselors help him learn strategies to avoid triggers which help prevent future relapse. He attends NA and AA meetings regularly for additional support-which was also part of his treatment plan.

The most challenging goal from Sam's treatment plan was learning and implementing parenting skills, which he himself never received from his parents growing up. Sam mentioned that it was difficult for him to implement practices that he did not receive as a child. He reported that he never had any strong role models. As such, the use of interactive skits and dialogues were used in group sessions to explore how to handle situations that arise with the child: issues relating to his son's education, setting boundaries, clear communication, and communicating with the child's mother. Pertaining to the legal goals, Sam learned that the fatherhood program helps non-custodial fathers find resources for legal proceedings and he was very enthusiastic about utilizing the support staff. The support staff will help Sam navigate the family court system and understand how to present himself when in front of the magistrate, which include things to say and things to avoid saying. This writer will work closely with the job developer to help Sam find gainful employment within the next six months; Sam mentioned that he would like to go back to school to earn his CASAC and to become a Credentialed Alcohol and Substance Abuse Counselor. In the meanwhile, he mentioned that he would like to be a human services aid in a hospital or rehab clinic, either in the field of substance abuse or HIV services. The job developer will meet with Sam to discuss free

program opportunities funded by the state to help recently incarcerated individuals towards earning their education, free CASAC programs, as well as to help Sam secure either part time employment in the field of human services. The Human Resource Specialists at the court will assist Sam with finding affordable housing. Sam would like to find an affordable studio apartment that will be suitable for having visits with his son once he gets his life together.

Family Psychiatric History

Sam reported that his mother had Bipolar Disorder. Sam's father reportedly abused alcohol and also had prior substance abuse history. Further, Sam reported that he had a family history of alcoholism.

Mental State Examination

Appearance, Behavior, Eye Contact and Rapport: During the initial session Sam appeared mildly anxious though he had strong eye contact. Sam was dressed in a clean outfit- sweater and jeans with sneakers.

Speech: Sam spoke at a faster rate than average, high volume and anxious intonation.

Thought form: Sam's thought form was coherent.

Thought Content: Sam's thought content was ruminatory without paranoid ideations.

Perception: Sam's perception was observed as normal; no evidence of delusions or hallucinations.
Mood: Depressed elevated

Affect: High range of intensity and mobility

Insight: Sam had strong insight into his mental condition and frame of mind.

Diagnostic Formulation

1. DSM-IV

296.6x Bipolar 1 Disorder, Most Recent Episode Mixed
305. 60 Cocaine Abuse
305.00 Alcohol Abuse
305.20 Marijuana Abuse
GAF= 53

Explanation

Sam has been taking his medication and receives extensive counseling services, which has contributed to his stabilization. Sam meets the criteria for DSM-IV diagnosis of Bipolar I Disorder, Most Recent Episode Mixed, as displayed by the following symptoms: A. Currently (or most recently) in a Mixed Episode, B. There has previously been at least one Major Depressive Episode, Manic Episode or Mixed Episode, C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizopreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Further, Sam has been clean from substance abuse since his release from incarceration but still has urges to use. There is evidence of the following criteria for cocaine, alcohol and marijuana abuse- as established within the DSM-IV: (1) recurrent substance use relating in failure to fulfill major role obligations at work, school, or home, (2) recurrent substance-related legal problems and (3) continued

substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Analysis via Classical Schools of Psychotherapy

Jung: Sam draws from the dark well of his psychic energy and needs to learn how to balance the light with darkness; to see himself as a manifestation of both will lead to his healing and is part of his quest for the grail (in this case, the grail is synonymous with happiness as manifested by his willingness and desire to be a nurturing father).

Adler: Sam's marked poor self-image is indicative of his inferiority complex that stemmed from a dysfunctional childhood.

Freud: Sam's libido is in severe disturbance; his ID overwhelms his Ego and Superego.

Rogers: Sam has the capacity to change but needs to learn how to accept himself and others.

Erikson: Sam is stuck at age sixe, hence his narcissistic tendencies.

Frankl: Sam's bipolar disorder and incarceration experience can be a cross with much wisdom, especially considering the fact that Sam is attempting to reform himself and has a son in his life to look forward to watching him grow.

Maslow: Sam has a stall in the basic needs from the very bottom of the hierarchy.

Sullivan: Sam's dysfunctional family dynamic contributed to his inability to communicate effectively with others, and leads to his

anxiety about being a good-enough dad.

CASE STUDY #4 OF 5: KEN

Introductory Statement

This fourth case study illustrates a diagnosis of Social Anxiety with co/occurring Substance Abuse Disorder. This case also demonstrates the added complexity of family dysfunction. This writer will focus primarily upon the family dysfunction aspect as it applies to, and is affected by, the psychiatric and substance abuse disorder.

Demography

Ken is a 54-year-old Caucasian male who is currently unemployed and lives in transitional three-quarter housing for individuals who were released from incarceration and who are recovering from substance abuse. Ken is separated from his spouse and has one 12-year-old son, Mark. Ken and his spouse have been separated for four years. His son currently lives with his mother. Ken has limited contact with his spouse and speaks only about matters regarding the child. Ken has one brother with whom he is close, and who has helped him through difficult times. Ken is originally from Long Island and obtained his GED. He has limited history of gainful employment and is currently searching for work in the field of custodial maintenance.

Mode of Referral

Ken was referred to the fatherhood program through his substance abuse counselor who believed that he would benefit from the supportive parenting groups.

History of Presenting Compliant

Ken initially had numerous presenting needs that pertained to parenting, works and staying sober. He mentioned his largest need was learning how to be a dad again. Ken came to the parenting and job-training program ready to make a positive change. Ken had very little work experience and was hesitant to participate in the job-training program. In addition to having the desire to strengthen his parenting and job training skills, Ken needed additional support towards staying sober. Further, for many years he attempted to cope with managing extensive anxiety when in social situations. Ken complained that his chest would get tight; he would have shortness of breath and difficulty focusing on tasks. He mentioned that he first experienced anxiety when he was a young adult and did not feel confident about his ability to perform well in school or in social situations. Ken never sought medical or psychiatric assistance for his anxiety and learned how to manage his anxiety by avoiding stressful or difficult situations, which serve as triggers. He made poor decisions later in life, which led to his incarceration. Ken spoke to his social worker upon entrance into the program and mentioned that he has determined to change his life and learned a lot from his incarceration.

Clinical Intervention

The staff of the parenting and job training programs determined that they would be able to assist Ken by: (1) teaching him nurturing parenting skills, (2) helping him develop co-parenting skills with the child's mother, (3) building his confidence and skills towards finding and securing gainful employment, and (4) helping him remain sober and drug free, and (5) learning ways of better managing his anxiety. Ken was eager to learn nurturing parenting practices and participated during group discussions. The second week of the

program, upon exploration of "healing the child within," he admitted that it took him years to come to know his inner child and to heal himself; it took his incarceration and self-reflection to make this happen for him. Through the various group activities, Ken was able to further understand the causes of what stunted his emotional growth-and learned ways to "catch up" with him. He desired to enhance the communication with the child's mother, whom he claimed is a very difficult person who refuses to enter treatment for alcohol use. She is in denial. Through group and individual counseling, Ken learned ways of communicating with the child's mother. Specifically, he learned strategies of improving his assertiveness skills and understanding how to combat denial and resistance that was prominent with his child's mother. Although Ken was confused with computer exercises within the job-training program, he kept trying and improved his skills. Ken was referred to interview with a local warehouse and was offered the position of stock clerk. Ken is grateful for the job opportunity and is currently maintaining his sobriety.

Family Psychiatric History

Ken reported that his family had a history of depression and substance abuse. Ken's mother and father had a history of alcoholism and depression, and he had many cousins who had history of alcoholism.

Mental State Examination

Appearance, Behavior, Eye Contact and Rapport: During the session Ken appeared anxious though he did have good eye-contact. Ken was dressed in a dark sweatshirt, dark jeans and clean sneakers. He had an athletic build.

Speech: Ken spoke at a slower rate than average, average volume and

calm intonation.

Thought Form: Ken's thought form was coherent.

Thought Content: Ken thought content was logical and was not ruminatory in nature.

Perception: Ken's perception was observed as normal; no evidence of delusions or hallucinations.

Mood: Mildly anxious

Affect: Average [typical] range of intensity and mobility

Insight: Ken had excellent insight into his mental condition and frame of mind

Diagnostic Formulation

1. DSM-IV

303.90 Alcohol dependence
300.23 Social Phobia (Social Anxiety Disorder)
GAF= 68

Explanation

Ken meets the DSM-IV criteria for alcohol dependence, specifically: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time during a 12-month period: (1) tolerance, (2) withdrawal, the substance is often taken in larger amounts or over a longer period than was intended, and (4)

there is a persistent desire or unsuccessful efforts to cut down or control substance use.

Further, Ken meets the criteria for Social Phobia, as manifest by the following symptoms: (1) a marked and persistent fear of one or more social of performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way that will be humiliating or embarrassing, (2) exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally-bound or situationally-predisposed Panic Attack, and (3) the person recognizes that the fear is excessive or unreasonable.

Analysis via Classical Schools of Psychotherapy

Jung: Ken needs to be more cognizant of his warrior-self that is buried within layers of shadow; only then will be able to muster the courage to master social situations and conquer his anxiety.

Adler: Ken's extensive anxiety is indicative of his inferiority complex that stemmed from a dysfunctional childhood.

Freud: Ken is caught in the battle between his ID and Superego; he realizes what he needs to do in order to live a righteous life.

Rogers: Ken has the tremendous capacity for resiliency and needs to learn how to trust himself.

Erikson: Ken is stuck in the stage of industry vs. inferiority.

Frankl: Ken can learn from his crosses; he has tremendous capacity to be a loving father and has a beautiful son to live for.

Maslow: Ken has a stall in the basic needs from the very bottom of

the hierarchy.

Sullivan: Ken's dysfunctional family dynamic contributed to his anxieties and difficult interactions with others.

CASE STUDY #5 OF 5: MICHAEL

Introductory Statement

This fifth case study illustrates the complexity of Borderline Personality Disorder with co-occurring Alcohol Dependency. This case also demonstrates the added complexity of family dysfunction. This writer will focus primarily upon the family dysfunction aspect- as it applies to, and is affected by, the psychiatric and substance abuse disorder.

Demography

Michael is a twenty four year old African American male who was born in the Spanish Harlem section of Manhattan. He reported to have two siblings with whom he has a close relationship, namely Angela and Theresa. Angela, who is 18, currently works as a cashier in a supermarket. Theresa, who is 22, currently works for the MTA as a booth clerk. Michael's father, Hector, who is 58 years old, is currently retired and worked as a janitor. Hector left Michael when he was two years old, during the same time when his mother was arrested for drug possession. Michael's mother, Marleen, who is 56 years old, is also retired and worked as a house cleaner for most of her life. Michael was raised predominantly by his grandmother up until the age of eight, at which time his mother was released from prison and reunited with her family. Michael is currently single and has a young son, Christopher, age four, from a previous relationship.

Michael's grandmother is the sole guardian of Christopher, since Michael and his child's mother are currently unemployed, and both have an extensive history with drugs and alcohol.

Mode of Referral

Michael was referred to the program through his probation officer who believed that he would benefit from parenting and substance abuse counseling services.

History of Presenting Complaint

Michael had five presenting problems: (1) alcohol dependence, (2) a poor self-image, (3) his stormy relationships with others, (4) unemployment and (5) lack of nurturing parenting skills. First and foremost, Michael has been diagnosed to have alcohol dependence. Michael started to drink alcohol when he was thirteen years old. He attributes his alcohol habit to peer pressure and to his chaotic childhood. Michael has recently been tested positive by his probation officer, which is why he was referred for treatment. The second issue is Michael's poor self-image due to his criminal background. Michael has been arrested four times and is currently serving a six-year probation sentence due to a drug charge. Michael perceives others as viewing him as a villain due to his criminal history. During counseling sessions Michael speaks about how people discriminated against him as a "druggie". The third problem is Michael's stormy relationships with others. Michael has difficulty forming close relationships with other people and has a fear that new people in his life will abandon him. As a result of this fear, he presents a callous exterior to those who try to help him and to everyone that he meets. Michael mentioned that he can't stand people because he always had it difficult in life and he feels like he compares himself to others all of the time. The fourth presenting problem for

Michael is unemployment; he has been unemployed for the past year. The fifth presenting issue for Michael was his desire to learn nurturing parenting skills to be present for Christopher. He mentioned that he didn't have a strong father figure in his life and would like to change history; when it comes to Christopher, he desperately wants to be a good dad to his son, but understands that he first needs to get his life in order before he can be fully present to Christopher.

Clinical Interventions

Michael's five major presenting issues were charted for remedy in the treatment plan. First, regarding alcohol dependence, Michael was assigned to meet with a substance abuse counselor four times per week for both group and individual counseling. The substance abuse classes were scheduled during the evening hours so that he can partake in additional counseling support and job training. Second, regarding Michael's self-image, this writer worked with Michael on methods to strengthen his self-esteem. Specifically, Michael learned strategies toward bolstering his self-image such as: (1) guided imagery, (2) mantras, (3) practicing assertiveness techniques, (4) identifying his strengths. Third, regarding his stormy relationship with others, Michael learned strategies towards becoming open minded, aware, and accepting of others. Strategies used in DBT were utilized such as non-judgmental thinking, and radical acceptance of the strengths and flaws of others. Michael learned how to add color to the scope of human interactions which for him was basically black and white. Michael was referred to the job-training program for assistance with employment. The job-training program was able to assist Michael in the field of custodial maintenance. Lastly, but most importantly, Michael learned nurturing parenting skills when communicating and spending quality time with Christopher. Michael had limited insight as to the meaning and scope of quality time. Like

many dads who had dysfunctional family backgrounds, Michael equated buying gifts for his child to quality time, (i.e., spoiling his child as spending quality time with him). Michael learned many constructive and healthy ways of spending quality time with the child such as engaging in conversation, playing with toys and games together, teaching the child new skills, eating meals with the child, holding the child, and letting him know how much his father loves him. Most importantly, Michael learned more effective ways of communicating with his child as well as with the child's mother.

Family Psychiatric History

Michael reported that his mother and father had a history of mental illness, including depression and anxiety. Further, Michael disclosed that alcohol abuse also was prominent in his family.

Mental State Examination

Appearance, Behavior, Eye Contact and Rapport: Michael appeared anxious, depressed and avoided eye contact. Michael was dressed appropriately in a turtleneck shirt, jeans and clean sneakers.

Speech: Michael spoke at a faster rate than average; high volume and anxious intonation.

Thought Form: Michael's thought form was coherent despite at times seemingly suspicious content.

Thought Content: Michael's thoughts contained paranoid ideations and ruminatory in nature.

Perception: Michael's perception was observed as normal; no evidence of delusions or hallucinations.

Mood: Depressed elevated, angry fearful

Affect: High range of intensity and mobility

Insight: Michael had poor insight into his mental condition and frame of mind

Diagnostic Formulation

1. DSM-IV

301.83 Borderline Personality Disorder
303.90 Alcohol Dependence
GAF=48

Explanation

Michael meets the criteria for a DSM-IV diagnosis of Borderline Personality Disorder, as evidenced by the following symptoms: (1) frantic efforts to avoid real or imagined abandonment, (2) a pattern of unstable and intense interpersonal relationships characterized by alternate extremes of idealization and devaluation, (3) identity disturbance: markedly and persistently unstable self-image or sense of self, (4) impulsivity in at least two areas that are potentially self-damaging and (5) chronic feelings of emptiness, (6) inappropriate, intense anger or difficulty controlling anger and (7) transient, stress-related paranoid ideation or severe dissociative symptoms.

Further, Michael meets the criteria for a DSM-IV diagnosis of Alcohol Dependence: (1) tolerance, (2) withdrawal, (3) the substance is often taken in larger amounts or over a longer period than was intended, (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use, (5) a great deal of time is spent in activities necessary to obtain the substance, use the substance of

recover from its effects.

Analysis via Classical Schools of Psychotherapy

Jung: Michael over-identifies with his shadow which he has not yet learned how to master.

Adler: Michael's marked poor self-image is indicative of his inferiority complex that stemmed from a dysfunctional childhood.

Freud: Michael's libido is in severe disturbance; his ID overwhelms his Ego and Superego.

Rogers: Michael has the capacity to change but needs to learn how to accept himself and others.

Erikson: Michael is stuck at age three, hence his borderline condition.

Frankl: Michael can learn from his crosses; he has tremendous capacity to be a loving father and has a beautiful child to live for who provides meaning in his life.

Maslow: Michael has numerous barriers that impede his ability to meet basic human needs.

Sullivan: Michael's dysfunctional family dynamic contributed to his inability to communicate effectively with his son as well as other social dysfunctions that he experienced as an adult. In this regard, Michael is essentially an adult-child.

Historical Unfolding of Psychotherapy: From Freud, to Adler, to Frankl

Ann V. Graber

Synopsis of Social-Political Milieu of Vienna, the Birthplace of Psychotherapy

It is well to consider the ethos or the inherent characteristics of a society, and the prevailing spirit of the times, when looking for the dynamic that produced a better understanding of human nature. Although it could have happened anywhere, history records that psychotherapy arose in Vienna and that it began in the days of Sigmund Freud. A closer look at the historical background and the social environment where the science of the human psyche arose may give us better insight why it happened as it did.

In the latter part of the nineteenth century and the first decade of the twentieth, Vienna was the old Imperial city. It was the capital of the Austro-Hungarian Empire, seat of the Emperors of the House of Habsburg, who had ruled since establishing their reign in Austria in 1278. Vienna was the cultural Mecca to the people living in the far-flung provinces that comprised the empire. During the late 1800's Vienna was the second largest city on the European continent. With a population of two million people, it was second only to Paris. Vienna was a German speaking political stronghold, a major economic center and citadel of learning that attracted many notables in the fields of music, art, literature, as well as the sciences. It also attracted thousands of immigrants from the many provinces and beyond – Freud's family among them. As the capital city of an empire of 60 million people, it was the administrative hub, the center of learning

where the arts flourished side by side with the sciences (Gould, 1993, 1-2).

The greatest flowering of Austrian culture coincided with its political decline. The reigning monarch at the time was Kaiser Franz Josef (Emperor Francis Joseph) who had ascended to the throne in 1847. Even though political unrest had been seething beneath the surface for some time, the end of Austria's political power and influence came fairly suddenly. A shot fired in Sarajevo, in 1914, killing Archduke Franz Ferdinand, heir to the throne, plunged Austria and the world into the First World War. The old emperor died in 1916, while the country was at war. The political decline reached its nadir in 1918. A defeated Austria signed an armistice with the Allies stripping it of much of its former holdings, and reducing Austria to one tenth of its former size. Shortly thereafter, the monarchy was overthrown and Austria became a republic. With World War One (WW-I) ended not only the monarchy, but also a life-style that had been conducive to cultural pursuits.

The armistice of 1918 brought harsh deprivations to the Austrian people, particularly to those living in the largest city of the former empire, Vienna. Austria had severe economic and political problems following WW-I. The economic problems were exacerbated by the world wide depression of the late 1920's and the 1930's. Austria's political problems centered on conflicts raging between two political parties, each one with its own army. The central political issue was whether to keep Austria independent or to unite Austria with Germany. This internal conflict raged until 1938 when German troops seized Austria and Hitler announced the *Anschluss* (annexation) of Austria and Germany. Austria's fate thus became tied to that of Nazi Germany, whose quest for power led to WW-II in 1939. The Allies, comprised of the United States, the United Kingdom, France, and the Soviet Union, finally defeated Germany and Austria in 1945.

After the war, a coalition government helped stabilize an Austria that was divided into American, British, French, and Russian zones of

occupation. In 1955, the Allies ended their occupation of the country. To obtain its independence, Austria agreed to be permanently *neutral* – that is, completely uninvolved in international military affairs. As a neutral nation, Austria became an important channel for the exchange of ideas between the non-Communist countries of Western Europe and the Communist countries of Eastern Europe. Vienna gradually resumed a position in the international community by becoming the home of a number of UN agencies (McGrath, "Austria," 2001).

With the restoration of its war-damaged cultural edifices and the rebuilding of its transportation systems Austria became again a favored attraction. Even though its political influence is now insignificant compared to its former days, the cultural influence it still exerts is considerable. For example, the re-opening of the bomb-damaged Vienna Opera House, in 1955, was a world-gala event; the Salzburg music festivals have upheld the banner of excellence for classical music and draw audiences from around the word; Austrian skiers have played a large part in developing and popularizing Alpine skiing worldwide; and, if you have not indulged in Viennese pastries yet, you are missing masterworks of the culinary arts.

Parallels Between the Tides of History and Waves of Psychological Theories

It is said that the times produce the man. One might also wonder if a place is propitious to the birth of new ideas and ideals. However the case may be, Vienna was the place that saw the birth of psychoanalysis and the subsequent development of three Viennese schools of psychotherapy. The theories of each of these three schools, and the problems they addressed, parallel the country's history and reflect the mood and the experience of its people, particularly of their capital city, Vienna.

A Viennese, Stephen Kalmar, gives us an on-site observer's view of the changing political and cultural currents of Vienna during

those times. Growing up during the Austro-Hungarian Monarchy, Kalmar knew the Imperial Vienna – the city of Freud. He also witnessed the tumultuous years subsequent to the fall of the Habsburg Empire, the struggle for freedom and the search for identity – the city of Adler. He furthermore experienced Vienna when the search for meaning in the midst of chaos was paramount – the city of Frankl (1982, xv-xxiv). The history of a new school of thought is, in its first phase, largely the history of its founder. A closer look at the historical and cultural milieu of the founders of the three Viennese schools of psychotherapy and their correspondent ideologies will bear this out.

Sigmund Freud (1856-1939)

Born around the middle of the nineteenth century, Sigmund Freud was a child of the monarchy. He lived and worked in a tradition-bound, paternalistic, authoritative, autocratic, hierarchically structured society. That was true of the home, where father ruled as head of the house; in school, where teachers laid down the law and meted out punishment; the state, where the Kaiser ruled supreme over his subjects; and church, where God ruled over his universe and had to be obeyed. Freedom of expression was not tolerated. Therefore, all that remained unexpressed went into hiding in the subconscious and festered as repression. Life appeared orderly on the surface, yet there was subconscious ferment and rebellion brewing. Repression of authentic feelings often presented as somatized symptoms and hysteria, which was socially more acceptable than disagreement with the status quo of the society. By and large, this was the condition of the patients Dr. Freud would have encountered: human beings living with external and internal repression. Dealing with this phenomenon led Freud to uncover the subconscious, explore its content of drives and instincts and their reaction formations, and helped him to formulate his theory of *Psychoanalysis* – giving birth to the first Viennese school of psychotherapy.

Alfred Adler (1870-1937)

Alfred Adler, who came to professional prominence almost a generation later, faced a different set of circumstances. Those first few years after the end of WW-I were years of great soul-searching in Austria, both individually and collectively as a nation. The Habsburg Empire, having played an important role in Europe for many centuries, had collapsed, creating an "existential vacuum," which the new Austrian republic was attempting to fill. An empire of sixty million people had been dismembered and reduced to a small nation of six million. Vienna's magnificent educational, cultural, and economic institutions – the universities, academies, theaters, operas and concert halls, the publishing houses, banks and insurance companies, administrative and industrial complexes – were to serve one-tenth of the population they had served before. Out of the six million Austrians, two million still lived in Vienna as before – a swollen head for that small body. Every Austrian had to confront the task of readjusting his or her life to the new situation. What did life mean for the large number of aristocrats now that the emperor's court was gone? What did life mean for the equally large number of well-educated professors, state officials, writers, musicians, and other artists? Kalmar describes his countrymen as follows:

> The majority of Austrians were strongly conservative, religious, mostly Catholic, looking for ways to preserve their old values, their traditions. In opposition to these conservative Austrians who formed the government were the Social Democrats, concentrated in Vienna, who saw it as their task to form a liberal, socialistic, and anti-traditional society, with equal rights for all leading to freedom of opinion, freedom from dogmas, freedom for academic research. This, to the Social Democrats,

> was to be the new meaning of life in the new Austria (1982, xvi-xviii).

As we can see from the above depiction this was a society in transition with values in collision. The very foundation of the established order had been profoundly shaken, if not demolished, on every front. What had been solid and dependably there, was suddenly gone. A new order was in the making but did not have solidity yet. Adler understood the needs of his patients and compatriots during these times of uncertainty and soul-searching, and broke away from Freud's reductionistic, cause and effect interpretation of the human person with its focus on sexual repression.

Alfred Adler had been one of Freud's most important disciples. Freud had even considered him the "heir apparent" of the psychoanalytic movement. But Adler later rebelled against Freud's theory of total biological and environmental determination. Having done some medical research independently he did not concur with some assumptions postulated by Freud. Adler was looking for an expanded psychological framework which would allow more freedom to forge individual identity. Feeling disempowered, individually and collectively, his contemporaries were in search of an identity and empowerment. Adlerian concepts suited the conditions and aspirations prevailing in the Vienna of the 1920's and 1930's very well. Adler went on to establish his *Individual Psychology* – giving rise to the second Viennese school of psychotherapy.

Viktor Frankl (1905-1997)

Meanwhile, a boy was growing up in Vienna, a precocious child. Born during the monarchy, Viktor Emil Frankl was nine years old when WW-I broke out. He saw much hardship during the four years of the war and witnessed the turmoil and chaos attendant to the post-WW-I era in his native city. In later years he would recall the

privations they suffered. He remembered having been sent to visit with relatives during summers in Moravia in order to have something to eat. These experiences made an indelible impression on the sensitive boy – he gained an empathy for the suffering (Gould, 1993, 2-3).

In 1920, when Viktor Frankl was 15 years old, the 64-year-old Sigmund Freud dominated the psychological scene internationally. Meanwhile, young Viktor, not being an athletic youngster, spent his time reading and attending lectures in many subjects that interested him: natural sciences, philosophy, and especially psychology. In his teens, we find an amazingly "old beyond his years" young man. Before graduating from high school Viktor Frankl had followed Freud's theories; he had even corresponded with the great Dr. Freud, who promptly answered the boy's letters. But new concepts were formulating in young Viktor's fertile mind. His idea, which grew into a conviction, that individuals had to find their own meaning in life, differed sharply from Freud's pandeterministic views, the view that we are totally determined by heredity and environment.

When Frankl entered the University of Vienna to start his medical studies, he first considered becoming a dermatologist or a gynecologist, but later decided to become a psychiatrist. Already in his first year at the university Frankl, who had become a Social Democrat (like Adler), became president of the Social Democratic student movement. Frankl was attracted to Adler and his Association for Individual Psychology, and became one of its youngest members. A few years after joining the Association of Individual Psychology, Frankl had become well known and well liked in that group. He was invited to read papers at meetings; even at the 1926 International Congress for Individual Psychology in Düsseldorf, Germany, when only twenty-one years of age. In this paper, and more so later on, Frankl developed ideas that were to some extent outside the traditional framework of Adlerian thinking.

Soon after, Frankl encountered the works of the philosopher and phenomenologist Max Scheler, which had a profound influence on the development of his logotherapy (Kalmar, 1982, p. xix). Viktor Frankl continued reading, studying, and developing his philosophy.

While preparing for his life work in psychiatry, ominous clouds were gathering on the horizon. Soon the world would be gripped in the Great Depression and its aftermath. Following the collapse of the stock market in 1929, inflation was rampant, unemployment rose sharply, and the suicide rate soared. Especially the young seemed hopeless and despairing, questioning the meaning of their existence. Frankl rose to the challenge of working with these distraught youths psychotherapeutically.

In 1930, Frankl began to set up youth counseling centers in Austrian cities, primarily for students and the unemployed. He lectured extensively for organizations of the socialist youth movement in Austria, and as far as Berlin, Prague, and Budapest. His theme revolved increasingly around the meaning of life. By 1933, he had systematized his ideas and talked about *logotherapy* – treatment through finding "meaning." He taught that we can "wrest meaning from life by turning suffering into a human triumph" (Frankl, 1997, p. 64). By this time he no longer belonged to the Adlerian Society. Once the "favorite son" of that circle, he was asked to leave when his ideas deviated from Adler's. Just as Adler had left Freud's *Psychoanalysis* to found his own school of thought, Frankl in turn left Adler's *Association of Individual Psychology* to found the third Viennese school of psychotherapy – *Existential Analysis* and *Logotherapy*.

Development of Psychotherapy into a Distinct Medical Specialty

For thousands of years humankind has been aware of different ontological dimensions: the visible, tangible, material form – called body; and the invisible, intangible, non-material aspect of being – variously referred to as the mind or psyche. Historically philosophy

had grappled with the mind/body concept and religion had tried to explain it. At the beginning of the 20th century yet another attempt was made to understand this non-somatic dimension of our being, the psyche. Leading the exploration on the frontiers of mind was an Austrian physician, Sigmund Freud (1856-1939).

Medicine at that time had a mechanistic Newtonian/Cartesian approach to healing. The human body was treated as a complex biochemical machine. Little attention was paid to what *animated* this "machine." The patient was viewed as an object in need of repair. Sigmund Freud was the first modern day physician who looked beyond the physical organism to a dimension that was non-material: the conscious, subconscious and unconscious mind or psyche. Freud discovered an important connection between health and well-being and the dynamics operative in the psyche. He discovered that certain physical sicknesses can originate in the psychological dimension, especially when the will to pleasure – particularly sexual pleasure – is repressed into the unconscious where it can cause neuroses, hysteria, and physical illnesses. This gave rise to Freud's theory of the "pleasure principle" or *drive to pleasure.* In fact, in Freud's time sex was repressed, even on a mass level. This was a consequence of puritanism, and this puritanism was predominant in Anglo-Saxon countries. Small wonder that it was these countries that proved to be most receptive to Freud's psychoanalysis – and resistant to those schools of psychotherapy that went beyond Freud (Frankl, 1988, p.12).

Freud showed the crucial importance of unconscious thinking to all human cognition and activity. His work on the origin and treatment of mental illness helped form the basis of modern psychiatry. Freud greatly influenced the field of abnormal psychology and the study of the personality. His theories on sexual development led to open discussion and treatment of sexual matters and problems. Freud's emphasis on the importance of childhood helped teach the value of giving children an emotionally nourishing

environment. His insights also influenced the fields of anthropology and sociology. Most social scientists accept his concept that an adult's social relationships are patterned after early family relationships (Decker, "Freud," 2001).

It is important to consider that Freud found himself constrained by the very nature of his work, and that his subsequent conclusions were drawn from observations of his patients. The healthy and well-adjusted did not need to seek the services of a psychiatrist. Therefore, the earliest theories of personality development were based on observations of abnormal development and abnormal functioning. Surprisingly, a century later they still prevail. Particularly in North America, the psychoanalytic and psychodynamic orientation is still a dominant influence.

Since Freud was a man with enormous influence in the medical world of his time, his theories and his psychoanalytic approach to mental health spread quickly, becoming the foundation for the new science that probed the depth of the human psyche and changed the way we perceive ourselves. In an interesting text on the thinking of Western culture, titled *From Freud to Frankl,* John H. Morgan states:

> The impact that Freud's thought has had upon Western culture in the last 75 years is profound. Since the Publication of his *Die Traumdeutung,* 1900 (*The Interpretation of Dreams*), Freud's thought has gained such widespread usage that it would be difficult to imagine a modern world devoid of his contributions to the understanding of the individual in society. If his studies of the human psyche have revolutionized man's thoughts about and attitudes toward the unconscious, his writings on religion, society, and culture have shaken older images of human experiences and ushered in a new

> era of religious and social theorizing (Morgan, 1987, p. 2).

Viktor Frankl also pays the highest tribute to his mentor Sigmund Freud. He alludes to Freud's place in history through a story that is told at the oldest synagogue of the world, Prague's medieval Alt Neu Synagogue. When the guide there shows the interior, he tells visitors that the seat once occupied by the famous Rabbi Loew has never been taken over by any of his followers; another seat has been set up for them because Rabbi Loew could never be replaced, no one could match him. For centuries no one was allowed to sit down on his seat. Frankl declares, "The chair of Freud should also be kept empty" (Frank, 1988, p. 12).

Beyond Freud, further insight into the human psyche was gained by Alfred Adler and Carl Jung in the early decades of the 20th century. Freud, Adler and Jung are considered to be the three founding figures of *depth psychology*, which emphasizes the unconscious and psychodynamics. (Since this discussion centers on the Viennese schools of psychotherapy, Jung, in his native Switzerland, will not be considered here further.)

Instead, we will turn our attention to Alfred Adler, who was the first major figure to break away from psychoanalysis to form an independent school of psychotherapy and personality theory. Following his ideological split with Freud, Adler would come to have an enormous, independent effect on the disciplines of counseling and psychotherapy as they developed in the course of the 20th century. Adler was one of the most brilliant psychiatrists and psychotherapists whose influence is still far-reaching. In Europe, Adlerian psychology became the most widely followed. Adler moved to New York City in 1934 and his influence spread in the New World as well. Historian Hannah S. Decker, in an online article on Adler, states:

> Adler, Alfred (1870-1937), Austrian psychiatrist, developed important theories concerning the motivation of human behavior. According to Adler, the major force of all human activity is a striving from a feeling of inferiority toward perfection. Adler at first referred to this force as an *aggressive drive.* He later called the force a *striving for superiority.* Adler termed his school of thought *individual psychology.* Today, it is often referred to as *Adlerian psychology* (Decker, "Adler," 2001).

The young science of psychotherapy was evolving and was being developed into a distinct medical specialty, psychiatry. Since the fathers of psychotherapy, notably Freud and Adler, were medically trained men, they brought the same prevailing mechanistic orientation to the exploration of the human psyche and to the development of psychiatry and psychotherapy. Thanks to Freud, a psychological dimension was recognized to exist beyond the physical. This added a new dimension to the treatment of a patient; however, at the same time the human spirit was ignored or forgotten by this new medical specialty. This was the state of the art when Frankl arrived on the scene.

The foregoing is, of course, a vast oversimplification of Freud and Adler's contributions to psychotherapy. It is intended only to delineate the historical development that led from Freud to Adler to Frankl.

Emergence of Viennese Schools of Psychotherapy

With all due respect to the luminaries of history, we must see them in the light of their times, within their historical context. So it is with the founders of schools of psychotherapy. As we have seen, Freud stepped upon the stage of history in a time very different from Adler's,

who was his junior by 24 years; and, distinctly different from Frankl's time, born 35 years after Adler.

Sigmund Freud, M.D.: Psychoanalysis

Freud had the luxury of making his painstaking observations and establishing his career during the relatively stable times before WW-I. In times of little change, tradition is a reliable guide and values are held in common by society. Freud's early major works, *Die Traumdeutung* (*The Interpretation of Dreams,* 1900) and *Totem and Taboo* (1912), were written before the turmoil that was to come engulfed his part of the world. He dealt largely with the attitudes and values prevalent in the Victorian era because his patients were steeped in those attitudes. Viktor Frankl in his book, *The Unconscious God,* quotes the Viennese poet, Arthur Schnitzler, as saying that there are only three virtues: "objectivity, courage, and a sense of responsibility." Frankl muses that it would be tempting to allot to each of these three virtues one of the schools of psychotherapy that have emerged from the Viennese soil. The virtue that fits Freudian psychoanalysis is objectivity. Frankl goes on to elucidate with poetic fervor:

> What else could it have been that enabled Sigmund Freud, like Oedipus, to look into the eyes of the Sphinx – the human psyche – and to draw out its riddle at the risk of a most dreadful discovery? In his time such an undertaking was colossal, and so was his accomplishment. Up to then psychology, particularly so-called academic psychology, had shunned everything that Freud then made the focus of his teaching. As the anatomist Julius Tandler jokingly called the 'somatology' which was taught in Vienna's junior high schools 'anatomy with the

> exclusion of the genital,' likewise Freud could have said that academic psychology was psychology with the exclusion of the libidinal. (Frankl, 1985, UG, p. 19).

Frankl continues by pointing out that Freud's psychoanalysis not only adopted objectivity – it succumbed to it. Objectivity eventually led to objectivation and reification. He asks, "How it is that psychoanalysis arrived at this technically minded, mechanistic view?" He continues, "This is understandable, considering the intellectual climate in which psychoanalysis emerged, but it must also be understood in the context of the social milieu of the time – a milieu full of prudery. It was a response – a reaction, to be sure, which is 'reactionary,' in that today it is out of date in many respects. But Freud not only reacted to his time, he also acted out of his time" (Frankl, 1985, UG, 19-20).

It is, therefore, not surprising that Freud reached the conclusions he did regarding the *will to pleasure* as a motivation for living upon which the first Viennese school of psychotherapy was founded. Only Freud's later mature works, *Beyond the Pleasure Principle* (1920), *The Future of an Illusion* (1927), and *Civilization and its Discontents* (1930) entertain the wider spectrum of influences beyond the repression of sexuality and its attendant pathology.

Freud's professional lineage was continued through the influence he had on his colleagues, even though some of them later went on to found their own systems of psychotherapy.

Alfred Adler, M.D.: Individual Psychology

Adler's lifetime and work in psychotherapy overlapped that of Freud. It also made a profound impact on Frankl and many others. Coming back to Schnitzler's list of virtues, Frankl attributes the virtue of "courage" to Adler, stating:

> It is obvious that the virtue of courage fits Adlerian psychology. The Adlerian, after all, regards his entire therapeutic procedure, in the final analysis, as nothing but an attempt at encouraging the patient. The purpose of this encouragement is to help the patient overcome his inferiority feelings, which Adlerian psychology considers to be a decisive pathogenic factor (Frankl, 1985, UG, p. 23).

It is noteworthy to point out that the Viennese schools of psychotherapy are extensions of each other, each an outgrowth of the preceding system. One builds upon the other. There is continuity, but the focus shifts. This is particularly noticeable when we look at the Freudian and Adlerian systems. The premise that the human being is psychodynamically driven remains the same, only for one it is the *drive to pleasure,* and for the other it is the *drive to power* that provides the motivation. In view of their Zeitgeist or time gestalt, this is not surprising. Where Freud encountered patients with Victorian attitudes of prudery and tradition-bound values, Adler primarily dealt with patients who had experienced the loss of traditional values and lifestyles. Following the collapse of the monarchy and being the vanquished of WW-I they felt disempowered and insecure; they were searching for an identity, individually and collectively. They had witnessed a rapid break-down of everything they thought was stable and secure. Their anxieties and fears wore a different mask than their Victorian progenitors had worn. The focus of their search was different from the previous generations. Adler was able to respond to their needs through his *Individual Psychology*.

Viktor Frankl, M.D., Ph.D.: Existential Analysis* and *Logotherapy

Since early childhood Viktor Frankl sensed a depth to life, and

pondered its meaning. He was an intellectually precocious child. As we learned previously, even before finishing high school, he had begun a scientific correspondence with Sigmund Freud, father of *Psychoanalysis*. Later, as a medical student, Frankl became a member of the inner circle of Alfred Adler, the founder of *Individual Psychology*. While Frankl credited Freud with finding new insights into human nature, and Adler with enriching the field, he felt that neither Freud's concept of the human person being motivated by a *drive for pleasure*, nor Adler's theory that we are motivated by a *drive for power*, adequately addressed the totality of being human (Fabry, 1987, 7-8).

Appreciating what his great teachers had taught him, he was later fond of saying, "Even a dwarf standing on the shoulders of a giant, can see farther than the giant himself." This was the background, the milieu from which Frankl stepped forth to formulate his own psychotherapy, *Existential Analysis* and *Logotherapy*, which is characterized by a *will to meaning.*

The young Viktor Frankl in his early years as a medical student at the University of Vienna felt very drawn to Adlerian psychology, studied under Adler, was even considered his star pupil. His article, *Psychotherapy and the World View*, published in Adler's Journal of Individual Psychology, in 1925, when Frankl was only twenty years old, already had a theme that would run through all of his work. "...[I]t concerns *the border area that lies between psychotherapy and philosophy, with special attention to the problems of meanings and values in psychology"* (Frankl, 1997, 59-60).

Frankl continued to develop his ideas and came into conflict with Adler. At a session of the Society for Individual Psychology Adler was openly challenged. Adler turned to Frankl and asked him to publicly express his views on the challenge that Adler had received. Frankl tried to present a compromise position that would allow for individual differences and to maintain a dialogue between Adler and his critics. However, Adler would have none of it and shortly thereafter Frankl

was expelled from the society at Adler's insistence (Frankl, 1997, p. 63-64).

Another Viennese compatriot, Joseph Fabry, relates how the young medical student became increasingly dissatisfied with the narrowness of the psychiatric orientation around him. He observed how Freud's ideas, like so many great ideas, had begun to harden into rigid concepts. In Frankl's opinion, what was needed was to understand the human being in his or her totality. "At that point," he recalled later, "I suspended what I had learned from my great teachers and began listening to what my patients were telling me – trying to learn from them." (Fabry, 1987, p. 8). Frankl found many opportunities to listen to patients. After receiving his M.D. degree in 1930, he worked at the neuropsychiatric clinic of the University of Vienna. In addition to his work at the university, Frankl founded "Youth in Distress" counseling centers. Here the fundamental formulations of Existential Analysis and Logotherapy (to distinguish it from Freud's Psychoanalysis) took shape: that all reality has meaning *(logos)* and that life never ceases to have meaning for anyone; that meaning is very specific and changes from person to person and for each person from moment to moment; that each person is unique and each life contains a series of unique demands that have to be discovered and responded to; that the response to these life demands provides meaning; that happiness, contentment, peace of mind, and self-actualization are mere side products in the search for meaning; and, that *the will to meaning* provides motivation for living (Fabry, 1987, 8-9).

The poet Schnitzler's third virtue, "a sense of responsibility," could be assigned to the third Viennese school of psychotherapy, Viktor Frankl's Existential Analysis and Logotherapy. Its very orientation and motivation, *the will to meaning,* is based on a sense of responsibility. Frankl himself thought so when he wrote:

> Just as we could apply the virtue of objectivity to psychoanalysis and that of courage to Adlerian psychology, so it is apt to apply to existential analysis [and logotherapy] the virtue of responsibility. In fact, existential analysis interprets human existence, and indeed being human, ultimately in terms of being responsible. (Frankl, 1985, p. 23).

To bring a person to an awareness of his responsibility is the very essence of Franklian theory. Through his Existential Analysis and Logotherapy it is not drives and instincts that come to conscious awareness, but the human spirit with its *will to meaning*, which seeks to live responsibly (Frankl, 1985, UG p. 23). Therefore, it has been termed *height psychology.* Existential Analysis is concerned with the present, the "here and now" of existence. From the vantage point of the present it seeks to orient the patient or client to the future where meaning possibilities are waiting to be realized. Logotherapy, as a treatment modality, provides the psychotherapeutic tools that help a person live his awareness of responsibility in meaning-centered ways.

Summary

The brief historical overview attempted to demonstrate the unfolding or evolutionary progression of the emerging field of psychotherapy at the time of its inception. It sketched the society and culture of its birthplace, Vienna, Austria, in its Zeitgeist around 1900, into the 1940's, and beyond. It paralleled historical currents with corresponding psychotherapeutic theories. In broad strokes, it has delineated the progressive development of the Viennese schools of psychotherapy: From Freud's, *Psychoanalysis,* Adler's *Individual Psychology,* to Frankl's *Existential Analysis* and *Logotherapy* – from "the drive to pleasure" and "the drive to power" to "the will to

meaning", respectively; from depth psychology to height psychology; from being psychodynamically driven to being pulled by spirit into heightened awareness of meaning and purpose.

This paper hopes to illustrate the interconnectedness of people and events in which they find themselves immersed. Being receptive to their visionary insights and perceptions, and harnessing the creative ferment -- found even in the worst of times and circumstances -- the founders of the three Viennese schools of psychotherapy brought about a better understanding of our humanness: Beginning with mere body orientation in medicine, to body-mind connection, and culminating in a three dimensional ontology of body-mind-spirit interconnectedness as being fully human. May we, the beneficiaries of their efforts, appreciate what we have received as our professional inheritance and practice it to the best of our ability.

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This essay is dedicated in loving memory to my esteemed Professor, Ordinarius, and friend, Dr. Ewert H. Cousins, Dean of the Graduate Theological Foundation, Fellow and Teilhard de Chardin Professor

of Theology and Spirituality. Dr. Cousins encouraged me to incorporate my familiarity with Austria's rich cultural heritage into my presentations. Heeding his counsel, this composition honors his generosity of spirit, so freely extended to his students, friends, and colleagues.

An American Muslim Approach to Islamic Compassionate Care and Counseling

Muhammad Hatim

Introduction

"Islamic Compassionate Care and Counseling (ICCC)" is a phrase often used to discuss a subject that in the Christian and Jewish Religious Communities is normally referred to as "Pastoral Counseling" The phrase is more user friendly among Muslim leaders than "Pastoral Counseling." The phrase ICCC works, in part, because the Glorious Qur'an in several places refers to Allah (*swt*)(1) as The Compassionate, Most Merciful.(2)

In an American Muslim setting, I define ICCC as concepts, levels of effort, and methodologies employed by Imams and Muslim caregivers to provide specific services to the American Ummah (Community). For the purpose of this discussion, I separate the functions of Imams, and Muslim caregivers. *Muslim caregivers* herein applies to men and women trained as professionals, or well-meaning individuals who offer some level of sustained mental/holistic health, and/or social services to individual mosques (masaajid), or to the America society in general. The person may be Muslim or non-Muslim. My focus is on the Muslim as a caregiver to his/her Community.

Most often, Caregivers are men and women who, among other activities, operate support groups, work with Muslim youth, visit the sick and shut-in, work with the prison population, or with Millati Islami (Muslim addiction recovery program). The purpose of this brief work is to explore several notions, strategies, and tools that can

add to continuing the much needed discussion on better professional training for Imams and Muslim caregivers.

In reality, ICCC looks as different and distinct as the many Communities that constitute the American Muslim Ummah. Therefore, one strategy will not fit all. Accordingly, any observations I make can only reflect my limited experience in the New York City Metropolitan Area. Any errors I make are my own. Any benefit gleaned from this work can only be due to the Mercy of Allah (*swt*), the Most Compassionate, Most Merciful Creator of the Universe. In this brief work, I propose to:

1. give a brief history of Muslim presence in America, as I understand it,
2. discuss the nature and duties of an Imam,
3. assess some of the needs of the Muslim Community related to care and counseling, and
4. propose some strategies and tool**s** for implementation of ICCC.

I note that any conversation on strategies affecting the Ummah must be based on the Glorious Al-Qur'an, the confirmed traditions and practices of the Prophet Muhammad (*peace be unto him*), relevant cultural traditions, and best professional practices.

ICCC Example of Unmet Needs

I witnessed part of the destruction of the World Trade Center (WTC) September 11, 2001. At 8:46am, I was seated at my desk on the 23rd floor of a newly constructed federal building. The building is located in a former African Burial Ground(3) located five blocks from the WTC. A co-worker in the adjoining cubical looked out his window, and told me that the WTC was on fire. My window framed both towers. I could also see the smoke. News reports and friends on the phone explained to me how a small plane had run into one of the

towers. However, I could see that the at the crash site, the wing span of the plane stretched over more than few floors. Therefore, I knew that it had to be a large plane, perhaps a jet, and not a small one that crashed. I watched large billows of white smoke spewed out the building, and spread over lower Manhattan.

About 9:00 am, as I looked out of my window on the 23rd floor, I saw a jet plane to my left that appeared at eye-level flying in front of the New York City Municipal Building. It was strange and shocking to see a plane fly so low. The jerky spurts of the plane caused me much concern. Suddenly, the plane appeared to lurch forward and upward. It banked so that it appeared that if it missed the second tower, it would hit my building. I wondered whether we were the target.

I could see the front window of the plane as it tilted on an angle to make certain that it made contact with as many floors as possible. The next thing I saw was engulfing flames and smoke rising upward, covering the building on all sides. Moments later, I and co-workers saw debris floating in the air, and people falling who possibly made the choice jump to certain death, rather than to be consumed by jet-fueled flames.

We watched in shock and awe. As we watched, it dawned upon us that the crashes indeed were no accident. We were under attack. Additionally, we became keenly aware that we were standing in a federal building, vulnerable, and a possible target. We learned later that indeed the FBI Terrorist Taskforce, at the time housed in the same building, had confiscated camera equipment several weeks before. However, they let the culprits go. I gathered my wits about me, grabbed, my belongings, and fled the building.

Still dazed, I made my escape to a friend's house uptown. I remember crying, perhaps out loud, on the train and walking the two blocks to his apartment. When I arrived, possibly on the last uptown Broadway local train that day, I knew that I was in a state of emotional overload. I asked for a blanket, and rested on a sofa.

Moments later, my friend who was following the sequence of events on the television in the next room, came to tell me that the first tower had fallen. Shortly after, he informed me that the second tower had also fallen.

I included a part of my experience on 9/11 to emphasize that in my case, and perhaps in the experience of others, neither the collective New York City Muslim leadership nor community members have adequately addressed the unmet needs of the Muslim victims of the events of 9/11. There may still exist subsequent emotional, and in some cases spiritual issues Muslims may be experiencing because of various assaults on our community. This work is a clarion call to address the healing needs of Muslims before 9/11 and those needs existing even today. In all fairness, I have to admit that there was a slight effort by the Interfaith Community to include some of the Muslim 9/11 experience in discussions surrounding the building of the World Trade Center Memorial.

Who are the American Muslims?

The information contained herein is not meant to be exhaustive. It simply is a starting place for beginning to understand the religion of Al-Islam and American Muslims. Islam is the second largest religion in the world, and the fastest growing religion in the United States of America. There are some 1.3 billion Muslims world-wide, an estimated 5 million in the USA. The Muslim Community in the United States consists of the Indigenous African American Muslims (descendants of formerly enslaved Africans forced to immigrate to the US), and Immigrant Muslim Communities (individuals who volunteered to come to the US for social or economic reasons). Although estimates vary, The American Muslim Council in 1992 suggested that in the United States the African American Muslims were the largest population at 42%, followed by South Asians 24%, Arabs 12.4%, Africans 5.2%, and others 16.4%.(4) There are an

estimated 1,209 mosques in the US,(5) and about 70 identified mosques (masaajid) in NYC.(6)

Muslims are scattered world-wide. Most of the Muslims in the world are Sunni. Sunnis follow closely Al-Qur'an as well as the principles and practices of the Prophet Muhammad (*peace be unto him*) as collected and recorded in the ahadith.(7) Shiites have the same theology as Sunnis, but differ in some cultural practices. They are approximately 10-15% of the world-wide Muslim Community.

A View of the African American Muslim Experience

Muslims were among the very earliest explorers of the American continent. Their travels to the "new world" are well documented in numerous books, and archives. Early Muslims arrived from Africa. One example is Abu Bakari from the Kingdom of Mali in 1312. Christopher Columbus reported that he saw a masjid near Gibara on the northeast coast of Cuba. And, Estevanico, who accompanied the Spanish explorer Paniflo de Narva'ez in 1527, was a Muslim from Morocco.(8)

Historical records also report that Muslims were among the very first Africans enslaved in North America. Enslaved Muslims from the Sene-Gambia area of Africa were reported in New York City (1741), Annapolis Maryland (1731), and Norwich Connecticut (1750). Many people are already familiar with the history of the author Alex Haley, and how he traced his ancestry to Kunte Kinte, his Gambian Muslim ancestor. Muslims in America also left their written legacy (in Arabic script) in letters and documents.(9)

Historically, some African American Muslims viewed the religion of Al-Islam as liberation from Western cultural and religious hegemony.(10) This is evident by figures such as The Honorable Noble Drew Ali (1886-1929) who established the Canaanite Temple in Newark, New Jersey in 1913.(11) He also established The Moorish Science Temple (MST) 1928 (Moor was another term for Muslim).

The MST was one of the earliest efforts of African Americans to reclaim their Islamic heritage. He taught that African Americans were Asiatics, not Negroes or Blacks. He also taught that the historical home of the members of the MST was the Kingdom of Morocco. Members of the MST considered themselves Muslims.(12)

The Honorable Elijah Muhammad is generally considered to be one of the founders of The Nation of Islam. There is some controversy concerning the teachings of the Honorable Elijah Muhammad. However, for the purpose of this discussion, he is important for several reasons:

1. He is a pioneer of Islamic discourse in America,
2. He discussed African American/African American Muslim issues of theology, social psychology, self-esteem, self-determination and self-development.
3. He established the religious framework for intellectual curiosity that inspired generations of African Americans through concepts of "*the original man*," "*know thyself*," and "*do for self*."(13)

African American Muslims claim their Islamic and general African American heritage in America as previously mentioned. Nevertheless, we acknowledge that our history here has been a challenging experience. It is the effect of the history that underscores the need for Islamic Compassionate Care and Counseling. Without belaboring the point, I will name a few examples:

1. Post Traumatic Slavery Syndrome,(14)
2. Institutional racism(15) and,(16)
3. Medical Malpractice,(17) and,
4. Psychological warfare.(18)

The good news is Islamic Compassionate Care and Counseling. It is a Mercy from Allah (swt) waiting to be realized.

A View of the Immigrant American Experience

It is generally agreed that the first wave of Muslim immigrants arrived in about the year 1875. They came mainly from the areas that are today Syria, Lebanon, and Palestine for economic and/or political reasons. There is little indication that they immigrated for the sake of Allah (*swt*) or His Prophet (*pbuh*). They settled in lower Manhattan, and in various parts of Brooklyn. During the beginning of the 20th century, Muslims immigrated to the USA from additional countries, and established mosques (masaajid) in various parts of the country:

1. Polish Tartars established *The American Mohammed Society* in Brooklyn (1907),
2. Albanian Muslims established a masjid in Biddeford, Maine (1915), and in Connecticut (1919),
3. Dr. Mufti Muhammad Sadiq established the headquarters of the Ahmadiyya Muslim Community in Chicago in 1921. For many years, the Ahmadiyya Community had a close working relationship with the African American Community. They were the first Muslim immigrants to reach out actively to the African American Muslim Community.

In 1957, President Eisenhower gave the opening remarks at the Islamic Center of Washington, DC. Other significant immigrant operations include the 1968 founding of the Islamic Circle of North America (ICNA – predominately Indo-Pakistani), and the 1953 founding of the Islamic Society of North America (ISNA – predominately Arab).

Over the years, African American Muslims and Immigrant Muslims historically have had friendly and not so friendly

relationships. Many immigrant Muslins are professionals, such as doctors, engineers, and businessman. As such, many vote(d) primarily Republican, and, until recently, typically did not align themselves with African Americans – Muslims or non-Muslims. In the past, some Muslim immigrants, in their attempt to integrate into the American society, either shortened their names or Anglicized them. For instance, some encouraged or allowed themselves to be called "Mo," as a nickname for Muhammad, or "Al," a shortened form of Ali. This was true at the same time some African Americans were embracing Muslim names.

However, after the attack on the World Trade Center on September 11, 2001, and in the wake of the subsequent polices of the Bush administration, many Muslim businesses have closed; families have been split apart; some children have had their education interrupted; men, women and children have suffered traumatic emotional distress; undercover policeman have operated, and still operate, in some mosques; and many men have lost their jobs as a result of extra-judicial detentions As a result of these circumstance, relationships between the African American and Immigrant Muslims Communities appear to have improved by necessity. Perhaps, it is because of a greater understanding and appreciation of the discrimination that some African Americans continue to experience.

Basis for Islamic Compassionate Care and Counseling (ICCC)

ICCC is based in part on the dictates of Al-Qur'an and on the revelation received by the heart of the Prophet Muhammad ibn Abdullah of the 6th century (*peace be unto him*). Numerous authentic ahadith in Sahih al-Bukhari and Muslim(19) also discuss various aspects of ICCC. I will focus on the Qur'anic references. In the broadest terms, these verses discuss and give guidance to believers, define righteousness, and support the provision of neighborly needs:

A.L.M. This is the Book. In it is guidance sure, without doubt, to those who fear Allah, who believe in the Unseen, are steadfast in (establish) Prayer, and spend out of what we have provided for them, and who believe in the Revelation sent to thee, and sent before thy time, and (in their hearts) have assurance of the Hereafter. They are on (true guidance) from their Lord, and it is these who will prosper. (Al-Baqara 2:1-5)

It is not righteousness that you turn your faces towards the East or the West, but it is righteousness to believe [have faith] in Allah and [believe in] the last day, and the angels and the Book, and the messengers; to spend of your substances (out of love for Him) for your kin, for orphans, for the needy, for the wayfarer, for those who ask, and to ransom slaves, to be steadfast in prayer, and practice regular charity; to fulfill the contracts which ye have made, and to be firm and patient, in pain (or suffering) and adversity, and throughout all periods of panic. Such are the people of truth, the God-fearing. (Al-Baqara 2:177) (20)

Seest thou one who denies the Judgment (to come)? Then such is the one who repulses the orphan, and encourages not the feeding of the indigent. So woe to the worshippers who are neglectful of their Prayers, those who (want but) to be seen (of men), but refuse (to supply even) neighborly needs. (Al-Ma'un 107: 1-7)

Grief, poverty, and adversities in life are but trials from Allah (*swt*). The provision of Islamic Compassionate Care and Counseling is a Mercy from Allah (*swt*) to assist the believer in his/her challenges:

> No misfortune can happen on earth or in your souls but is recorded in a Book before We bring it into existence; that is truly easy for Allah, in order that ye may not despair over matters that pass you by, nor exult over favors bestowed upon you. For Allah loveth not any vainglorious boaster, such persons as are covetous and commend covetousness to men. And if any turn back (from Allah's Way), verily Allah is Free of All Needs, Worthy of All Praise. (Al-Hadid 57:22-24)

> Be sure We shall test you with something of fear and hunger, some loss in goods, lives and the fruits (of your toil), but give glad tidings to those who patiently persevere, who say, when afflicted with calamity, "To Allah we belong, and to Him is our return." They are those on whom (descend) blessings from their Lord, and Mercy; and they are the ones that receive guidance. (Al-Baqara, 2:155-157)

Finally, believers are the protectors of themselves, the family, and by extension, the Ummah. They have a responsibility to Allah (*swt*) to protect one another and the planet that He has provided:

> The Believers, men and women, are protectors, one of another. They enjoin what is just, and forbid what is evil. They observe regular prayers, practice regular charity, and obey Allah and His Messenger.

> On them will Allah pour His mercy; for Allah is Exalted in Power, Wise. (At-Tauba 9:71)

Imams and Islamic Compassionate Care and Counseling

The traditional Islamic education usually does not prepare the Imam for leadership in a contemporary American context. There is a need for additional training in such areas as administering non-profit organizations, and providing Pastoral Care/Counseling. Additionally, there is an increasing question as to whether Imams or community members will/should play a role in Chaplaincies in hospitals, prisons, and nursing homes. But even as the question is being discussed, some Imams are already functioning as professional chaplains, some paid, some as volunteers.

In his traditional role, the Imam performs any or all of the following functions:

1. leads the five daily required prayers,
2. conducts the Friday services (*Jumah*), as well as the two Eid celebrations,
3. performs marriages,
4. presides at the funeral prayer (*janaza*),
5. teaches classes in Islamic law (*sharia*), and
6. provides/teaches Qur'anic recitation.

In many instances, the Imam is also the administrative head of the mosque (*masjid*), virtually operating as the chief decision-maker. In other instances, the mosque (*masjid*) may be operated/incorporated by a Board of Directors which may have the authority to hire and fire the Imam. In some instances, the Imams are imported from the cultural homeland of a particular community, e.g. Pakistan, Mauritania, Indonesia. Or, sometimes, the community will send students overseas so they can be trained in the traditions of the homeland.

While the training and traditions they bring with them are important, and not to be minimized, the training may not have addressed several foundational needs/issues within the American Muslim experience. For example, greater skills are needed for dealing with issues and needs of Muslims who are:

1. still grieving, or remain traumatized by the 9/11 World trade Center Disaster and its aftermath,
2. victims of abuse from Islamophobia,
3. returning to the community from an extended prison term or from the military,
4. were involved in substance abuse, and
5. need family/marriage counseling.

The new and under-developed area of concern for Imams is the role as Chaplain. The subject has implications for both the Muslims and institutions such as hospitals, nursing homes, and prisons. Some Imams make visits to hospitals to see community members. It is almost certain that this practice will continue. However, the Muslim Community is significantly challenged with the hiring of Muslim Chaplains at various public and private institutions. In a sense, American healthcare and services institution are driving the religious discussions. They are causing the Muslim Community and its leadership to reconsider and adapt to a dynamic, contemporary caring America society. On the subject of Muslim Chaplains, the Muslim Community is behind it its self-analysis/self-promotion.

Some of the challenges for Imams and Muslim Communities include:

1. the need for adequate training in Pastoral Care and/or Clinical Pastoral Education (CPE) in order for Imams to be taken seriously as competent practitioners in public professional settings,

2. embracing the role of women Muslims as professionals and/or certified chaplains or chaplain supervisors (leaders) in hospitals, prisons, and the like, and
3. producing appropriate literature for assisting all chaplains to better address the spiritual and emotional needs of Muslim clients/patients.

Some challenges to public and private institutions may include:

1. making emotional space for, and respecting Islamic traditions. These requirements may be similar to the orthodox Jewish protocols, already in place at certain hospitals for handling the body of the deceased,
2. prohibiting certain interactions between men and women. These may include shaking hands, or certain environments/conditions for individual and group counseling,
3. respecting dietary restriction (halal foods), and
4. making provision for/awareness of the need to make the prayer (*salaat*) on time, and to attend the Jumah service on Friday.

Muslim Caregivers

I define Muslim Caregiver as any individual who provides services/support to members of a Muslim community. They may be the professional counselor, social worker, psychologist, or psychiatrist who is a regular member of the community, or in private practice. They may be a paraprofessional. Their education and training may vary greatly. They may be male or female. Their activities may be formal or informal. These caregivers are people who console the family members at the time of a death, in times of insecurity and strife, and during other significant events.

Muslim Caregivers may also receive training in pastoral counseling from religious or mental health institutes. Pastoral

counseling is the academic discipline for ministering to religious communities. Pastoral counselors usually have at least a Master's Degree, as do pastoral psychologists. However, some programs offer certificate programs which require fewer courses and clinical work (training). Some of the training offered to professionals and paraprofessionals alike include, but are not limited to the following:

1. end-of-life issues,
2 accidents and related trauma,
3. loss and grief, loneliness, suicide,
4. sudden death of a child,
5. still-born babies,
6. abortion,
7. chronic illness, and AIDS;
8. sadness, and anger,
9. health care proxies, and do-not-resuscitate orders.

This training especially will benefit believers and is much needed in our Community.

Muslim Community and Chaplaincies

The concept of Chaplaincy as a part of *Islamic Compassionate Care and Counseling* is relatively new in the Muslim Community. As the Community and its leadership embrace more of what is typically referred to as "Pastoral Care" in the Jewish tradition and Christian Communions, the need for Muslim Chaplains becomes more apparent. To my knowledge, there are a number of Imams and Muslim Caregivers serving as Chaplains in various prisons and hospitals. However, with Clinical Pastoral Education (CPE) as the standard, many existing Muslim caregivers may not be qualified to participate in Chaplaincy programs.

I believe that CPE training is useful. Also, there are also crossover principles and strategies that can be applied by Muslim Caregivers within the masjid. There is especially a role for Muslim women. This is an area that is ripe for exploration. In all, it would be best for the individual community though an ash-shurah (mutual consultation process, i.e. both men and women) to determine how best to service the Compassionate Care needs individual community. Furthermore, there are a number of additional concerns to be addressed. There are a number of Muslim women who have been trained in Christian seminaries/secular programs who are trained as Chaplains. However, I observe that very little of their skills are employed or utilized within the Muslims Community. This is unacceptable and in denial of a great blessing from Allah (*swt*). I believe that the Muslim Community will eventually come to terms with the reality of these women and their valuable training. Otherwise, Allah (*swt*) one day may call us to account for our ingratitude.

In the New York City Metropolitan Area, I observe that the role of the Muslim Chaplain in the hospital and in City prisons differ greatly. In the prison system, the Muslim Chaplain services primarily the Muslim population. Indeed, it has been my experience that certain Muslim Chaplains resent visits from outside Imams. In my case, I once was challenged by an Imam at one of the Riker's Island detention facilities who told me that I could not visit a Christian inmate who asked to see me. On the other hand, I was once called by another Imam because he feared for the life of a particular Muslim brother and wanted an outside person to be aware of what was happening. My point is that prison chaplaincy is an area that is not addressed adequately by the Muslim Community.

This issue of training Muslim women as Chaplains and their status within the Muslim Community is an area that has to be addressed. When a woman is a Chaplain in a women's prison and she leads the prayers, is she then an "Imam"? She certainly functions as a

leader. For example, the New York City Department of Correction (NYCDOC) has a Muslim woman who is a Chaplain in a women's facility. She has the same status as a male chaplain, Muslim or non-Muslim. She occasionally leads the women in her facility in prayers. In her role, she functions as an Imam (leader). The Institution appears to be at a loss on how to refer properly to her, without offending the Islamic community. She is a chaplain by their definition. But is she also an Imam? And if so, should she be addressed as such? In any event, individual Muslim communities may want to decide for themselves which terms are appropriate, and how they should be used. One possible solution is to use only the term "chaplain" in governmental/private institutions, reserving the term Imam only for males functioning within the masjid.

Another concern is the status of the present training of Imams as discussed earlier. I am aware that several years ago, a Muslim woman successfully completed six or seven units of CPE at major New York City hospitals. However, because she did not have a degree, and possibly because she was not an Imam, this woman was not offered a chaplain position. Perhaps this was a political situation that has resolved itself in more recent times.

Closing Remarks

Where is the Muslim hospital? There is certainly a plethora of excellent Muslim surgeons, specialists, and administrators. Then, how is it that, to my knowledge, there is no Muslims hospital in the United States? There was a time during the life of the Honorable Elijah Muhammad when The Nation of Islam had a program for building a least one hospital. A Muslim hospital can be a resource and focus for Islamic Compassionate Care and Counseling. The hospital administration can build close ties with Muslim Communities, provide proper Islamic adab (behaviors) in terms of patient care, provide for dietary needs, offer professional training in a variety of

areas, and be a source of pride and accomplishment for the Muslims. Additionally, a Muslim hospital can be an example of Muslim contribution to the American society.

Islamic Compassionate Care and Counseling is an idea whose time has come. It is a concept that services the needs of Muslims and all Americans. It is a strategy for bettering the individual masjid, for providing professional training and development for Imams and Muslim Caregivers, and it is a moral responsibility. May Allah (*swt*) continue to guide us on the path of righteousness; may He forgive us for our short-comings; may He grant us success in this life and in the life to come. Ameen.

Endnotes

1. Subhana watallah (Glory to Allah); a phrase often written with initials or spoken after the name of God.
2. For example, Al-Fatiha 1:1;
3. The building at 290 Broadway in Lower Manhattan is erected in a 17th century African burial ground. Over 400 remains were removed for construction and subsequently placed in an adjoining National monument.
4. Fareed Nu'man, *The Muslim Population in The United States*, American Muslim Council, 1992
5. Ihsan Bagby, et al, *The Mosque in America: A National Portrait*, in American Religious Identification Survey 2001, The Graduate Center (CUNY), 2001.
6. New York Times, May 4, 1993, citing Dawud Assad of the Muslim World League in NYC.
7. Many Muslims consider the collection of the sayings and actions of Prophet Muhammad and his companions as an important component of the religion of Islam. Muslims refer to these writings as *ahadith*, (singular, *hadith*). The most widely used ahadith are the ones compiled by Bukhari, Muslim, Abu-Dawud and Imam Malik.

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18. Na'im Akbar. (2004). The Evolution of Human Psychology for African Americans. In *Black Psychology* (4th ed.) (p. 37). Hampton, VA: Cobb & Henry Publishers.
19. Works by Persian Muslim scholars Muhammad ibn Ismail al-Bukhari, and Imam Muslim (Muslim ibn al-Hajjaj)

20. Brackets are added in order to make a distinction between “faith” and “belief.” Our faith is in Allah (swt) and Allah (swt) alone. Belief from my perspective is based upon empirical evidence such as senses or experience. Our only faith-based relationship is with Allah (swt).

Sartre's Existentialism and the Human Predicament

Jennifer Little

"*. . . so that's the idea. I'm to live without eyelids. Don't act the fool, you know what I mean. No eyelids, no sleep; it follows doesn't it? I shall never sleep again. But then how shall I endure my own company?"*—Garcin, *No Exit*. (1)

In Sartre's character Garcin, we see the situation of the human predicament: "life without a break."(2) If one is to truly be a human being, according to Sartean existentialism, one wakes up to one's self in hell—life without a break—life without "sleep"—in which one must make an infinite number of essential decisions which have essential consequences for all others and for one's self. One can never escape the self-gaze or the gaze of others—if one is to live an authentic existence. In his play, *No Exit*, Sartre provides a glimpse of the anguish of the human person (becoming) aware of herself without illusion. Sartre's collection of essays in *Existentialism and Human Emotions* (1957) excerpted from his works *Being and Nothingness* (1943) and *Existentialism* (1945 lecture) provides the light that inexorably shows us what committed being might mean for us. The essays in this collection furthermore provide the reader with an entré into a psychoanalytic process that suggests what one might do and be when one wakes up in the "hell" of one's self and others without illusion –when one realizes that "L'enfer c'est les autres!"

Presented with the frightening prospects of authentic being –"life without a break" criticism of existentialism arose from two main groups—the communists and Christians. Both groups suggest existentialism is a form of faulty subjectivity which is "ugly" and

leads to inaction and quietude. This essay shall begin a two-part discussion of subjectivity.

Sartre begins his essay "Existentialism" by addressing the concern of "inaction" or "quietism" raised by the communist point of view in response to the concept of "despair" ("no solutions").(3) A second concern is that the stark individualism of the *cogito* makes solidarity of the kind necessary for viable communism impossible.(4)

We begin with Sartre's response to the communist point of view. We begin with "subjectivity," addressing the thinking, being subject; the **I** expressed in the *cogito* ("Je pense, donc je suis"). There are two ways of understanding subjectivity. First, it means "that an individual chooses and makes himself," according to Sartre.(5) Second, Sartre emphasizes that in his subjectivity, "it is impossible for man (sic) to transcend his subjectivity."(6) In other words, it is not possible for human beings to "step outside" the limit of their own self-construction and perception to posit a transcendent, universal human "essence" as a source or referent for their choices. Nor is it possible to posit God's existence for the same reasons. Therefore, argues Sartre, "our responsibility is much greater than [otherwise] because it involves *all* mankind: "When we say that man *chooses* his own self, we mean that every one of us does likewise; but we also mean that in making *this choice*, he also chooses all men."(7) In choosing, I simultaneously construct myself and self-understanding as well as what I understand others to be—what post-modernity calls a "constructivist" point of view. It is noted that Marxist post-modernists might argue alongside the communists that the individual Otherness in such a philosophy can never be bridged.

In Sartre's argument, however, the solidarity communism seeks resides in the responsibility of each choice being constructive of *all others*: "I am responsible for myself *and* for everyone else."(8)

The other argument under the category of communist criticism of Sartre's existentialism has to do with "quietism." The question can be raised (as a consequence of each person's choices and freedom): If

"men are free" and if "tomorrow they will freely decide what man will be," and if "things will be as man will have decided they are to be, does that mean **I** should abandon myself to quietism?"(9) Sartre's answer is an unequivocal "NO" because of man's radical freedom and responsibility for choice in context of the non-existence of God. One chooses—even in "not choosing"—for there is no referee, or divine intervention, or divinely ordained human nature. Such an understanding of human subjectivity negates, really, the possibility of "non-action." What humankind is "is nothing else than a series of undertakings, that he is the sum, the organization, the ensemble of relationships which make up these undertakings."(10)

This brings us to consideration of the second category of criticisms—those of the Christian or humanist.

Christianity (and other theistic religions) derives human subjectivity from God's subjectivity, positing an "essence" from which existence (especially but not only) human existence derives. Human nature, then, is that which is conceived of by God.(11) The *individual* human nature is "the realization of a certain concept in the divine intelligence" in such a system.(12) Thus is the criticism leveled at Sartre's existentialism: to identify human nature as radically free and self-creating necessarily leads one to moral relativity (situation ethics) on the one hand, and a kind of depraved naturalism on the other.

Sartre clearly points out that *any* interpretive act (that of self-reflection, perception, action) is relative to the extent that it comes from a free human being.(13) Secondly, rather than "inaction" in the face of not being able to rely on the idea of "human goodness" or "human concern for society,"(14) one is compelled to responsible action: "a human being is [. . .] nothing else than the ensemble of his acts, nothing else than his life."(15)

According to Sartre, "There is no doctrine *more optimistic* [about human nature], since man's destiny is within himself [. . .]."(16)

Therefore, according to existentialist subjectivity, human beings become true subjects and not objects.(17)

Sartre's development of subjectivity (only begun in this discussion) is refreshing. I believe it provides a powerful source for thinking about the self, freedom, and individual responsibility in authentic relationship—which, it seems to me, is the center of Christian community.

As John H. Morgan points out in his summary of Jean Paul Sartre's work, the key to a viable and honest existentialism is the *premise* that "God does not exist."(18) It is upon this premise that Sartre bases his exposition of existentialism which "begins with a human person in the here and now of the immediate world environment, not in some abstracted Platonic Ideal or religious *imago dei."*(19)

Even if one reverts (or progresses) to a Christian existentialism as Paul Tillich and others have tried from the tents of existentialism, it is the core of authentic personhood—constructed and not given—that creates each human being. There is, for Sartre, no "essential" humankind, just "existent" particular humans, self-creating through their individual choices in each moment.

Without a divine being on which to "blame" the "accidents" of existence, human beings are left with the radical responsibility for not only his or her particular life, but by extension, the lives and situation of *all* human beings.(20) This awareness leads to characteristic "anxiety" (angst) in a person.

A further amplification of the anguish an individual feels at this realization of total responsibility and "no exit" from one's self and one's choices is the *despair* that leads to authentic freedom.(21)

In his short volume *Existentialism and Human Emotions* (1948)(22), Sartre addresses the criticisms leveled at existentialism by critics while further explaining the tenets (although that word is too concrete) of existentialism that he developed through his fiction. Perhaps Sartre himself would suggest that the particularities, the

situation, of his novels and plays are the more accurate existential expression of being in that they are themselves primary and not general discussions.

In his essay, "The Desire to Be God," Sartre seems to want to refute the idea that the impulse toward God (faith in God, belief in God) is fundamentally different from other desires for possession. In his refutation of the idea that faith in God is qualitatively different from "desire for a woman" or any other strong impulse, Sartre argues that the impulse toward God is no *less concrete* than the impulse toward a particular woman. On the contrary, it is a matter of rediscovering under the partial and incomplete aspects of the subject the veritable concreteness which can be only the totality of his impulse toward being, his original relation to himself, to the world and to the Other, in the unity of internal relations and of a fundamental project.(23)

This is not to say, however, that desire –the desire to be God, the desire to play tennis—does not "reach beyond itself" on a symbolic level.(24) Rather, such desires are constructive and have a symbolic "transcendence" insofar as they function in constituting the self in the "impulse toward being."(25)

The "desire to be God" is one manifestation of the desire for meaning as Sartre develops it further in the second essay "The Desire to Be God (continued)." The desire to be God is the desire to possess God, which is in reality the desire to possess one's self as are all concretely expressed desires. One can trace Sartre's logic clearly:

The desire to possess a particular woman, for example, is not the desire to *be* a woman (to be "her" a particular woman) but rather to *be one's self.* Following Sartre's logic, the desire to "possess God" is not the desire to be God –only the desire to *be one's self.* Consequently, the "desire to be God" as Sartre has expressed it, is only the desire to *be one's self.*

Thus, Sartre's continuing discussion of "The Desire to Be God" is a further definition of human being: "To be [human] means to reach

toward being God [. . .] man (sic) fundamentally *is* the desire to be God."(26) This desire is a "complex symbolic structure" that has "at least 3 stories (levels)."(27)

The first "story" is the "fundamental concrete desire" that is the "*person himself*."(28) On this "level" is the existential decision/awareness/anxiety expressed in the questioning of his own being (the awareness of the possibility of non-being).(29) Second, the "fundamental desire" is a concrete expression of a "second level" which "envelops the individual" and which is an "abstract meaningful structure (the "desire of being in general") which "must be considered as human reality *in the person*."(30) Third, "the fundamental desire" or "project" (which constitutes the human person at the "second level") becomes "the free realization of *human truth*" which is therefore "everywhere in all desires."(31)

In this three "level" understanding of human being, Sartre seeks to emphasize that the human person is constituted by existence which *precedes* essence. Furthermore, we have shown that in Sartre's thought, the desire to be (human, free) is primarily and fundamentally a concrete experience of the possession of the self which, according to Sartre's thought is the "desire to be God."

In his essay "Existentialist Psychoanalysis," we see Sartre further develop the implications of the existential subject. Here Sartre examines the dynamics of the subject as a self-reflective entity and the extent to which Freudian psychoanalysis differs from existential analysis.

We recall that the foundation of the subject in existentialism is the construction of the self by or in "choice" and in the situation of awareness of non-being. Thus the subject is hindered in its ability to be "objectively" self-reflective, for the anxiety of non-being and the impulse of "being-for-others" makes authentic freedom of the subject in each choice difficult.(32)

Sartre differentiates existential psychoanalysis from Freudian psychoanalysis in specific areas. To begin with, rather than a self-

constructed of *complexes.* Sartre identifies the "primary choice" as the identity-forming nexus the psychoanalyst must help a person identify.(33) This is important in the project of existentialism because the understanding of the subject is predicated on consciousness. One has authentic being in one's free choices. One arrives at that being by consciously understanding the present situation and the choices *consciously* made. Therefore, Sartre dismisses the concept of the "unconscious" in Freudian psychoanalysis. "How," Sartre asks, "can the unconscious complex recognize itself" if it lacks understanding?(34) For Sartre, the idea of the "unconscious" functions like the idea of God: an *a priori* source of identity from which one mistakenly attempts to understand human nature. The unconscious functions as a transcendent or privileged source of behavior.(35)

After dismissing the idea of the unconscious in favor of "the original contingency" Sartre addresses the function of the psychoanalyst in illuminating the symbolism that helps one to "discover" not only the "primary choice" and to *understand* it, but to recognize the continuing choice of being presented to one in every situation.(36)

Because the psychoanalyst works with symbolic language in which the subject expresses her reality, it is important to Sartre to deal with symbol interpretation in the process of existential psychoanalysis.

As a result of dismissing the existence of the unconscious in its "mechanical causation," existentialist psychoanalysis "renounce[s] at the same time all *general* interpretation of symbolization confronted."(37) Because of the particularity of situations and radical free choice occurring within the totality of each being, symbols may function differently in each being.(38) Furthermore, the psychoanalyst is not in a privileged position to determining symbolic meaning for the subject in question can certainly revoke any associations she makes.(39)

Additionally, in the Saussurian paradigm S/s (Signifier bar signified) requires redefinition. Rather than a bar separating the Signifier from the signified the "space" between them may be better identified as a "suture" which is both an opening (a "wound") and the closing or "barring" of the opening.(40)

Yet, we must address the "wound" or "hole" as Sartre understands it; we must not close our eyes to this aspect of his thought.

That this "obscene" absence has been associated with women—beginning with Freud and continuing in Lacan and here in Sartre—has been well documented by feminist thinkers.(41) The implications of this symbolic association between absence and women can be devastating to a woman's sense of being; for despite her subjective choices, in Sartre's economy (and in Freud and Lacan), a woman's essential being is that of lack: she requires the phallic presence to "transform her into fullness of being by penetration and dissolution."(42)

Despite Sartre's assertions in "Existentialist Psychoanalysis" that authentic being ("being-for-itself") is constructed in the nexus of individual choice and situation,(43) and that "the [symbolic] choice is living and consequently can be revoked by the subject (sic) who is being studied,"(44) Sartre objectifies women by stating their being is "in the form of a hole."(45) This attempt to symbolize personhood in relationship to the symbol of "the hole" constructs men (maleness) as primary subjects – able to establish their own authentic being "in losing himself as man" via "castration" by women (feminine) thereby "losing [himself] so as to be found."(46) Women (femininity), therefore, are *first* objects or at best *secondary or derivative* subjects who are only able to find their existence through the intervention of the presence which "stops up the hole."(47)

It *seems* that in Sartre's economy, primary ontological status is given to "the hole" as privileged signifier. *Yet* this privileged signifier is that of absence or "non-existence" which can only really *come into*

being by negating itself in a destructive act –that of "filling the hole" and being "swallowed," "devoured," or "castrated."(48)

Perhaps the Tillichian image of "separation" is a better image for the "lack of authentic being" that is at the heart of the troubled self.

The second half (and somewhat disconnected) of Sartre's essay attempts to deal with the psychoanalytic issues of "taste" and "preference." Certainly, these issues ought to be considered in attempting to identify or "determine" the "free project" of the construction of the authentic self. Doing so *does* require an understanding that "tastes [. . .] reveal to us the fundamental project of the person"(49) and that qualities of objects (colors, temperature, texture, etc.,) are subjective; yet they represent (here we ought to read "*re-present*") a particular type of being originally presented in the "fundamental project" or "original choice" of a person.(50)

We note, however, that Inez, Sartre's lesbian character in *No Exit* is the clearest example of a person without illusions. Inez is certainly not a likeable or admirable character, but Sartre puts most of the clearest examples of existentialist thought in her speech. Inez recognizes, for example, that her suffering and the human condition is to be "conscious of one's self" as well as the fact that it is "absurd" to attempt to "forget about others." She states that she (and we) "feel others and cannot prevent their being present to us at all times." There is no exit from the reality of and responsibility for others.

In the concluding essay of *Existentialism and Human Emotions,* having presented the human predicament and situation, Sartre ends with a series of questions. It is appropriate that Sartre ends the essay "Ethical Implications" with a series of questions. To provide statements rather than questions here would be a violation of the foundational freedom that is the situation and goal of the human person as well as existentialist psychoanalysis itself.

The final essay in this collection serves as a summary of the fundamental praxis of existentialist psychoanalysis: Rather than "formulat[ing] ethical principles," Sartre reminds us, existential

psychoanalysis "allows us to catch a glimpse" of the ethics "*human reality in situation*" requires.(51)

This "glimpse" is not an all-encompassing, fixed set of precepts, for it arises from the sense of non-being, "lack," (even "hole" (sic)) of the individual in her situation. In the courageous embrace of the reality of human situation and the possibility of non-being (including being-for-others) comes *value* as praxis.(52) Existential psychoanalysis provides the synthesis "in the form of value or self-cause [being-for-itself] which provides a "moral description," and enabling "ethical meaning" for human projects.(53)

Throughout this short essay Sartre discusses the "results" of this value praxis. First he states that the principle result is to "repudiate the *spirit of seriousness*" –the criticisms raised in his first essay collected here "Existentialism."(54) The "spirit of seriousness" causes a person to "pursue being blindly by hiding from himself the free project."(55) A person thereby becomes "passively obedient to objects" and others' mute demands. She becomes, then, no longer an authentic subject in this relationship—rather an object among objects.

It is the goal of existentialist psychoanalysis to "reveal to man the real goal of his project, which his being as a synthetic fusion of the in-itself with the for-itself"(56) what I have above termed "value praxis."

Thus, existentialist psychoanalysis reveals a person as a "moral agent" who, in light of the realization of her "non-being" either through succumbing to the press of objectification or through "quietism" as a retreat comes to awareness of possible *being* through anguish and despair finally dis-covering her freedom in the "quest for being."(57)

At this point in the essay (and in the process of existentialist psychoanalysis itself), the freedom of the authentic subject must proceed to choose itself in the specificity and reality of her situation in light of her "original choice." Thus, Sartre's essay concludes with questions only. These questions provide a heuristic for existential psychoanalytic practice and the praxis of value.

Endnotes

1. Sartre, Jean Paul. *No Exit.* Tr. Stuart Gilbert. (1944).
2. Ibid.
3. Sartre, Jean Paul. (1957). Existentialism. *Existentialism and Human Emotion.* (p. 9). (Bernard Frechtmann, Trans.). New York: Citadel Press.
4. Ibid., 10.
5. Ibid., 16.
6. Ibid., 17.
7. Ibid., 17, emphasis mine.
8. Ibid., 18, emphasis mine.
9. Ibid., 31, emphasis original.
10. Ibid., 33.
11. Ibid., 15.
12. Ibid., 14.
13. Ibid., 23.
14. Ibid., 32.
15. Ibid.
16. Ibid., 35-36, emphasis mine.
17. Ibid., 37.
18. Morgan, John. H. (2005). Jean Paul Sartre and Human Possibility (Existentialism). In *Naturally Good: A Behavioral History of Moral Development from Charles Darwin to E. O. Wilson.* (p. 119). South Bend, IN: Cloverdale Books.
19. Ibid., 121.
20. Ibid., 123.
21. Ibid., 125.
22. Sartre, Jean Paul. *Existentialism and Human Emotions.* (1948) Tr. Bernard Frechtman and Hazel E. Barnes. New York: Citadel Press, 1957.

23. Sartre, Jean Paul. (1957). The Desire to Be God. *Existentialism and Human Emotions.* (p. 61). (Hazel E. Barnes, Trans.). New York: Citadel Press.
24. Ibid., 60.
25. Ibid., 61.
26. Ibid., 63, emphasis mine.
27. Sartre, Jean Paul. (1957). The Desire to Be God (continued). *Existentialism and Human Emotions.* (p. 64). (Hazel E. Barnes, Trans.). New York: Citadel Press.
28. Ibid., emphasis mine.
29. Ibid.
30. Ibid., 64, emphasis mine.
31. Ibid., 65, emphasis mine.
32. Sartre, Jean Paul. (1957). Existentialism and Psychoanalysis. (pp. 72-74). (Hazel E. Barnes, Trans.). New York: Citadel Press
33. Ibid.,71.
34. Ibid., 80.
35. Ibid., 75.
36. Ibid., 81.
37. Ibid., 78, emphasis original.
38. Ibid.
39. Ibid.
40. Luce Irigaray develops the idea of "suture" rather than a "bar" separating the Signifier from the signified in her work. We shall address this concept more when we get to Satre's unfortunate essay titled "The Hole."
41. See Luce Irigaray. (1985). *This Sex Which Is Not One.* (Catherin Porter, Trans.). New York: Cornell University Press.
42. Sartre, "The Hole." 85-86.
43. Sartre. (1957). Existentialism and Psychoanalysis. *Existentialism and Human Emotions.* (p. 75). (Hazel E. Barnes, Trans.). New York: Citadel Press.
44. Ibid., 78.

45. Sartre, "The Hole." 86.
46. Ibid., 90.
47. Ibid., 86.
48. Ibid., 86.
49. Ibid., 71.
50. Ibid.
51. Sartre, Jean Paul. (1957). Ethical Implications. *Existentialism and Human Emotions.* (p. 91). (Hazel E. Barnes, Trans.). New York: Citadel Press, emphasis original.
52. Ibid.
53. Ibid.
54. Ibid., 92.
55. Ibid., 93.
56. Ibid., 93.
57. Ibid., 94.

The Ethics Committee as a Venue for Long-Term Pastoral Care(1)

James R. Michaels

Ethics committees in acute care medical facilities play an integral role in the care of people in the last stages of life. Such committees meet at least weekly to discuss issues which are immediately pressing: questions of medical futility; allocation of limited medical resources when the demand is greater than the supply; unpleasant decisions about a patient's care when relatives might disagree about what that treatment should be.

As Nancy Berlinger, a noted specialist in Medical Ethics at the Hastings Institute, has observed, ethics committees in long-term care facilities have less-defined roles. The issues presented usually do not involve discontinuation of care and, often, residents' wishes are well known. Instead, long-term care ethics committees may be drawn in the direction of counseling with family-members as they accompany their elderly parents on their last journey.

As director of pastoral care at the Charles E. Smith Life Communities in Rockville, Maryland, I serve as staff liaison to the ethics committee. Over the years, I have realized the committee can play a different and integral role in the care of our residents. Since most of our decisions are not imminent ones concerning life or death, we can assume a role more oriented toward pastoral care. This article will examine various scenarios in which such a role is appropriate.

History of the ethics committee of the Hebrew Home of Greater Washington(2)

Until the mid-1970's, issues of medical ethics were rarely discussed by individuals. What changed at that time was the awareness that medical technology could keep patients alive, but not necessarily guarantee any quality of life. Cases like that of Karen Quinlan made people focus attention on issues which previously had been theoretical, that is, when can life support systems be discontinued. In particular, Jews wanted to know if Jewish law and tradition allowed them to sign advance directives and living wills, and what they could request in such documents.

As the only Jewish health care facility in the Washington DC area, the Hebrew Home became the natural location for discussion of these questions. Even though the ethics committee was already well established, it was reorganized to respond to community needs. Although empowered to decide on cases, the committee's meetings usually took an educational format. Local rabbis and doctors sat on the committee. They researched questions of ethics and presented papers for discussion. The meetings were primarily held in the evening hours, in order to allow attendance by interested members of the community.

Later, as members of the community became more aware of their options with regard to making health-care decisions, the format was changed again. Official meetings were held once each quarter. A mechanism was also developed to create case consultation committees; requiring only a few members of the committee, these could be convened at short notice, sometimes within a few hours. It has been within these case consultations that the pastoral role of the committee has been most clearly in evidence, as the following cases will illustrate.

Caring for residents

Mr. and Mrs. C, an elderly couple from South America, were admitted to the facility's sub-acute rehabilitation unit. Both husband and wife had recently been brought to the United States and did not speak any English. The husband was in hospice care, and the wife was quite frail. She was eventually transferred to one of our long-term care units. A problem presented itself when the woman, still in control of her cognitive abilities, was asked if she would sign a "Do-Not Resuscitate" (DNR) order. Her children had lived in the United States for a long time, and understood the importance of leaving such instructions.

Mrs. C initially said she did not want to sign the DNR form. According to her children, she had said that she did not want to give up on any medical care to keep her alive. Her doctors had recommended against administering CPR in the event of a heart attack because it could result in pain and suffering due to broken ribs.

The couple's children asked for a consultation with the Ethics Committee. They told the committee that while they respected their mother's wishes, they also feared that she did not understand the implications of not signing a DNR. They wanted to know what they could do. The consultation committee explained that because the resident was cognitively intact, they could not unilaterally order a change in protocol without her consent. However, it was recommended that the mother be brought to talk with the committee members in the hopes that they could persuade her to sign the form.

A few days later, the family brought Mrs. C to visit her husband. By coincidence, they passed me in the hall and introduced me to their mother. They explained that I was "a Jewish minister". As she was an Evangelical Christian, meeting a member of the clergy carried significant importance for her. By additional coincidence, two members of the initial consultation committee were nearby; we

quickly convened a second meeting, and sat with the woman and her family.

I explained to Mrs. C (through her children's translation) that her desire to live was admirable, but that if she elected to receive CPR, it could result in significant pain and suffering. I asked her to consider if she wanted to live with such pain. She thought for a few minutes, and then said, "I will now leave everything in the hands of God." She agreed to sign the DNR.

Mr. C died a few days later. Mrs. C lived for another four months and passed away quietly with her family nearby.

The pastoral implications of this case were significant. First, even though the children had expressed respect for their mother's choices, there was probably some subliminal conflict between them and her. Second, by using my "priestly authority", I was able to overcome Mrs. C's resistance to considering what might be in her best interest. Third, once she agreed to sign the DNR, she had peace of mind and was able to enjoy the remainder of her life with her family.

Care for medical professionals

As a large skilled nursing facility, the Hebrew Home is able to have a number of physicians on staff. Although residents are permitted to maintain their own personal physicians, most take advantage of the services of the staff doctors. I was surprised one day when one doctor asked if he and his colleagues could learn more about the Jewish perspective on end-of-life issues.

He explained that, over the years, they had been told Orthodox Judaism insists that end-stage patients be kept alive at all costs. They were distressed because they thought patients' best interests were not being served. They also perceived a wide gulf between the beliefs of Orthodox and non-Orthodox Jews in this area. I invited the doctors to attend the next quarterly meeting, and said I would arrange for an Orthodox rabbi to attend.

I called Rabbi Yitzchak Breitowitz, a noted expert in Jewish medical in Jewish medical ethics and a professor of law at the University of Maryland. An Orthodox rabbi, he had previously been a member of the ethics committee, so he agreed to attend the meeting.

Rabbi Breitowitz explained that Jewish law's views on this subject are much more subtle than normally assumed. He said that most people are familiar with responsa in English which discourage withdrawal or withholding of life support. There are others in Hebrew, he said, which present options for withholding life support. He said, "We're obligated to preserve life, but we're also obligated to prevent suffering." He indicated, therefore, that this issue is much more subtle and nuanced, even among Orthodox Jews.

The immediate result of this meeting was that doctors were reassured when they discussed this. They felt more comfortable discussing hospice care with families of Orthodox residents. After hearing Rabbi Breitowitz, the doctors felt more comfortable referring their non-Orthodox Jewish patients who believed they had no choice in end-of-life matters, to rabbinical authorities for consultation.

There were other positive results. The doctors realized that Jewish law is not radically at odds with their own beliefs. Non-Jewish physicians felt they were not forced to adhere to a specific approach to end-of-life issues; Jews felt more comfortable with their own tradition.

When religious tenets guide a decision

As medical technology becomes increasingly adept at keeping people alive, the nuances of Jewish law expressed by Rabbi Breitowitz have become important for how chaplains and other staff deal with end-of-life issues. The two examples offered below illustrate how these nuances – or their absence – can affect ethical decisions and thereby influence a resident's quality of life.

The first is example involved Mrs. G, who had spent a long time in a hospital in New York, before being moved to the Jewish long-term care facility in a different city (not the Hebrew Home of Greater Washington) where her daughter and son-in-law, an Orthodox rabbi, were living. Mrs. G had a number of co-morbidities and it was the opinion of the facility's medical director that additional medical interventions would not help Mrs. G, and might actually shorten her life.

A meeting was convened between the daughter and her husband, and members of the staff, including the medical director, the social worker, and the chaplain. After the physician explained Mrs. G's condition to her daughter and son-in-law. He said that the best course of action would be to keep her as comfortable as possible at the nursing home. The social worker then told them that the plan was to move Mrs. G to a part of the building that would better assure her comfort. Expressing respect for the family's traditional beliefs, the chaplain gently introduced the possibility of hospice services, adding that many of the Jewish chaplains who work in hospice are themselves Orthodox rabbis. Using language that he knew they would understand, he told them that the nursing home staff members were indeed partners with God in caring for residents, including Mrs. G, but that given the realities of Mrs. G's situation, God might be saying that it was time for human beings to step aside, and let Him take over.

As the chaplain spoke, both the daughter and son-in-law nodded their heads, and then expressed their deep appreciation for all that was being done for Mrs. G. They explained, however, that they, of course, could not "give up" on Mrs. G and would do everything they could to preserve her life. In addition, they would continue to consult with their own rabbi, who lived out of the city, but who was Mrs. G's rabbinic "power of attorney". They would share the conversation with him, and would abide by his decision as to how they should proceed.

Ultimately, the family decided to follow a more aggressive, rather than palliative, course of action. A day or so later, at the insistence of her daughter, Mrs. G was sent to the ICU "for tests". When the chaplain went to visit her in the hospital he saw that Mrs. G had a feeding tube, and that she had been placed on a ventilator. She did not respond visibly to any verbal stimuli. During the chaplain's several visits, Mrs. G's daughter and her sister who had come in from out of town, expressed appreciation for his visits and the prayers that were being offered for their mother. Mrs. G remained in the ICU for three weeks until she died.

The postscript to this case is that after Mrs. G's death, the chaplain spoke with another Orthodox rabbi in whose congregation Mrs. G's daughter and son-in-law are members. The chaplain raised the case with this rabbi. The rabbi, however, was very aware of the situation firsthand. When the chaplain asked the rabbi's opinion about the family's decision, his answer was "there are some rabbis who are more strict in these situations, and others who are not." He explained that his inclination was to follow rabbinic authorities who are more sensitive to the bigger picture and the nuances involved. He added that, if they had approached him, his religious counsel to the family would have been very different.

For some, the above case would argue that a religiously conservative approach will not be sufficiently sensitive to the resident/patient's situation and quality of life, However, another case in which I was personally involved, demonstrates that such a religiously conservative approach can at times arrive at a correct—and effective—decision:

Mr. T, a resident in his late 80's, had lived in the Hebrew Home's nursing facility for several years; his wife still lived independently. Upon her husband's admission, she had told the staff that he had been active in his synagogue and wanted to attend our services as often as possible. We made arrangements for volunteers to bring him almost

every day. Even though he had significant dementia, he still enjoyed his time spent in religious services.

As the years passed, the man's physical condition worsened and he came much less often to the synagogue. Eventually it was determined that he needed dialysis three times each week to survive. The family was in a quandary. He had never signed an advance directive, nor had he ever told anyone in the family if he wanted to extend his life. Together with social workers and me, the family engaged in a long discussion about what to do. Would he have wanted to continue his life, albeit with dementia? The family had difficulty making the decision. Some said that as a religious man, he would want to prolong his life. Others felt he was too pragmatic and wouldn't want to live with dementia and ill health.

Finally, one of the nurses treating the patient mentioned that he had a permanent IV port inserted in his arm. On the basis of that fact, the family came to the conclusion that he would want to prolong his life. They began sending him for dialysis treatments three times a week. On the days when he didn't go, he would be brought to services. Although he had trouble focusing on the prayer book, he enjoyed hearing the words of prayer and even made up some of his own. When called for an *aliyah*,(3) he would recite the words loudly and clearly. Moreover, he enjoyed spending time with his family and friends, as well as residents and staff in the nursing facility.

In this case, the religious impulse to "preserve life" prevailed with the result that the patient continued to have a modicum of quality in his life. The family felt gratified that they could continue to visit, share music, and occasionally go to services with him.(4) [Note: Mr. T. died in 2011, with his family at his bedside. Because his condition had deteriorated, they once again had been presented the option of aggressive treatment. This time, however, they declined because those measures would not have added any quality of life, and probably would have prolonged his suffering.]

Who defines "dignity"?

Over the past 40 years, hospice care has become widely accepted as an alternative to aggressive treatment of a terminal illness. In my role as chaplain, I have sat with many residents or their families who have made the decision to provide only comfort measures during the patient's last days and hours. Often described as "death with dignity," this phrase has almost become a mantra among medical professionals for what *should be done* for all those with terminal illness. As the case of Mr. T, described above, illustrates sometimes it is not the appropriate choice. Another case which was recently presented to me further illustrates how the term "dignity" may be an elusive target.

Early in the morning of my first day back to work after the New Year's weekend, our medical director came into my office, clearly disturbed. Over the weekend, a patient (Mr. W.) with pancreatic cancer had been admitted to a heavy care unit. He had come to Maryland from Florida shortly after his diagnosis in early November. His son, who lives in a suburb of Washington, had tried to provide care in his home, but his medical issues were too complex.

Upon admission, the doctors and nurses had tried to broach the subject of hospice care, but Mr. W. refused to talk about it. He was adamant that he wanted aggressive treatment for his cancer. When they met with no success, the doctor asked if I would talk with him. His frustration was palpable. "This man should be getting his affairs in order!" he said. "He's with his wife, children, and grandchildren; he should be spending quality time with them!" I agreed to see Mr. W, and planned to visit in the afternoon. (In the intervening hours, I received similar requests from the director of nursing, the unit social worker, the attending nurse, and the unit's nurse manager!)

Later that afternoon, I had my initial conversation with Mr. W. I focused primarily on getting to know him. His wife was with him, but didn't enter the conversation. After a few minutes, his son came in the

room and asked to be allowed to discuss "important matters" with his parents. I took the cue and left, promising to return the following day.

When I returned, Mr. and Mrs. W. seemed more free to talk. The conversation went as follows:

Chaplain: How are you feeling?

Mr. W.: Well, I'm not in any pain, and I'm trying to decide the best treatment for my condition.

Chaplain: Please tell me more.

Mr. W.: Several professionals here are trying to persuade me to go on hospice, but I don't know what it entails.

Mrs. W.: Oh, please! I don't want to talk about it! (Her demeanor became very agitated.)

Chaplain (to Mr. W.): A decision to go on hospice doesn't mean you're giving up; you can opt for as much treatment you'd like. The main point is that you'll be in control of these decisions.

Mr. W.: Do you have some literature I could read?

Chaplain: Not with me, but I can get something and bring it back.

Mrs. W.: (Still agitated) Please, let's not talk about it. I can't bear to think about doing anything which could shorten his life.

Chaplain: Have you discussed this with each other?

Mrs. W.: Yes, we have, but I've made it clear that I don't want hospice. My sister tried to persuade me to put him on hospice, but I won't have it!

Mr. W.: I don't want to do anything to upset my wife. We've been married for many years, and we've never disagreed about any important matters. I don't want to start now. (At this point, Mr. W's son came in the room. As he had done the previous day, he asked to be alone with his parents; I left the room.)

Mr. W. seemed willing to entertain the idea of hospice, but Mrs. W. was clearly pre-disposed against it. If I had more time, I would have tried to explore the reasons behind Mrs. W.'s attitude. What was obvious, however, was that Mr. W. wouldn't deviate from the decision-making process he had developed with his wife. Seeing his wife get upset, he preferred to honor her thoughts and feelings, even if it meant going against what his care-givers had advocated. Unfortunately, I didn't have a chance to discuss the matter any further because Mr. W. had a seizure shortly after this discussion and was taken to a hospital. He didn't return to the Hebrew Home; we learned of his death a few weeks later.

As a healthcare professional, I believe strongly in the benefits of hospice and palliative care. As a chaplain, however, I had to respect Mr. W.'s concern for his wife and his desire to honor her feelings. From a strictly medical perspective, Mr. W. was probably opting for more pain and less dignity. On the other hand, it's possible that Mr. W.'s concept of dignity included living as he and his wife had done for many years.

It should be noted that no consideration of Jewish tradition entered these discussions. Based on Rabbi Breitowitz's position, the medical practitioners were probably correct in wanting to prevent Mr. W. from suffering. One can only speculate as to whether Mrs. W.'s

emotional demeanor, and Mr. W.'s wish to honor it, should have taken precedence over this worthy goal.

Pastoral Care for Nursing Staff

Even though physicians are responsible for residents' medical care, the nursing staff is more involved in the day-to-day decisions and care. Because of their close contact with residents, nurses can experience strong feelings of care and concern for the patients in their charge. This usually results in great dedication to their work. When they feel a patient's best interests are not being met, these same emotions can lead to frustration. At such times, they need a strong statement of support for their work and for their concern. The following case, involving conflict between nurses and a family member, will illustrate how the ethics committee can provide this important affirmation.

Mrs. B was an immigrant from the Philippines, in her nineties, greatly debilitated, and able only to speak a native dialect. Although many of the staff members speak Spanish, they were unable to communicate with the resident; instead, her granddaughter assumed the responsibility for communicating and translating for the staff. Even though Mrs. B's sons had medical power of attorney, the granddaughter (whose mother was deceased) was more involved in decisions about day-to-day care. She visited almost every day, while the sons came once each week, at most.

Over time, the granddaughter became very intrusive in the resident's care issues. She demanded that nurses respond immediately to her wishes, often accusing them of neglecting her grandmother. For example, she insisted that her grandmother be turned frequently while in bed, or weighed almost daily. The nurses were distressed, wanting to care for the woman, but also anxious not to be pulled away from caring for other residents by the granddaughter's demands.

The unit's nurse manager came to me, nearly in tears because of the situation. She said her staff was unable to function properly. She pointed out that objective criteria, such as the absence of bed sores and maintenance of body weight, indicated that Mrs. B had not been neglected. The granddaughter, however, would not desist in her demands, even when shown the data.

A case consultation was organized; the Mrs. B's sons were asked to attend. The granddaughter also came, bringing her own senior-care advocate. After all the data were presented, and all parties were allowed to present their concerns, the advocate told the granddaughter that she was not acting in her grandmother's best interests. The committee told the sons to become more involved in their mother's care.

The case consultation had affirmed the nurses' care for Mrs. B as well as the other residents on the unit. Word about the decision quickly spread among the facility's nursing staff. They realized the Ethics Committee was a forum where they could express their concerns and find needed support when they were facing difficult issues of care-giving; nurse managers from every unit now attend all quarterly meetings.

Issues Affecting Holocaust Survivors and their Families

Holocaust survivors in residential care facilities often relive many of the traumas they experienced in their younger years. In our facility, we've occasionally encountered issues that affect such residents, along with members of their families and staff entrusted with their care.

One case involved Mrs. A, a woman who had survived the Nazis' attempts to wipe out the Jews during World War II. She had immigrated to the United States, married and had a family. Now in her late 80's she was admitted to our facility for rehabilitation after a heart attack. Since she had an increased risk of further cardiac events,

her daughter was asked if she, as medical power of attorney, wanted to sign a DNR order. The daughter adamantly refused, claiming that since her mother had survived the Holocaust, she wasn't going to give up in the face of death.

Mrs. A's nurse manager and other staff felt that the daughter was not aware of the ramifications of her decision. They requested an ethics consult, at which time the case was thoroughly discussed. At that meeting, she once again stated her opposition to signing a DNR form. I explained that while we all respected her right not to sign the form, it was important that she understand that, because of her mother's frail condition, application cardio-resuscitation could result in cracked ribs, from which she would endure great pain. I asked if she was willing to commit her mother to the possibility of suffering without any chance of relief. After a couple of days, the daughter agreed to sign the DNR form. Fortunately, the mother was discharged before any additional events occurred.

Since many of the nurses in our skilled nursing facility come from Third World countries, few know details about the Holocaust. At a meeting of the Ethics Committee, they asked for more information about the events of that horrible time, and how they have affected not only the survivors but also their families. An adult child of a survivor was invited to speak to a subsequent meeting. He explained how he and his fellow "children of survivors" had learned to deal with the post-traumatic stress experienced by their parents, including issues of survivor's guilt, the trauma of remembering the witnessing of repeated beatings and public executions, and the lasting effects of malnutrition.

The nurses were very grateful for the information the man presented. However, one committee member realized that much more education was needed, and that one of the world's great resources--the United States Holocaust Memorial--was nearby and readily available. Tapping monies available in a fund for staff education, the facility organized a trip for 22 nurses to the Memorial, representing each

nursing unit and coming from a wide variety of countries-of-origin. A special docent was assigned to the group. Witnessing the photographs and graphic description of the persecutions, forced deportation, and dying (or living) in the concentration camps, the care-givers expressed greater sensitivity to what residents in their care had experienced.

Summary

In addition to offering guidance and advice, ethics committees in senior residential care facilities have the opportunity and the power to provide pastoral care for residents, family members, and staff. Unlike their counterparts in acute-care settings, members of these committees do not need to make major commitments of time and energy to participate. To the contrary, the experience at the Hebrew Home of Greater Washington indicates that quarterly meetings are sufficient for the committee's work; of course, there should be a mechanism for quick consultations, like the one our committee created.

Family members and staff should be notified and reminded frequently and regularly of the availability of the ethics committee for consultation. In addition, we have found it important that *all* staff, including GNA's and support staff, understand that anyone can come to the committee if he/she feel a resident's interests are not being served. While it may occasionally be necessary for the committee to impose a decision if disputing parties do not agree among themselves, meetings of the ethics committee should stress mediation, allowing those concerned to formulate a workable decision.

Finally, promoting a pastoral response to ethical issues sends a message: disputes in patient care need not result in irreconcilable anger and hurt feelings. Instead, ethics committees in senior residential care facilities, the institutions' principles and values, can demonstrate how to resolve such issues and, in the process, establish a model of sanctity for the entire community.

Endnotes

1. This article appears in slightly altered form in *Flourishing in the Later Years: Jewish Pastoral Perspectives on Senior Residential Care*, (2nd edition), James Michaels and Cary Kozberg, eds., Mazo Publishers, Jerusalem, 2011.
2. In 2006, the name of our facility was changed to the Charles E Smith Life Communities, but it had been known as the Hebrew Home since its founding in 1910. I am indebted to my predecessor, Rabbi Seymour Panitz, for information in this section of the article. The first full-time chaplain of the Hebrew Home, he was witness to the formation of many aspects of our mission. I wish him and his wife Barbara many more years of life and good health.
3. Literally "to go up". An *aliyah* refers to the honor of being called to say the blessings before and after a part of the Torah is read during a worship service.
4. Some situations present even more difficult dilemmas for Jewish chaplains, particularly with regard to role-definition. Cf. Ephraim Karp, "Ethical Considerations in Chaplaincy" *National Association of Jewish Chaplains* Newsletter, Kislev 5771/December 2010.

Pastoral Nurture of the Elderly: The 'Happy Memory' in Geriatric Logotherapy

John H. Morgan

Logotherapy is a type of psychotherapeutic analysis and treatment which focuses on a *will to meaning*. It is founded upon the belief that striving to find meaning in one's life is the primary, most powerful motivating and driving force within the human experience. Sometimes called existential analysis (Frankl, 1967; 2004), logotherapy is the Third Viennese School of Psychotherapy founded by Viktor Frankl, the first and second schools were founded by Freud, called psychoanalysis, and Adler, called individual psychology (Frankl, 1963; 1969; 1997; 2001). In recent years, Victor E. Frankl has emerged as the leading proponent in psychotherapeutic circles of the centrality of the experience of "meaning" in mental health (Frankl, 1962a). Pastoral Logotherapy is the application of logotherapeutic analysis and treatment within the context of a spiritual understanding of the human situation and its relevance to mental health. Though not specifically faith-based, pastoral logotherapy is practiced within the context of a spiritual awareness of self-transcendent reality (Graber, 2004). Geriatric Logotherapy, then, is a sub-set of this analytical approach designed to address issues uniquely confronted in the pastoral encounter with the elderly.

According to Frankl, life has meaning under all circumstances, even in the direst situations. "What matters is not the meaning of life in general," Frankl suggested "but rather the specific meaning of a person's life at a given moment." Meaning is not "invented" but rather "detected," he points out. We can discover meaning in life in three different ways: (1) by doing a deed; (2) by experiencing a value

– nature, a work of art, another person, love, etc., and (3) by suffering. Frankl discounts the effective utility of the Second Viennese School of Psychotherapy, i.e., Alfred Adler and his notion of humankind's "will-to-power," by arguing that personal power in the face of suffering and in the absence of personal meaning has no visible function within the personality (Frankl, 1962b).

A concept of humanity is held, consciously or not, by every school of psychotherapy (Morgan, 2012). We see it in Freud, Adler, and Jung, and so likewise with Frankl. That concept of the human person, suggests Frankl, affects everything, all conceptual development, all theories of treatment, all clinical perceptions. Resulting from his wartime concentration camp experience, Frankl became convinced of the *sui generus* nature of the will-to-meaning, what he later developed as logotherapy (Frankl, 1958). We must elevate this concept of the person for critical analysis from the logotherapeutic perspective if we ever hope to understand the differences in psychotherapeutic modalities of treatment. "For," explains Frankl, "a psychotherapist's concept of man … can reinforce the patient's neurosis and, therefore, can be wholly nihilistic." For Frankl, there are three fundamental characteristics of human existence which converge to define the human person, namely, spirituality, freedom, and responsibility. This tripartite foundation inevitably affects every attempt to understand who we are and what we are to do. Frankl labored hard and long for a philosophical structure to logotherapy, believing that any model of psychotherapeutic analysis and treatment must have a strong philosophical basis (Frankl, 1961b).

Neither a proponent nor an opponent of a faith-based worldview *per se*, Frankl simply intends for spirituality not to be tied up with a specific notion of religion. Where faith helps a person through the day, Frankl has no objection to it. Where religious worldview and ethos stifle, cripple, or delude an individual, Frankl is opposed to it. What Frankl means by "spirituality" as a fundamental component of human nature is man's capacity for a sense of awe, wonder, and

mystery, even reverence, in one's assessing the meaning, value, and purpose of one's own personal life. The surprising feature about Frankl's psychotherapeutic formulations is that throughout he consistently makes inferential comments about the religious dynamic operative in his own theory while constantly omitting any specific reference to its fundamentally Jewish character (Frankl, 1957; 1961a). The connectedness of all things as experienced in moments of high sensitivity or even ecstasy is the role spirituality plays in the human character. A deeply felt sense of beauty, power, and wonder in the universe, a heightened experience of integrality, what I have in another place chosen to call "systemic integrality," constitutes what spirituality means in logotherapy (Morgan, 2009). "By helping prisoners then and patients later remember their past lives – their joys, sorrows, sacrifices, and blessings – he emphasized the "meaningfulness" of their lives as already lived (Frankl,1954)." Whether one is a theist, an atheist, or an agnostic, Frankl contends that the dynamics of spirituality can be equally and meaningfully operate within a person's life bringing value and purpose.

Complementing this sense of spirituality within the logotherapeutic model is a freedom which functions in the face of three things: (1) the instincts; (2) inherited disposition; and (3) environment. Frankl engages in a long and definitive discussion of freedom in his celebrated classic, *The Doctor and the Soul*, owing no doubt to his own personal encounter with the existential vacuum during his trying experiences in captivity. The converging of these three components of instincts, heredity, and environment constitutes the matrix out of which the human experience of freedom can grow and thrive in a person's life. To rise above one's instincts, says Frankl, is a distinctively human possibility and, unlike Freud's obsession with the power of instincts governing human behavior, Frankl specifically calls upon the responsible person to take his instincts in hand, use them but control them, for service to others. Likewise with heritage, one cannot deny one's own genetic

composition but in the acknowledging of it one asserts power over its domination. A determinist, Frankl was most certainly not. He believed in the human person's ability to respond responsibly to self-knowledge. He emphasizes not only the recollected past, but calls attention to the existential meaningfulness of suffering and tragedy in life as testimonies to human courage and dignity (Frankl, 1961c). By knowing one's instincts and one's genetic heritage comes a source of strength and power to control, direct, and utilize the primordial nature of these characteristics for the good of self and humanity.

Finally, Frankl was not a member of the "nurture" crowd of behavioral psychologists who would attribute, even blame, one's social and physical environment for the way individuals turn out in their maturity. These three fundamental components of freedom, namely, instincts, heritage, and environment, may be used by the human person to realize freedom if he becomes aware of them, embraces them, and directs them towards a meaningful purpose in life. In logotherapy, Frankl differentiates meaning and values. Values are socially held meanings whereas "meaning as the *sine qua non* of life is a unique experience and possession of every single individual in every moment of one's own life (Frankl, 1961d)."

Besides spirituality and freedom, however, there is responsibility. Having been greatly influenced in his formative years with the writings of the existentialists, not least being Kierkegaard, Sartre, and Heidegger, Frankl was most insistent that in order for a person to be fully human, he must exercise responsibility. The individual is responsible to his own conscience first and foremost, says Frankl. Conscience, he suggests, is a "thing in itself," it is *sui generis*. It is so fundamental to the human person that humanity cannot exist without it nor the human person remain human without it. Conscience has to do with the drive to do the right thing because it is the right thing to do. This is so fundamental to the human experience that without it neither humanity nor civilization itself could exist. Of course, the "origin" of conscience is a point of controversy and contention within

the various schools of psychotherapy and depth psychology. The three schools of thought regarding the origins of ethics and moral behavior I have discussed at length elsewhere, first in my book *Naturally Good: A Behavioral History of Moral Development* (2005), and more specifically the three school as Ethical Theism, Ethical Humanism, and Ethical Naturalism in my book *Beyond Divine Intervention: The Biology of Right and Wrong* (2009).

More so with Frankl than with any other psychotherapist, the personal life story of each individual proved to be a major factor in the development of his own therapeutic system of theory and practice. Frankl contended that this will-to-meaning – as Freud argued for "pleasure" and Adler for "power" – pervades every secret recess of one's personal life. Meaning, he pointed out, can be found in any situation within which we find ourselves (Frankl, 1953). Freud's life, Adler's life, and Jung's life have all proven interesting and have in their own way shown how their life and work were integrated. But with Frankl, it is inconceivable to imagine logotherapy as a school of thought being produced in the absence of his concentration camp experience. The viability of his theory and the utility of his clinical practice both rely upon the life history of its creator. Frankl's relevance to contemporary treatment in therapeutic settings is becoming increasingly recognized and appreciated within a broad spectrum of clinical practice. The impact of his therapeutic system of theory and treatment has yet to reach its maximum level of influence in contemporary counseling circles but the establishment of the Graduate Center for Pastoral Logotherapy at the Graduate Theological Foundation under the direction of Dr. Ann Graber (Graber, 2004) constitutes a major leap forward in this development.

When logotherapy is applied to the geriatric patient, there is a challenge to transform the central concepts of the therapeutic practice to the life situation of the individual whose life has, for all practical purpose, already been lived. Believing that logotherapy has, indeed, something yet to offer the geriatric patient, it is imperative that the

"will to meaning" not be only thought of as an agenda for future living but as a hermeneutic for "living in the moment." Existential episodes of happiness constitute what the clinician might imagine to be the practical application of logotherapy in dealing with older and elderly individuals (Morgan, 2006). Rather than seeking for that window of hope for the future which is so characteristic of this modality of therapeutic practice, the logotherapist must creatively search for "existential episodes of happiness," as I have chosen to call them, (i.e., remembered events in which the older person demonstrably attributes the experience of "happiness"). This approach, rather than focusing upon hope, focuses upon memories, times past which bring a moment of reflective happiness now. The existential character of the remembered happy event constitutes the possibility for a treasure trove of episodic happiness vignettes bringing comfort to the elderly facing a limited future.

Illustrative of this existential moment or window of happiness is the case of Mrs. Williams, a nursing home patient in her mid-80s suffering from acute and near debilitating depression. Other complicating health issues included high blood pressure, diabetes, and arthritis. A retired librarian for some twenty-plus years, Mrs. Williams came to the nursing home after falling in her home where she lived alone. The decision was made for institutional care in conjunction with family members (all distant cousins as she was widowed with no children). In meeting with her over several sessions, the therapist struggled with finding the "door of happy memories" through which to follow Mrs. Williams. Finally, during the third clinical session, some passing reference was made to her childhood farm life and swimming with her girlfriends in the cow pond behind the barn. As this passing reference seemed to cause her to pause and smile as she was formulaically reciting her "life's story" to the therapist, it became clear to the observing therapist that she enjoyed the memory and might enjoy elaborating upon it. The result was a meandering recollection of her childhood experiences with her

friends on the family farm which, she said, "I haven't thought of in years." Subsequent sessions always harped back to these happy memories and provided a substance to her solitary reflections beyond the therapy sessions.

Often, the geriatric patient needs assistance in conjuring these past episodes of happiness and the therapist then can employ what I have chosen to call "memory suggestions," (i.e., asking the individual to back track consciously in search of "illustrative events" in his or her life to which they themselves attribute a blissful and happy experience). However, an important key here for the therapist to keep in mind is "stress avoidance," that is, redirecting the individual away from remembered events in their past which clearly, by facial expression or voice intonation, suggest stress or anxiety or unhappiness (Morgan, 2010). Family history is quite frequently the source of these happiness episodes but the therapist is advised to watch carefully lest the family history stories drift downward into negative memories.

It is crucial that the therapist keep in mind the logotherapeutic agenda lest one imagine that the purpose and goal of the therapeutic session is to search out the "meaning and purpose of life" yet to be lived. With the older and elderly patient, the acutely practical nature of the existential utility and viability of therapy must always be kept in the forefront of the therapeutic encounter when employing logotherapeutic analysis. Though sometimes a challenge in dealing with the elderly (geriatric dementia often manifests itself in the individual's disinclination to converse), the therapist must employ what I have chosen to call "points of conversation" as an impetus and incentive for the geriatric patient to engage the therapist in the quest for existential episodes of happiness (Morgan, 1987). Places, times, and people constitute for me the three fundamental arenas within which the patient may find these points of conversation leading to the "discovery" and "revisiting" of happiness episodes in their earlier life.

Another example of geriatric logotherapy is the case of Dr. Watson, a retired philosophy professor living alone in his home as a widower with two adult children living far away. Dr. Watson is in his late 80s, was once a nationally recognized scholar, author of several books, but these days finds reading increasingly difficult owing to glaucoma and writing virtually impossible due to arthritis in both hands. Reduced to sitting on his expansive front porch when weather permits and before the fireplace otherwise, Dr. Watson has sunk into a debilitating depression resulting in a consistent failure to eat regularly or to converse over the phone with friends and family. A concerned son precipitated the contact with a logotherapist who made an initial home visit, finding the above situation. Dr. Watson had essentially "given up," as he put it, because of an inability to read or write, his life's work and passion. When the therapist encouraged the professor to "tell me about your life's work," Dr. Watson commenced slowly and deliberately rattling off his educational background, teaching appointments, books written, conferences attended, all with little passion and near expressionless. However, when the therapist asked about specific colleagues mentioned in the monotone narrative, he noticed that the patient became somewhat animated, enthusiastic, even excited to relate story after story involving colleagues, happy stories, fun stories, all leading to an extremely productive journey through time and people of importance. Subsequent sessions centered upon the same topics with the results that Dr. Watson began calling old friends, inviting other retired colleagues in town to come for morning coffee and chat. The door of happy memories had been opened and entered and Dr. Watson's life took on renewed vitality.

One of the greatest challenges for the logotherapist is to acknowledge and own the inevitable reality of the brevity of life left to the elderly patient. The therapeutic goal here is clearly not some form of contrived "cure" for what might be the presenting symptoms of depression which is most commonly the driving force in seeking help for the patient either by the patient or the family or residential

institutional staff responsible for caring for the patient. A cure certainly is not what is sought here, but rather, beyond and after the notion of a cure for the aged patient, there is an urgent need for the identification of the "rightful place for palliative care" in such situations. A quest for existential happiness, episodic joy from happy memories, constitutes the driving force in the therapeutic encounter with the geriatric patient who most commonly is suffering from depression.

A concluding illustration of the value of geriatric logotherapy and its use in existential counseling is the case of Miss Horton, an elderly spinster school teacher from a small town, whose life had been synonymous with teaching elementary school children, living in the background, watching them grow up, move away, establish families, and launch careers. Now nearly 90 years old residing in an assisted living facility in her little town, she had drifted into depression owing to a lack of social stimulus (most other residents were suffering from acute and severely debilitating geriatric dementia). Her health had declined gradually owing to heart problems and toward the end of her life she had taken to the bed and was less and less willing to converse, even with the nurses. The nursing director called in the logotherapist (based on the therapist's reputation in dealing with geriatric dementia) and from the beginning the initial encounter was fruitless, bordering on hopeless. As the therapist explored Miss Horton's social life through interviews with nursing staff who knew the patient's personal history and in the therapist's search for the "magic door" that would introduce happy memories and reflective thoughts of joys gone by, it occurred to him that since her life had been lived for the children she taught, why not get some of those children, now adults, to come say goodbye to her in her closing days of life. It worked wonders. Through the local school, the therapist was able to contact several of her past students, now parents and successful people, to come for a visit. Since most people are uncomfortable visiting someone on their death bed, the therapist always arranged to be present, coaching the

visitor to help Miss Horton "remember" episodes in the classroom and on the playground in which she was a major player and to share with her, as she lay mute but alert, the stories of their own lives as they left school and entered the world, always with reference to her contribution to their own personal lives. The results were remarkable, not that she lived much longer, for she did not, but during the closing weeks of her life, she became conversant, sitting up in bed, asking about this student and that student, remembering to the therapist more and more "happy moments" in her teaching life that brought a twinkle to her eyes and a smile on her face.

The practicality and professional humility of Viktor Frankl is evidenced in his quick and ready willingness to acknowledge the therapeutic limits of logotherapy, never claiming it to be a comprehensive analytical modality for all types of mental illness. Unlike other schools of thought which too frequently presume to be the panacea for all mental disorders, logotherapy has self-consciously identified its arenas of success and knows those in which it has little or no value. The distinctions center around psychogenic and biogenic classifications. Certainly and with little contradiction, logotherapy has a long clinical history of effective use in the treatment of psychogenic depression. When applied to the treatment of the elderly, not as a curative but as a palliative therapy, there is a promise of great success. When it is not hope for the future which is being sought but rather an effective and celebrative address to the existential realities confronting the elderly patient who is facing decline and death, the quest for those "happy moments" conjured in the patient's memory constitute a promising field of treatment. Geriatric logotherapy is uniquely constructed to do just that.

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III. A Tribute to Carl Rogers

John H. Morgan

On Becoming a Person (1961)
Carl Rogers' Celebrated Classic *in Memoriam*

Carl Rogers (1902-1987), though he wrote much and often, established himself on the basis of two major works, namely, *Client-Centered Therapy: Its Current Practice, Implications, and Theory* (1951) and *On Becoming a Person: A Therapist's View of Psychotherapy* (1961). Roger's first and overriding characteristic in the writing of his first major book was to emphasize the warmth and acceptance of the counseling relationship between the counselor and the client. His first major book was meant to emphasize the new rationale of his approach, namely, "The client, as the term has acquired its meaning, is one who comes actively and voluntarily to gain help on a problem, but without any notion of surrendering his own responsibility for the situation" (1951:17). From non-directive counseling to client-centered counseling to, finally, person-to-person therapy, Rogers' thought has continued to grow and expand. Yet, his initial entry into the cauldron of psychotherapeutic theorizing in his first book (1951) to his major opus of 1961 finally culminating in his later work all bespeak of his capacity to grow through learning in the clinical environment. He gradually came to realize that the relationship between therapist and client is the most important aspect underlying personality change. Herein lay his interest and this is where he concentrated the bulk of his entire career (1942).

Rogers brought to the psychotherapeutic table a new way of

seeing the counselor's role in relationship to the client (1980). He suggested that the emphasis shift should be from an objectified standoffish posture to an empathic approach in understanding the client's world, and then the therapist should seek to communicate that understanding directly to the client. In mirroring back to the client the feelings the counselor pick up on in the interview encounter, the counselor simultaneously transmitted the desire to perceive the world as the client perceives it, thus, leading to the role of non-directivity in the dyadic relationship. Rogers insisted that the counselor's role was to achieve an internal frame-of-reference with the client. "It is the counselor's aim," says Rogers, "to perceive as sensitively and accurately as possible all of the perceptual field as it is being experienced by the client … and having thus perceived this internal frame of reference of the other as completely as possible, to indicate to the client the extent to which he is seeming through the client's eyes" (1961:43)

In this new psychotherapy, Rogers emphasized four important principles. First, the new therapy "relies much more heavily on the individual drive toward growth, health, and adjustment. Therapy is not a matter of doing something to the individual, or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development" (1961:59). Second, "this new therapy places greater stress upon the emotional elements, the feelings aspects of the situation, than upon the intellectual aspects." Third, "this new therapy places greater stress upon the immediate situation than upon the individual's past." And, fourth, this new approach "lays great stress upon the therapeutic relationship itself as a growth experience.

Here, explains Rogers, "the individual learns to understand himself; to make significant independent choices, to relate himself successfully to another person in a more adult fashion." Rogers firmly believed that individual, by and large had it within themselves to solve their own problems (1967b). The task, then, of the therapist

in Rogers' view was to establish the conditions which would allow individuals to attain this insight for themselves. Attainment of insight was, therefore, one of the key goals of nondirective therapy. On the other hand, the counselor's chief task was to reach the "clarification of feelings" through rephrasing the emotional content of the client's statements such that the client gains a new insight into his own stated condition. "Effective counseling," says Rogers, "consists of a definitively structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation" (1961:31).

The three major elements characterizing Rogers' theory of personality were (1) the necessity for the counselor to provide a warm and permissive relationship for the client, (2) the necessity for the counselor to assume the internal frame of reference of the client and to communicate empathic understanding of the client's world, and (3) finally, to reach a mutual expression of feelings between the client and the counselor thereby realizing the full potential of the client-centered theory of personality and psychotherapeutic treatment. Rogers identified six conditions of client-counselor relationships which, if met, would constitute the basis for a successful therapy (1967a).

Rogers believed he had already proven clinically that a theoretical rationale for personality change in therapy was possible which implied that constructive alterations in personality could occur regardless of the specific verbal techniques employed by the counselor. He recited these six conditions to reinforce his theory. First, two persons are in psychological contact such that each of them is fully aware that the other's presence makes a difference. Second, the client is in a state of incongruence in relationship with the counselor due to a discrepancy between the client's self-image and his existential experience in the counseling environment. Third, the therapist is, on the other hand, congruent (which means integrated) in

the relationship due to the pre-set definition of his role in the situation. Fourth, the therapist experiences unconditional positive regard for the client as this is crucial in order to establish a meaningful relationship in the counseling milieu. Fifth, the therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client such that the encounter proves therapeutically successful in direct correlation to the therapist's capacity to emote empathy. And, sixth and finally, the communication to the client of the therapist's empathic understanding and unconditional positive regard must be minimally achieved or, otherwise, no helpful therapeutic result will occur.

Rogers was a conspicuous member of the Third Force, the humanistic school of psychology which set itself vis-à-vis both to psychoanalysis and to behaviorism (Maslow, 1968; 1976). His understanding of human nature was, of course, central to his position as a leader in the Third Force movement. He speaks of the driving force in his work which is "the continuing clinical experience with individuals who perceive themselves, or are perceived by others to be, in need of personal help." "Since 1928, for a period now approaching thirty years," he wrote in 1958, "I have spent probably an average of 15 to 20 hours per week, except during vacation periods, in endeavoring to understand and be of therapeutic help to these individuals. From these hours, and from my relationships with these people, I have drawn most of whatever insight I possess into the meaning of therapy, the dynamics of interpersonal relationships, and the structure and function of personality." Rogers firmly believed that at their core, every human being is fundamentally good, being essentially purposive, forward-moving, constructive, realistic, and trustworthy (Morgan, 2011a). Because of this essential goodness of the human person, every individual, given the right opportunity for growth, love, and affirmation, will blossom forth in his own innate potential, optimum personal development and effectiveness (1951).

Christianity, Rogers argued, has nurtured a core belief in the innate evil of the human person, an inclination to evil and sin. Furthermore, he is unabashed in arguing that this demented notion of human nature has been influenced, even trumped, by Freud and the psychoanalytic school of psychotherapy. If permitted to run free from the scrutiny and domination of the ego and the superego, the human personality's unconscious id would manifest itself, according to Freud and Christians, in incest, homicide, thievery, rape, and other horrendous acts of self-destructive behavior (1980). People do engage in such behavior and this occurs when they have been stifled, been misdirected, or their natural personality development has been suppressed from its natural inclinations. When, however, people are able to function as fully human beings, when they are free to experience and express themselves, they show a positive and rational approach to life which elicits trust and nurtures harmony in interpersonal relationships.

Rogers protested against those cynical and jaded psychotherapists and theologians who thought of him as naïve and simplistic: "I do not have a Pollyanna view of human nature," he argued. "I am quite aware that out of defensiveness and inner fear individuals can and do behave in ways which are incredibly cruel, horribly destructive, immature, regressive, anti-social, and harmful. Yet, one of the most refreshing and invigorating parts of my experience is to work with such individuals and to discover the strongly positive directional tendencies which exist in them, as in all of us, at the deepest levels" (1977). This driving force in human nature towards the good and self-fulfilling he calls the actualizing tendency, and he believes it is latent in every human being. He defines it as "the inherent tendency of the organism (the personality) to develop all its capacities in ways which serve to maintain or enhance the person." Therefore, he says, the fundamental principle guiding every person's life is the drive to actualize, maintain, or enhance themselves, indeed, to become the best that their inherited natures will permit them to be. This is,

essentially, the sole motivating principle in Roger's theory of personality (1954).

To be sure, there are certain definitive characteristics which establish this actualizing tendency. Let us explore them momentarily here. Of course and to begin with, says Rogers, there is a biological factor which is operative here, namely, this tendency is an inborn characteristic necessary to maintain the individual but also for the enhancement of the individual by providing a mechanism for the development and differentiation of the body's functions, growth, and development. But, of more importance than even this is the motivating force which the actualizing tendency provides for in increased autonomy and self-reliance in pursuit of the individual's full potential in life. Furthermore, the actualizing tendency is not merely for the reduction of tension in the stresses of one's physical or biological life, contrary to Freud's insistence on the prominence of instincts. Rather, the individual is motivated, says Rogers in an earlier work, by a growth process in which potentialities and capacities are brought to realization (1942). This actualizing tendency, then, he says, "is the essence of life itself."

The actualizing tendency, explains Rogers, serves as a criterion against which all of one's life experiences are evaluated and, particularly, when individuals engage in what he calls the "organism valuing process." This process involves the individual's overt effort in maintaining and enhancing the sought after and valued positive behaviors and experiences in life for they produce within the individual a strong feeling of satisfaction in the realization of one's full potential. This process is a mechanism for the evaluation, the weighing, the determining whether or not an experience is affirmative or negative to self-fulfillment (1946). And, the most critical aspect of this actualizing tendency, says Rogers, is the individual's drive toward self-actualization, what he has called the "self-actualizing tendency." This particular tendency, then, is what gives a forward thrust to life, to the individual who must encounter and incorporate

life's complexities, as well as its self-sufficiencies and its maturation processes. Self-actualization, then, is the process of becoming a more adequate person.

Rogers counted himself among the phenomenologists of the day who were practicing humanistic psychology as members of the Third Force (Morgan, 2010). The Third Force was never a formal body but consisted of humanistic psychologists who pushed their worldview as a viable alternative to Freud and Skinner, or psychoanalysis and behaviorism, in both theory and practice (1968). Phenomenological psychology contends that the psychological reality of the individual's world is exclusively a function of the way in which the world is perceived by that individual. The truth does not really matter because it can never really be identified. What really matters to the individual is what that person thinks is true, sees to be true, acts in relationship to what he sees and thinks to be the truth. Phenomenological psychology argues that what is real to an individual, that is, what reality is thought, understood, or felt to be, is that which exists within that person's internal frame of reference. It is this frame of reference which is important in the psychotherapeutic relationship. Rogers was insistent upon this point, namely, that every individual interprets his world and that interpretation is that with which the therapist must come to grips. The only way to understand an individual's behavior and attitude is to come to an understanding of this internal frame of reference. It is the subjective reality of the client's perceived world which is important, not the objective truth (Morgan, 2011b).

Needless to say, Rogers' identification with the phenomenological approach to personality theory is based upon his strong conviction that the complexity of human behavior can only be understood within the context of the whole person. His emphasis upon the holistic view of personality, namely, that the person reacts as an integrated organism and that his unity cannot be derived from mere behaviorism, is at the core of his therapy. It is the self which constitutes the focus of his analysis for it is the fundamental center of

human personality. His theory of personality development is based upon this conviction (1961). "The self, or self-concept," says Rogers, "is defined as an organized, consistent, conceptual gestalt composed of perceptions of the characteristics of the 'I' or 'me' to others and to various aspects of life, together with the values attached to these perceptions. It is a gestalt which is available to awareness though not necessarily in awareness." The self-concept is comprised of (1) what the individual thinks he is, (2) what he thinks he ought to be, and (3) and the ideal self or what he thinks he would like to be. This tripartite composition of the self constitutes the core of Rogers' personality theory.

Rogers does not believe that the self *per se* manages and monitors the individual's behavior but rather it symbolizes the individual's conscious experiences of the world – who he thinks he is, who he thinks he ought to be, and who he thinks he wants to be. He discounts, not the reality of unconscious data, but its relevance to the individual's self-concept and its viability in the therapeutic situation for it is the individual's own self-understanding, as he explains it, describes it, characterizes it, that is important therapeutically. Phenomenology trumps unconscious data as the basis for psychological therapy, says Rogers, for the structure of the self is formed through the individual's interaction with the familial, social, and cultural environment (1951). The "content of one's self-concept," argued Rogers, "is fundamentally a social product and not the result of the bombardment of the psyche with unconscious and repressed data."

Therefore, there are identifiable components needed for the development of a healthy self-concept and when they are absent or twisted from experience, the individual suffers. First, Rogers suggests that every person has a basic desire for warmth, respect, admiration, love, and acceptance from people important in his life. He calls this the "need for positive regard." Whether innate or socially learned, this drive is strong from the earliest days of

childhood (1969). Rogers believes a person, whether infant, child, adolescent, or adult, will do almost anything to meet this innate need for positive regard. There is a reciprocal component to this drive as well, namely, in the giving of this positive regard, one receives it in turn. The reciprocity of positive regard is a strong re-enforcer of social relationships. The self, says Rogers, is profoundly influenced by this need and rather than suggest that individuals are driven to satisfy the demands and expectations of their self-concept, he argues that people are driven to satisfy their need for positive regard, both to give it and to receive it. Where there is a conflict between what the individual's wants in service to his self and what he recognizes as in service to his need for regard, Rogers calls "incongruence." "This, as we see it, is the basic estrangement in man. He has not been true to himself, to his own natural organism valuing of experience, but for the sake of preserving the positive regard of others has now come to falsify some of the values he experiences and to perceive them only in terms based upon their value to others" (1961:89). The internal conflict, that is, incongruency, is the result of the individual choosing to service his need for positive regard at the expense of serving his own self's perceived personal needs. The conflict often leads to psychological stress, tension, and mental illness. "Yet," Rogers continues, "this has not been a conscious choice, but a natural – and tragic – development in infancy. The path of development toward psychological maturity is the undoing of this estrangement in man's functioning as the achievement of a self which is congruent with experience, and the restoration of a unified organism valuing process as the regulator of behavior." Too often, it is the people pleaser who emerges from this incongruity, the individual who is so drives to please the other person that he forgets to please himself in the process (1981).

Within the context of self-concept development within every individual from childhood is the presence of what Rogers called "conditional positive regard," namely, that situation in the family and

society in which the individual is the recipient of positive regard only so long as that individual conforms to the expectations of the positive regard provider. In other words, positive regard is contingent upon compliance with outside expectations of family and society members. "I will love you so long as," or "only if" situations constitute conditional positive regard. This situation, Rogers believes, is detrimental to the child becoming a fully functioning and self-actualized individual (1972). The child, and eventually the adult, relinquishes ownership of his own needs and desires in order to conform to the conditions laid out by the parent, the family, and society for the giving of positive regard. The individual runs the serious risk of "losing himself" to himself in the process of conforming to the conditions established by others for the giving of positive regard. This condition of worth is compliance with the expectations of others, regardless of one's own sense of what is valued. This was painfully true in Rogers' own personal life as a child raised in an extremely restrictive religious home environment (Kirchenbaum, 1979).

To counter act the mental health dangers of conditional positive regard, Rogers developed the concept of unconditional positive regard, and this concept characterizes all of his psychotherapeutic practice and theorizing about psychological treatment. In light of his own childhood experience, Rogers developed this concept as a counterpoise to the detrimental character of the conditions of worth operative in conditional positive regard. He believed strongly that it is possible to give and receive positive regard without attaching it to behavioral compliance. Positive regard can be given to individuals in situations where the behavior of the other individual is not necessarily to the liking of the positive regard giving individual (1970). This requires every individual to be accepted and respected for who and what they are, without conditions of ifs, ands, or buts. Such unconditional positive regard is most evident in a mother's love of a misbehaving child. Parental love is not, then, given to the child when

and only when the child conforms to the parents' behavioral expectations but love, positive regard, is given unconditionally. Rogers was quick to criticize the Christian saying from Jesus, "You are my friends if you do what so ever I tell you." This is conditional worth, not love, and it can be, and usually is, damaging to the child as well as the adult.

Rogers believes that if children were raised in the unconditional positive regard familial environment, "then no conditions of worth would develop, self-regard would be unconditional, the needs for positive regard and self-regard would never be at variance with organism evaluation, and the individual would continue to be psychologically adjusted, and would be fully functioning. This chain of events is hypothetically possible, and hence important theoretically, though it does not appear to occur in actuality" (1969). Discipline is not absent from the family environment, but the circumstances under which it is used and understood by child and parent are radically different because it is disassociated from self-worth. The creation of an unconditional love atmosphere provides the mechanism for a positive use of discipline wherein the child can grow into a fully functioning and potentially self-actualized person with a deep and unchallenged sense of self-worth.

Growing out of Rogers' understanding of the nature of the experience of incongruity were the experiences of threat, anxiety, and defense. These three very common experiences are all interrelated and are manifested in the presence of the individual's awareness or lack of awareness in an incongruous situation. Every individual strives for what Rogers calls "consistency in behavior," attempting at all times to keep an even keel in interpersonal relationships based upon the individual's self-concept. Where there is an incongruity between the individual's self-concept and the social situation making demands upon him inconsistent with his idea of himself, that individual feels a threat. The threat in Rogers' theory occurs when a person recognizes an incongruity between his self-concept and its

corollary condition of worth and the experience which precipitates the incongruity. This threatening situation is not always self-evidently conscious but the individual feels anxious by the encounter (1946). Whenever this experience of incongruity exists in the individual's encounter where self-concept and outside experience are at odds, the individual feels a sense of vulnerability and often personality disorganization. Anxiety is, then, an emotional response to a threat to the individual's self-concept such that there is real danger of a debilitating discrepancy between the person and the situation.

When this situation arises, namely, a perceived conflict between self-concept and objective situation, the individual attempts to protect himself by the use of a defense mechanism. The process of defense, explains Rogers, is the behavioral response of the individual to the threat and the goal is for the reestablishment and maintenance of the self-concept. "This goal," Rogers continues, "is achieved by the perceptual distortion of the experience in awareness, in such a way as to reduce the incongruity between the experience and the structure of the self, or by the denial of any experience, thus denying any threat to the self" (1961:107). The production of defenses, then, is the individual's primary method of protecting himself, his self-concept, and his self-worth.

These defense mechanisms are of two kinds, says Rogers. There is the perceptual distortion and the denial. The first occurs when an incongruent experience is allowed into an individual's perception but only in a form that makes it consistent with that individual's self-image and not something alien to his own experience. Thus, when an experience occurs challenging the individual but not outside the sphere of possibility, that individual employs a defense mechanism to explain the distortion in the experience rather than denying its reality. This occurs when someone is caught stealing when that individual is aware that even though he is not habitually a thief it can, does, and might happen that he takes something that is really not his. This often occurs with employees of a company who help themselves to various

items, aware that it is theft, but explaining to their own satisfaction that it is acceptable behavior. This, Rogers calls, "rationalization." Perceptual distortion produces rationalization thereby allowing an individual to maintain his self-concept without any or much jeopardy. However, in the case of denial as a defense mechanism, the individual attempts to protect their self-concept by simply denying that the situation of incongruity has occurred (1939). When this defense mechanism, much more so than the previous one, is permitted to reign in a person's life, there is grave potential for the development of mental illness.

Throughout his writing career, Rogers made much of what he called the good life in which he used a specific term for that experience, namely, the fully functioning person. The good life, for Rogers, is not a static state of experience, but a process, a direction, a way of living and comporting oneself through all of life's trials and tribulations. The good life "is a process of movement in a direction which the human organism selects when it is inwardly free to move in any direction. The general qualities of this selected direction appear to have a certain universality," Rogers contends, and "the person who is psychologically free moves in the direction of becoming a more fully functioning person" (1961:79). There are five major personality traits of such individuals and we will recite them briefly here: (1) Openness to experience (wherein the individual is not temperamentally closed to new situations, encounters, opportunities, challenges), (2) Existential living (wherein the individual is ready and willing to face whatever may come his way with hope, courage, and fortitude), (3) Organismic trusting (wherein the individual has confidence in his ability to make sound decisions and to act upon them with assurance of their wisdom), (4) Experiential freedom (wherein the individual embraces the possibilities of life without false or shallow constraints superimposed by family and society but with a willingness to explore possibilities for living), and (5) Creativity (wherein the individual is fully at liberty to venture into new realms

of experiential living and expressiveness of life's possibilities). "The good life," Rogers expounds, "involves a wider range, a greater richness, than the constricted living in which most of us find ourselves. To be a part of this process means that one is involved in the frequently frightening and frequently satisfying experience of a more sensitive living, with greater range, greater variety, greater richness" (1977).

The juxtaposition of Rogerian psychology and that of Freud and Skinner is most profoundly realized in their differences over the nature of the human person. The Third Force school of humanistic psychology was intentionally launched to counter the negativity and pessimism of both Freud's determinism and Skinner's behaviorism (Maslow, 1976). Eight distinguishing traits are counterpoised in these schools of thought with Rogers and the phenomenological humanists on the one hand and the psychoanalysts and behaviorists on the other. First is that of freedom versus determinism, with Rogers strongly for the former and Freud and Skinner quite conspicuously on the side of the latter. Freedom, for Rogers, is an indispensable characteristic of human nature and without it the fully functioning individual has no chance of self-actualization. Again, rationality versus irrationality characterizes the radical distinction between these schools of thought (Morgan, 2010). For Rogers, the human person is essentially a rational being, controlling and directing his own life when given the opportunity and, with help, can correct misdirection in one's life in a way that Freud and Skinner could never conceive nor would they allow. Holism, for Rogers, is his alternative to behaviorism's elementalism, by which is meant the behaviorist's happy dissecting of the human personality into elemental parts for analysis whereas with the humanists the person is treated and respected as an entity in its entirety.

A further distinction has to do with the difference between constitutionalism and environmentalism, with the former on the side of the humanists who would have us know that individuals are

constituted of an innate tendency to self-actualization whereas the behaviorists would have us rely upon the organic and instinctual situation of the individual as determinate in behavior. Whereas Skinner and Freud would emphasize the objectivity of the human person's behavioral modalities of being without reference to the individual's own self-understanding, Rogers would have us know that the human person is essentially a subjective being with thought processes and behavioral modalities employed at his own initiative and to his own desired ends. Again, Rogers would have us understand that the human person is "proactive" rather than "reactive" to life's situations and that the positive view of the human person is one in which every individual has the ability and is encouraged to assume responsibility for his actions rather than rely helplessly upon his instinctual urges and unconscious cuing for behavioral responses. We are a proactive being rather than a mere reactive animal say the humanists of the Third Force.

Because human beings are innately driven toward self-actualization, every individual is heterostatic rather than homeostatic, that is to say, every person is in a mode of action, moving towards greater fulfillment, greater self-actualization, rather than bound and gagged by the instinctual and unconscious variables operative in his life but outside his control. Man is moving forward, not staked to his mere animal confines. And, finally, Roger would emphasize knowability whereas the behaviorists would claim unknowability as our life situation and destiny. Because of his embracing of the phenomenological school of psychology, Roger believed that man cannot use scientific knowledge to better understand who and what we are without a much greater reliance upon our own capacity at self-understanding. We are not merely the objective subject of scientific enquiry, but we are the subjective focus of interpersonal self-understanding. Science can help, but it must serve rather than dominate our enquiry.

Early on in our discussion, we called attention to the evolution of

Rogerian psychotherapeutic methods of treatment, moving from a non-directive to client-centered to finally person-to-person center focus. In this context, Rogers has identified six conditions necessary for the therapeutic relationship to be beneficial. In closing, we will list these and comment briefly: (1) Two persons are in psychological contact (wherein two individuals, one self-defined as therapist and the other as client, meet together to address a personal issue of the client); (2) The client is in a state of incongruence, being vulnerable or anxious (wherein the situation presumes an interactive relationship of the two individuals addressing the incongruent feelings of the client), (3) The therapist is congruent or integrated in the relationship (by which is meant that this individual is aware of his role, his situation, and his responsibility in relationship to the client), (4) The therapist experiences unconditional positive regard for the client (such that the client does not raise defenses and is rather openly convergent with the therapist about his situation of anxiety), (5) The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client (such that the client is enabled to better see and assess the situation which has arisen in his life which has produced the incongruence), and (6) The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved (thereby setting the client on the road to recovering or discovering a sense of self-worth and fulfillment).

Roger's person-to-person therapeutic method is a reflection of his whole image of man in general and more specifically of the therapist as a facilitator of personal growth of the client towards self-actualization. Believing individuals are innately inclined to personal fulfillment and, therefore, Rogers is ever optimistic about the healing process. His phenomenological theory has produced a great deal of research dealing with self-concept and his methodology has been widely adopted by various schools of psychotherapy, and not least within the ranks of pastoral counselors who have benefited the most

and utilized his method extensively in their training and practice. On the occasion of the jubilee year of the publication of his now classic text, *On Becoming a Person*, it seems only appropriate that we pause in gratitude for his great contribution to an understanding of the development of the human person.

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Rogers, Carl R. (1980). *A Way of Being.* Boston: Houghton-Mifflin.

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Rogers, Carl R. (1983). *Freedom to Learn for the 80s.* Columbus, OH: Charles E. Merrill Publishing Company.

IV. A Practitioner's Resource Directory

A. Professional Associations

American Association of Christian Counselors (AACC)*
www.aacc.net

American Association of Marriage and Family Therapy (AAMFT)**
www.aamft.org

Who We Are

The American Association for Marriage and Family Therapy (AAMFT) is the professional association for the field of marriage and family therapy. We represent the professional interests of more than 24,000 marriage and family therapists throughout the United States, Canada and abroad. Since our founding in 1942, the AAMFT has been involved with the problems, needs and changing patterns of couples and family relationships.

The association leads the way to increasing understanding, research and education in the field of marriage and family therapy, and ensuring that the public's needs are met by trained practitioners. The AAMFT provides individuals with the tools and resources they need to succeed as marriage and family therapists. Our members meet rigorous standards for education and training and are held to the highest ethical standards of the profession. Clinical Members have met the highest standards of the profession for education and clinical

*Because of the difficulties involved in securing copyright release for their mission statement, we have not included it here.
**Permission granted to quote website

experience. Associate and Student membership categories are available for therapists in training for clinical practice. Members of allied professions and other persons who are interested in marriage and family therapy are eligible to become Affiliate Members.

WHAT WE DO

Our association facilitates research, theory development and education. We develop standards for graduate education and training, clinical supervision, professional ethics and the clinical practice of marriage and family therapy. The AAMFT hosts an annual national training conference each fall as well as a week-long series of continuing education institutes in the summer and winter. We publish the scholarly research journal *Journal of Marital and Family Therapy*, news about the field in *Family Therapy Magazine*, and a variety of brochures and pamphlets that inform the public about the field of marriage and family therapy. Also, we offer a range of professional and practice development products, including videotapes, books and brochures.

American Association of Pastoral Counselors (AAPC)***
www.aapc.org

Pastoral Counseling is a unique form of psychotherapy which uses spiritual resources as well as psychological understanding for healing and growth.

Pastoral Counselors are certified mental health professionals who have had in-depth religious and/or theological training. The American Association of Pastoral Counselors (AAPC) represents and sets professional standards for over 3,000 Pastoral Counselors and 100 pastoral counseling centers in North America and around the

***Permission granted to quote mission statement

world. AAPC was founded in 1963 as an organization which certifies Pastoral Counselors, accredits pastoral counseling centers, and approves training programs. It is non-sectarian and respects the spiritual commitments and religious traditions of those who seek assistance without imposing counselor beliefs onto the client. Persons become members of AAPC through a process of consultation and review of academic and clinical education which leads to competent professional ministry. For members, AAPC offers vital continuing education opportunities; encourages networks of members for professional support and enrichment; facilitates growth and innovation in the ministry of pastoral counseling; and provides both specialized in-service training and supervision in pastoral counseling.

American Counseling Association (ACA)***
www.counseling.org

The American Counseling Association is a not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association exclusively representing professional counselors in various practice settings. By providing leadership training, publications, continuing education opportunities, and advocacy services to nearly 45,000 members, ACA helps counseling professionals develop their skills and expand their knowledge base. ACA has been instrumental in setting professional and ethical standards for the counseling profession. The association has made considerable strides in accreditation, licensure, and national certification. It also represents the interests of the profession before congress and federal agencies, and strives to promote recognition of professional counselors to the public and the media. The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and

practice of counseling to promote respect for human dignity and diversity.

American Psychological Association (APA)**
www.apa.org

WHO WE ARE

Based in Washington, DC, the American Psychological Association (APA) is a scientific and professional organization that represents psychology in the United States. With 150,000 members, APA is the largest association of psychologists worldwide.

MISSION STATEMENT

The mission of the APA is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

VISION STATEMENT

The American Psychological Association aspires to excel as a valuable, effective and influential organization advancing psychology as a science, serving as:

- A uniting force for the discipline
- The major catalyst for the stimulation, growth and dissemination of psychological science and practice
- The primary resource for all psychologists
- The premier innovator in the education, development, and training of psychological scientists, practitioners and educators
- The leading advocate for psychological knowledge and practice informing policy makers and the public to improve public

policy and daily living
- A principal leader and global partner promoting psychological knowledge and methods to facilitate the resolution of personal, societal and global challenges in diverse, multicultural and international contexts
- An effective champion of the application of psychology to promote human rights, health, well being and dignity

APA Core Values

The American Psychological Association commits to its vision through a mission based upon the following values:

- Continual Pursuit of Excellence
- Knowledge and Application Based on Methods of Science
- Outstanding Service to Its Members and to Society
- Social Justice, Diversity, and Inclusion
- Ethical Action in All That We Do

Organizational Purposes

APA seeks to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare. We do this by:

- Encouraging the development and application of psychology in the broadest manner
- Promoting research in psychology, the improvement of research methods and conditions, and the application of research findings
- Improving the qualifications and usefulness of psychologists by establishing high standards of ethics, conduct, education, and achievement
- Increasing and disseminating psychological knowledge through

meetings, professional contacts, reports, papers, discussions, and publications

Adapted from APA Bylaws I.1

Definition of "Psychology"

Psychology is a diverse discipline, grounded in science, but with nearly boundless applications in everyday life. Some psychologists do basic research, developing theories and testing them through carefully honed research methods involving observation, experimentation and analysis. Other psychologists apply the discipline's scientific knowledge to help people, organizations and communities function better. As psychological research yields new information, whether it's improved interventions to treat depression or how humans interact with machines, these findings become part of the discipline's body of knowledge and are applied in work with patients and clients, in schools, in corporate settings, within the judicial system, even in professional sports. Psychology is a doctoral-level profession. Psychologists study both normal and abnormal functioning and treat patients with mental and emotional problems. They also study and encourage behaviors that build wellness and emotional resilience. Today, as the link between mind and body is well-recognized, more and more psychologists are teaming with other healthcare providers to provide whole-person healthcare for patients.

Association for Clinical Pastoral Education (ACPE)**

www.acpe.edu

Mission Statement

The Association for Clinical Pastoral Education, Inc. is a professional

association committed to advancing experience-based theological education for seminarians, clergy and lay persons of diverse cultures, ethnic groups and faith traditions. We establish standards, certify supervisors and accredit programs and centers in varied settings. ACPE programs promote the integration of personal history, faith tradition and the behavioral sciences in the practice of spiritual care.

Vision Statement

As the Association for Clinical Pastoral Education, Inc., we will be distinguished as the premier provider of clinical pastoral education and recognized by the United States Department of Education:

- Encouraging creative response to the changing context of spiritual care in the communities we serve
- Modeling professional competence, integrity and high ethical standards
- Sustaining a welcoming organizational culture in which members are encouraged to learn and grow
- Embracing diversity, collaboration, and accountability on a national and international level
- Prophetically advocating for excellence in pastoral education and the practice of spiritual care.

National Association of Catholic Chaplains (NACC)**
www.nacc.org

Mission

The National Association of Catholic Chaplains advocates for the profession of spiritual care and educates, certifies, and supports chaplains, clinical pastoral educators, and all members who continue

the healing ministry of Jesus in the name of the Church.

VISION

The National Association of Catholic Chaplains (NACC) is cultivating the ministry of chaplaincy and transforming spiritual care locally, nationally, and globally to faithfully reflect the healing presence of Jesus Christ by:

- forming life-giving relationships with individuals, families, colleagues, and organizations;
- advancing compassionate care through creative educational and spiritual growth opportunities;
- promoting the dignity of persons of every age, culture, and state in life.

NACC is a light of hope, whose members are persistently advocating for those dedicated to the spiritual care of people experiencing pain, vulnerability, joy, and hope.

National Association of Jewish Chaplains (NAJC)**
www.najc.org

The National Association of Jewish Chaplains (NAJC) founded in 1989, strives to enhance the skills of Jewish Chaplains in order that they might provide quality Jewish religious and spiritual care. The NAJC is at the forefront of promoting the highest standard of professional training and practice for Jewish Chaplains.

TO FULFILL THIS MISSION, THE NAJC:

- Sets certification standards and grants certification to qualified

Jewish chaplains

- Promotes the ongoing education and professional growth of Jewish chaplains
- Advocates on behalf of Jewish chaplains and Jewish chaplaincy programs to other professional chaplaincy organizations, rabbinic and cantorial associations, to seminary and educational institutions, and to the community
- Serves as a clearinghouse for professional full-time and part-time chaplaincy positions
- Provides opportunities for mutual support and hevruta
- NAJC members span the denominational spectrum, serving in hospitals, long-term care centers, hospices, healing centers, educational centers, community chaplaincy programs, prisons, the military and on college campuses. We are truly a pluralistic organization.

B. State Licensure Laws

ALABAMA
Board of Examiners in Counseling
950 22nd Street North
Suite 765
Birmingham AL 35203
800-822-3307
205-458-8716
205-458-8718 (fax)
www.abec.alabama.gov

Licensed Professional Counselor (LPC)
Associate Licensed Counselor (ALC)

ALASKA
Board of Professional Counselors
P.O. Box 110806
Juneau AK 99811-0806
907-465-2551
907-465-2974 (fax)
www.commerce.state.ak.us/occ/ppco.htm

Licensed Professional Counselor (LPC)

ARIZONA
Board of Behavioral Health Examiners
3443 North Central Avenue #1700
Phoenix AZ 85012
602-542-1882
602-364-0890 (fax)
information@azbbhe.us
http://azbbhe.us

Licensed Professional Counselor (LPC)
Licensed Associate Counselor (LAC)

ARKANSAS
Board of Examiners in Counseling
P.O. Box 70
Magnolia AR 71754-0070
870-901-7055
870-234-1842 (fax)
arboec@sbglobal.net
www.arkansas.gov/abec

Licensed Professional Counselor (LPC)
Licensed Associate Counselor (LAC)

CALIFORNIA
On October 11, 2009 the California counselor licensure bill was signed into law, establishing licensure of professional clinical counselors (LPCCs).

California Licensure Implementation Dates:

January 1, 2010: The bill becomes law and the CA Board of Behavioral Sciences then has the responsibility for developing the rules and regulations to implement the bill and it will gear up to accept LPCC applications.

January 1, 2011: Applications for grandparenting and reciprocity will be available through the Board of Behavioral Sciences. These requirements are posted now on CCCL's website, under Licensure Requirements.

January 1, 2012: Applications for regular licensure will be available for those not eligible for grandparenting or reciprocity. These requirements are posted now on CCCL's website, under Licensure Requirements.

COLORADO
Board of Licensed Professional Counselor Examiners
1560 Broadway, Suite 1350
Denver CO 80202

303-894-7745
303-894-7764 (fax)
MentalHealth@dora.state.co.us
www.dora.state.co.us/mental-health

Licensed Professional Counselor (LPC)
Provisional Licensed Professional Counselor

CONNECTICUT
Department of Public Health
Professional Counselor Licensure
410 Capitol Avenue, MS #12APP
P.O. Box 340308
Hartford CT 06134-0308
860-509-7603
860-707-1980 (fax)
dph.counselorsteam@ct.gov
www.ct.gov/dph/cwp/view.asp?a=3121&q=396902&dphNav_GID=1821
Main website: www.ct.gov

Licensed Professional Counselor (LPC)

DELAWARE
Board of Mental Health and Chemical Dependency Professionals
Cannon Building
Suite 203
861 Silver Lake Blvd.
Dover DE 19904
302-744-4500
302-739-2711 (fax)
customerservice.dpr@state.de.us
http://dpr.delaware.gov/

Licensed Professional Counselor of Mental Health (LPCMH)
Licensed Associate Counselor of Mental Health (LACMH)

DISTRICT OF COLUMBIA
Board of Professional Counseling
717 14th Street, NW, Suite 600
Washington DC 20005
877-672-2174
202-727-8471 (fax)
http://doh.dc.gov/node/160252

Licensed Professional Counselor (LPC)

FLORIDA
Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way, BIN C-08
Tallahassee FL 32399
850-245-4474
850-921-5389 (fax)
mqa_491@doh.state.fl.us
www.doh.state.fl.us/mqa/491

Licensed Mental Health Counselor (LMHC)
Provisional Mental Health Counselor
Registered Mental Health Counselor Intern

GEORGIA
Composite Board of Professional Counselors, Social Workers, and Marriage & Family Therapists
237 Coliseum Drive
Macon GA 31217
478-207-2440
866-888-7127 (fax)
http://sos.georgia.gov/plb/counselors/

Licensed Professional Counselor (LPC)
Associate Professional Counselor (ALPC)

HAWAI'I
Department of Commerce and Consumer Affairs - PVL
Mental Health Counselor Program
P.O. Box 3469
Honolulu HI 96801
808-586-2693
counselor@dcca.hawaii.gov
www.hawaii.gov/dcca/areas/pvl/programs/mental/

Licensed Mental Health Counselor (LMHC)

IDAHO
State Licensing Board of Professional Counselors and Marriage & Family Therapists
1109 Main Street, Suite 220
Boise ID 83702
208-334-3233
208-334-3945 (fax)
cou@ibol.idaho.gov
www.ibol.idaho.gov/

Licensed Clinical Professional Counselor (LCPC)
Licensed Professional Counselor (LPC)
Registered Counselor Intern

ILLINOIS
Professional Counselor Licensing and Disciplinary Board
320 W. Washington Street, 3rd Floor
Springfield IL 62786
217-785-0800
217-782-7645 (fax)
217-524-6735 (TDD)
www.idfpr.com/dpr/who/prfcns.asp

Licensed Clinical Professional Counselor (LCPC)
Licensed Professional Counselor (LPC)

INDIANA
Behavioral Health & Human Services Licensing Board
402 W. Washington Street, Room W072
Indianapolis IN 46204
317-234-2064
317-233-4236 (fax)
pla5@pla.in.gov
www.in.gov/pla/social.htm

Licensed Mental Health Counselor (LMHC)

IOWA
Board of Behavioral Science
Lucas State Office Building, 5th Floor
321 E. 12th Street
Des Moines IA 50319
515-281-4422
515-281-3121 (fax)
www.idph.state.ia.us/licensure/

Licensed Mental Health Counselor (LMHC)

KANSAS
Behavioral Sciences Regulatory Board
712 S. Kansas Avenue
Topeka KS 66603
785-296-3240
785-296-3112 (fax)
www.ksbsrb.org/

Licensed Clinical Professional Counselor (LCPC)
Licensed Professional Counselor (LPC)

KENTUCKY
Board of Licensed Professional Counselors
P.O. Box 1360
Frankfort, KY 40602
502-564-3296, x239

502-564-4818 (fax)
http://lpc.ky.gov

Licensed Professional Clinical Counselor (LPCC)
Licensed Professional Counselor Associate (LPCA)

LOUISIANA
Licensed Professional Counselors Board of Examiners
8631 Summa Avenue
Baton Rouge LA 70809
225-765-2515
225-765-2514 (fax)
lpcboard@eatel.net
www.lpcboard.org

Licensed Professional Counselor (LPC)
Counselor Intern

MAINE
Board of Counseling Professionals Licensure
35 State House Station
Augusta ME 04333
207-624-8674
888-577-6690 TTY
207-624-8637 (fax)
www.maine.gov/pfr/professionallicensing

Licensed Clinical Professional Counselor (LCPC)
Licensed Professional Counselor (LPC)
Conditional LCPC
Conditional LPC
*Registered Counselor**

*As of August 1, 2008, the Board is no longer issuing initial licenses in this category, however current Registered Counselors may continue to renew.

MARYLAND
Board of Examiners of Professional Counselors and Therapists
4201 Patterson Avenue, 3rd Floor
Baltimore MD 21215
410-764-4732
410-358-1610 (fax)
http://dhmh.maryland.gov/bopc

Licensed Clinical Professional Counselor (LCPC)
Licensed Graduate Professional Counselor

MASSACHUSETTS
Board of Registration of Allied Mental Health & Human Services Professionals
239 Causeway Street, Suite 500
Boston MA 02114
617-727-3080
617-727-2197 (fax)
www.mass.gov/dpl/boards/mh

Licensed Mental Health Counselor (LMHC)

MICHIGAN
Board of Counseling
P.O. Box 30670
Lansing MI 48909
517-335-0918
517-373-2179 (fax)
bhphelp@michigan.gov
www.michigan.gov/healthlicense

Licensed Professional Counselor (LPC)
Limited Licensed Professional Counselor (LLPC)

MINNESOTA
Board of Behavioral Health & Therapy
2829 University Avenue SE, Suite 210
Minneapolis MN 55414

612-617-2178
800-627-3529 TTY
612-617-2187 (fax)
bbht.board@state.mn.us
www.bbht.state.mn.us

*Licensed Professional Clinical Counselor (LPCC)**
Licensed Professional Counselor (LPC)

*New licensure tier as of 08/01/07

MISSISSIPPI
State Board of Examiners for Licensed Professional Counselors
P.O. Box 1497
129 E. Jefferson Street
Yazoo City MS 39194
662-716-3932
888-860-7001
662-716-3021 (fax)
www.lpc.state.ms.us

Licensed Professional Counselor (LPC)

MISSOURI
Committee for Professional Counselors
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City MO 65102
573-751-0018
800-735-2966 TTY
573-751-0735 (fax)
profcounselor@pr.mo.gov
http://pr.mo.gov/counselors.asp

Licensed Professional Counselor (LPC)
Provisional Licensed Professional Counselor (PLPC)

MONTANA
Board of Social Work Examiners and Professional Counselors
301 S. Park, 4th Floor
P.O. Box 200513
Helena MT 59620
406-841-2392
406-841-2305 (fax)
dlibsdswp@mt.gov
http://bsd.dli.mt.gov/license/bsd_boards/swp_board/board_page.asp

Licensed Clinical Professional Counselor (LCPC)

NEBRASKA
Board of Mental Health Practice
P.O. Box 94986
Lincoln NE 68509
402-471-2117
402-471-3577 (fax)
Mental Health Practice License:
http://dhhs.ne.gov/publichealth/Pages/crl_mhcs_mental_mentalhealth.aspx
Professional Counselor Requirements:
http://dhhs.ne.gov/publichealth/Pages/crl_mhcs_mental_cpc.aspx
Main website: http://dhhs.ne.gov

Licensed Independent Mental Health Practitioner-Certified Professional Counselor
or *Licensed Professional Counselor (LIMHP-CPC/LPC)*

Licensed Mental Health Practitioner-Certified Professional Counselor
or *Licensed Professional Counselor (LMHP-CPC/LPC)*

Licensed Mental Health Practitioner (LMHP)
Provisional Licensed Mental Health Practitioner (PLMHP)

NEVADA
Board of Examiners for Marriage and Family Therapists
and Clinical Professional Counselors
P.O. Box 370130
Las Vegas NV 89134-0130
702-486-7388
702-486-7258 (fax)
nvmftbd@mftbd.nv.gov
http://marriage.state.nv.us/

Licensed Clinical Professional Counselor (LCPC)
Licensed Clinical Counselor Intern

NEW HAMPSHIRE
Board of Mental Health Practice
117 Pleasant Street
Concord NH 03301
603-271-6762
800-735-2954 TDD
603-271-3950 (fax)
www.nh.gov/mhpb

Licensed Clinical Mental Health Counselor (LCMHC)

NEW JERSEY
Board of Marriage and Family Therapy Examiners
Professional Counselor Examiners Committee
P.O. Box 45007
Newark NJ 07101
973-504-6582
973-648-3536 (fax)
www.njconsumeraffairs.gov/proc

Licensed Professional Counselor (LPC)
Licensed Associate Counselor (LAC)

NEW MEXICO
Counseling and Therapy Practice Board
Toney Anaya Building
2550 Cerrillos Road
Santa Fe NM 87505
505-476-4610
505-476-4633 (fax)
counselingboard@state.nm.us
www.rld.state.nm.us/boards/Counseling_and_Therapy_Practice.aspx

Licensed Professional Clinical Mental Health Counselor (LPCC)
*Licensed Professional Mental Health Counselor (LPC)**

*The Board is no longer issuing initial licenses in this category, however current LPCs may continue to renew.

NEW YORK
State Board for Mental Health Practitioners
State Education Building – 2nd floor
89 Washington Avenue
Albany NY 12234
518-474-3817, x450
518-486-2981 (fax)
mhpbd@mail.nysed.gov
www.op.nysed.gov/prof/mhp/

Licensed Mental Health Counselor (LMHC)

NORTH CAROLINA
Board of Licensed Professional Counselors
P.O. Box 1369
Garner NC 27529
919-661-0820
919-779-5642 (fax)
ncblpc@mgmt4u.com
www.ncblpc.org

Licensed Professional Counselor (LPC)

*Licensed Professional Counselor Associate (LPCA)**

*New licensure tier as of 10/01/09

NORTH DAKOTA
Board of Counselor Examiners
2112 10th Ave SE
Mandan ND 58554
701-667-5969 (phone & fax)
ndbce@btinet.net
www.ndbce.org

Licensed Professional Clinical Counselor (LPCC)
Licensed Professional Counselor (LPC)
Licensed Associate Professional Counselor (LAPC)

OHIO
Counselor, Social Worker and Marriage & Family Therapist Board
50 West Broad Street, Suite 1075
Columbus OH 43215
614-466-0912
614-728-7790 (fax)
cswmft.info@cswb.state.oh.us
http://cswmft.ohio.gov

Licensed Professional Clinical Counselor (LPCC)
Licensed Professional Counselor (LPC)
Professional Counselor/Clinical Resident

OKLAHOMA
Division of Professional Counselor Licensing
1000 N.E. 10th Street
Oklahoma City OK 73117-1299
405-271-6030
405-271-1918 (fax)
nenaw@health.ok.gov
http://pcl.health.ok.gov

Licensed Professional Counselor (LPC)

OREGON
Board of Licensed Professional Counselors and Therapists
3218 Pringle Road, S.E., Suite 250
Salem OR 97302-6312
503-378-5499
503-373-1427 (fax)
lpct.board@state.or.us
www.oregon.gov/oblpct

Licensed Professional Counselor (LPC)
Registered Intern

PENNSYLVANIA
State Board of Social Workers, Marriage and Family Therapists and Professional Counselors
P.O. Box 2649
Harrisburg PA 17105-2649
717-783-1389
717-787-7769 (fax)
ST-SOCIALWORK@pa.gov
www.dos.state.pa.us/social

Licensed Professional Counselor (LPC)

PUERTO RICO
Board of Examiners of Professional Counselors
P.O. Box 10200
San Juan PR 00908
787-765-2929
www.salud.gov.pr

Licensed Professional Counselor (LPC)
Professional Counselor with Provisional License (PCPL)

RHODE ISLAND
Board of Mental Health Counselors
and Marriage & Family Therapists
3 Capitol Hill, Room 104
Providence RI 02908
401-222-2828
401-222-1272 (fax)
www.health.ri.gov/hsr/professions/mf_counsel.php

Licensed Clinical Mental Health Counselor (LCMHC)

SOUTH CAROLINA
Board of Examiners for Licensure of Professional Counselors,
Marriage and Family Therapists and Psycho-Educational Specialists
P.O. Box 11329
Columbia SC 29211-1329
803-896-4658
803-896-4719 (fax)
www.llr.state.sc.us/pol/counselors

To obtain an application for licensure please contact the Center for Credentialing and Education (CCE), an affiliate of NBCC, at:
336-482-2856
888-817-8283 (toll-free)
336-482-2852 (fax)
cce@cce-global.org
www.cce-global.org

Licensed Professional Counselor (LPC)
Professional Counselor Intern (LPC/I)

SOUTH DAKOTA
Counselors and Marriage and Family Therapist Examiners
P.O. Box 2164
Sioux Falls SD 57101
605-331-2927
605-331-2043 (fax)
sdbce.msp@midconetwork.com

http://dss.sd.gov/behavioralhealthservices/licensingboards/board_examiners.asp

Licensed Professional Counselor - Mental Health (LPC-MH)
Licensed Professional Counselor (LPC)

TENNESSEE
Board of Licensed Professional Counselors, Licensed Marital & Family Therapists and Licensed Pastoral Therapists
227 French Landing, Suite 300
Nashville TN 37243
615-532-3202
800-778-4123
615-532-5369 (fax)
http://health.state.tn.us/boards/PC_MFT&CPT/

Licensed Professional Counselor-Mental Health Service Provider (LPC/MHSP)
Licensed Professional Counselor (LPC)

TEXAS
State Board of Examiners of Professional Counselors
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin TX 78714
512-834-6658
512-834-6677 (fax)
lpc@dshs.state.tx.us
www.dshs.state.tx.us/counselor

Licensed Professional Counselor (LPC)
Licensed Professional Counselor Intern (LPC-I)

UTAH
Division of Occupational and Professional Licensing
P.O. Box 146741
Salt Lake City UT 84114-6741

801-530-6628
866-275-3675 (toll-free in Utah)
801-530-6511 (fax)
DOPLWeb@utah.gov
http://dopl.utah.gov/licensing/professional_counseling.html

Licensed Professional Counselor (LPC)
Certified Professional Counselor Intern
Certified Professional Counselor Extern

VERMONT
Board of Allied Mental Health
National Life Building
North FL2
Montpelier VT 05620-3402
800-828-2390
http://vtprofessionals.org

Licensed Clinical Mental Health Counselor (LCMHC)

VIRGINIA
Board of Counseling
9960 Mayland Drive, Suite 300
Henrico VA 23233-1463
804-367-4610
804-527-4435 (fax)
coun@dhp.virginia.gov
www.dhp.virginia.gov/counseling

Licensed Professional Counselor (LPC)

WASHINGTON
Mental Health Counselors, Marriage and Family Therapists, and Social Workers Advisory Committee
Department of Health
P.O. Box 47852
Olympia WA 98504-7852
360-236-4700

360-236-4818 (fax)
Hpqa.csc@doh.wa.gov
www.doh.wa.gov/licensing/

Licensed Mental Health Counselor (LMHC)
*Licensed Mental Health Counselor Associate (LMHCA)**
*Certified Counselor**
*Certified Adviser**
*Agency Affiliated Counselor**
*Registered Counselor*****

*New licensure credential as of 07/01/09
**This credential is no longer available to new applicants; current Registered Counselors must transition to one of the above credentials by July 1, 2010 or stop practicing as a counselor.

WEST VIRGINIA
Board of Examiners in Counseling
815 Quarrier Street, Suite 212
Charleston WV 25301
304-558-5494
800-520-3852
304-558-5496 (fax)
counselingboard@msn.com
www.wvbec.org

Licensed Professional Counselor (LPC)

WISCONSIN
Examining Board of Marriage & Family Therapists, Professional Counselors and Social Workers
P.O. Box 8935
Madison WI 53708
608-266-2112
877-617-1565 (toll-free outside Wisconsin)
DSPSBoards@wisconsin.gov
http://drl.wi.gov/profession.asp

Licensed Professional Counselor (LPC)
Professional Counselor Trainee

WYOMING
Mental Health Professions Licensing Board
1800 Carey Avenue, 4th Floor
Cheyenne WY 82002
307-777-3628
307-777-3508 (fax)
WyoMHPLB@wyo.gov
http://plboards.state.wy.us/mentalhealth/index.asp

Licensed Professional Counselor (LPC)
Provisional Professional Counselor (PPC)

(Websites accessed October 2012.)

C. State Licensure Laws for Pastoral Counselors

The American Association of Pastoral Counselors offers the following website for individuals seeking relevant information regarding licensure for a variety of professional levels of counseling practice. Log on to this website for details for every U.S. state:

www.aapc.org/content/state-licensing-pastoral-counselors

Pastoral Counselors are able to work with a state license in most states today. Only six states actually license the title Pastoral Counselor: Arkansas, Kentucky, Maine, New Hampshire, New York, North Carolina, and Tennessee. In many other states Pastoral Counselors may qualify for licensure as Marriage and Family Therapists or as Professional Counselors. They may have to take supplemental courses to match a model curriculum, or take a certified post-graduate program. Read the regulations for a specific state to see what equivalencies are allowed.

The American Association of Pastoral Counselors provides addresses, phone numbers, and websites, if available.

Abbreviation Legend

CCPT - Certified Clinical Pastoral Therapist
CpastC - Certified Pastoral Counselor
LPC - Licensed Professional Counselor
LPP - Licensed Pastoral Psychotherapist
LCPC - Licensed Clinical Professional Counselor
LpastC - Licensed Pastoral Counselor
LMHC - Licensed Mental Health Counselor
LMFT - Licensed Marriage and Family Therapist
CPC - Certified Professional Counselor

LMFC - Licensed Marriage and Family Counselor
LPCMH - Licensed Professional Counselor of Mental Health
LCMHC - Licensed Clinical Mental Health Counselor

D. Glossary of Terms

Accusation Used by Adlerians as a safeguarding tendency whereby one protects magnified feelings of self-esteem by blaming others for one's own failures.

Activity The degree of activity is the level of energy or interest with which one moves toward finding solutions to life's problems as used in Adlerian psychology.

Actualizing tendency A Rogerian term referring to the tendency within all people to move toward completion or fulfillment of potentials.

Aesthetic needs A term used by Maslow which refers to human needs for art, music, beauty, etc.; though they may be related to the basic conative needs, aesthetic needs are a separate dimension.

Aggression 1. An Adlerian term referring to safeguarding tendencies that may include depreciation or accusation of others, as well as self-accusation, all designed to protect exaggerated feelings of personal superiority by striking out against other people.

2. A Freudian term referring to one or two primary instincts or drives that motivate people. Aggression is the outward manifestation of the death instinct and is at least a partial explanation for wars, personal hostility, sadism, masochism, and murder.

Analytical Psychology Theory of personality and approach to psychotherapy founded by Carl Jung.

Anima Jungian archetype that represents the feminine side in the personality of males and originates from men's inherited experiences with women.

Animus Jungian archetype that represents the masculine component in the personality of females and originates from women's inherited experiences with men.

Anticathexis A Freudian term referring to a check or restraint upon an instinctual drive.

Anxiety A felt, affective, unpleasant state accompanied by physical sensation.

Apathy A term used by Sullivan to refer to the dynamism that reduces tensions of needs through the adoption of an indifferent attitude.

Archetypes Jung's concept that refers to the content of the collective unconscious.

Attitude Jung's specialized usage referring to a predisposition to act or react in a characteristic manner, that is, in either an introverted or an extraverted direction.

Autistic language A term used by Sullivan to refer to private or parataxic language, which makes little or no sense to other people.

Autoeroticism Self-gratification and in Freudian terms, infants are seen as exclusively autoerotic since their interest in pleasure is limited to themselves.

Aversive stimulus A painful or undesired stimulus which, when associated with a response, decreases the tendency of that response to be repeated in similar situations.

B-love A concept developed by Maslow to refer to love between

self-actualizing people characterized by the love for the "being of the other."

B-values A concept developed by Maslow that refers to the values of self-actualizing people, including beauty, truth, goodness, justice, wholeness, etc.

Basic anxiety A term from Maslow suggesting that anxiety arises from the inability to satisfy physiological and safety needs.

Behaviorism A school of psychology that limits its subject matter to observable behavior. John B. Watson is usually credited with being the founder of behaviorism, with B.F. Skinner its most notable proponent.

Castration complex Freudian suggesting a condition that accompanies the Oedipus complex, but takes different forms in the two sexes. In boys it takes the form of castration anxiety, or fear of having one's penis removed, and it is responsible for shattering the Oedipus complex. In girls it takes the form of penis envy, or the desire to have a penis, and precedes and instigates the Oedipus complex.

Cathexis A Freudian term referring to a driving or urging force.

Client-centered therapy Approach to psychotherapy originated by Carl Rogers, which is based on respect for the person's capacity to grow within a nurturing climate.

Clinical Pastoral Psychotherapy The study and treatment of dysfunctions in interpersonal relationships within the context of a spiritual worldview and ethos which provides a values-based framework for analysis and therapy.

Cognitive needs A Maslovian term suggesting needs for knowledge and understanding; related to basic or conative needs, yet operating on a different dimension.

Collective unconscious Jung's idea of an inherited unconscious. He believed that many of our acts are motivated by unconscious ideas that are beyond our personal experiences and originate with repeated experiences of our ancestors.

Complex A Jungian term suggesting an emotionally toned conglomeration of ideas which comprise the contents of the personal unconscious. Jung originally used the Word Association Test to uncover complexes.

Compulsion neurosis Neurotic reaction characterized by phobias, obsessions, and compulsions.

Conditions of worth A term employed by Rogers to suggest restrictions or qualifications attached to one person's regard for another.

Congruence Rogers' term for the matching of organismic experiences with awareness, and with the ability to express those experiences. One of three "necessary and sufficient" therapeutic conditions.

Conscience As used by Freud, that part of the superego which results from experience with punishment and which, therefore, tells a person what is wrong or improper conduct. As used by Frankl, conscience "is that capacity which empowers a person to seize the meaning of a situation in its very uniqueness."

Conscious As used by Freud, a term referring to those mental

elements in awareness at any given time.

Consensual validation The agreement of two or more people on the meaning of experiences, especially language. In Sullivan's thought, consensually validated experiences are said to operate on the syntaxic level of cognition.

Constructing obstacles Adler developed this term to suggest the safeguarding tendency characterized by a person creating a barrier to success so that self-esteem can be protected by either using the barrier as an excuse or by overcoming it.

Conversion hysteria Neurotic reaction characterized by the transformation of repressed psychological conflicts into overt physical symptoms.

Counter transference A Freudian concept referring to the strong undeserved feelings the therapist develops toward the patient during the course of treatment. These feelings can be either positive or negative and are considered by most writers to be a hindrance to successful psychotherapy.

D-love A term developed by Maslow to refer to deficiency love or affection (attachment) based on the lover's specific deficiency and the loved one's ability to satisfy that deficit.

Death instinct A Freud concept which suggests one of two primary drives or impulses, the death instinct is also known as Thanatos or aggression.

Deductive method Approach to factor analytical theories of personality that gathers data on the basis of previously determined hypotheses or theory. Reasoning from the general to the particular.

Defense mechanisms A Freudian concept referring to techniques such as repression, reaction formation, sublimation, etc., whereby the ego defends itself against the pain of anxiety.

Defensiveness Rogerian term for the protection of the self-concept against anxiety and threat by denial and distortion of experiences inconsistent with it.

Denial Rogerian term for the blocking of an experience or some aspect of an experience from awareness because it is inconsistent with the self-concept.

Depreciation Adlerian safeguarding tendency whereby another's achievements are undervalued and one's own are overvalued.

Dereflection According to Frankl, dereflection focuses attention away from the situation. "…on two essential qualities of human existence, namely, man's capacities of self-transcendence and self-detachment."

Desacralization Maslow suggests that this is the process of removing respect, joy, awe, rapture, etc., from an experience resulting in the purification or objectifying of that experience.

Dissociation A term used by Sullivan to suggest the process of separating unwanted impulses, desires, and needs from the self-system.

Dynamisms Sullivan's terms for the relatively consistent patterns of action which characterize the person throughout a lifetime. Similar to traits or habit patterns.

Ecclesiogenic damage According to Frankl, damage caused by the

clergy.

Ego 1. A term used extensively by Freud and Freudians to refer to the province of the mind that refers to the "I" or those experiences which are owned (not necessarily consciously) by the person. As the only region of the mind in contact with the real world, the ego is said to serve the reality principle.

2. A term used extensively by Jung and the Jungians to refer to the center of consciousness. In Jungian psychology the ego is of lesser importance than the more inclusive self and is limited to consciousness.

Ego-ideal In Freud terms, that part of the superego which results from experiences with reward and which, therefore, teach a person what is right or proper conduct.

Eidetic personifications Sullivan's concept for imaginary traits attributed to real or imaginary people in order to protect one's self-esteem.

Empathy 1. Rogers's term for the accurate sensing of the feelings of another and the communication of these perceptions. One of three "necessary and sufficient" therapeutic conditions.

2. Sullivan's term for an indefinite process through which anxiety is transferred from one person to another, for example, from mother to infant.

Empirical Based on experience, systematic observation, and experiment rather than logical reasoning or philosophical speculation.

Energy transformations Sullivan's term for the overt or covert actions designed to satisfy needs or reduce anxiety.

Enhancement needs Rogers's term for the need to develop, to grow, and to achieve.

Erogenous zones Organs of the body that are especially sensitive to the reception of pleasure. In Freudian theory, the three principal erogenous zones are the mouth, anus, and genitals.

Excuses Adlerian safeguarding tendencies whereby the person, through the use of reasonable sounding justifications, becomes convinced of the reality of self-erected obstacles.

Existential As used by Frankl, "…may be used in three ways: to (a) existence itself, i.e., the specifically human mode of being; (b) the meaning of existence; and (c) the striving to find a concrete meaning in personal existence, that is to say, the will to meaning."

Existential Analysis As used by Frankl, psychotherapy whose starting-point and whose particular concern is making man conscious of his responsibility. It is the "analysis of the responsibility aspects of being human."

Existential frustration In Frankl's terms, a "frustration of the will-to-meaning which may lead to neurosis. …It is in itself neither pathological nor pathogenic. A man's concern, even his despair, over the worthwhileness of life is a spiritual distress but by no means a mental disease."

Existential vacuum A general sense of meaninglessness and emptiness, an "inner void," an "abyss-experience" according to Frankl and Logotherapists, and it manifests itself "mainly in a state of boredom."

External evluation A Rogerian term for the conditions of worth

placed on a person, which may then serve as a criterion for evaluating one's own conduct. Conditions of worth block growth and interfere with one's becoming fully functioning.

Extraversion A Jungian concept which refers to an attitude or type characterized by the turning outward of psychic energy so that the person is oriented toward the objective.

Feeling A Jungian concept which refers to a rational function that tells us the value of something. The feeling function can be either extroverted (directed toward the objective world) or introverted (directed toward the subjective world).

Fiction An Adlerian term used to refer to a belief or expectation of the future, which serves to motivate present behavior. The truthfulness of a fictional idea is immaterial since the person acts as if the idea were true.

Fixation A defense mechanism that arises when psychic energy is blocked at one stage of development, thus making change or psychological growth difficult.

Formative tendency A term used by Rogers to refer to the tendency in all matter to evolve from simpler to more complex forms.

Genital stage A period of life recognized in Freudian psychology beginning with puberty and continuing through adulthood. This second sexual stage of the person's life should not be confused with the phallic phase, which takes place during the first sexual stage, that is, during infancy.

Hesitating A term used by Alderian psychologists applied to the safeguarding tendency characterized by vacillation or procrastination

designed to provide a person with the excuse, "It's too late now."

Heuristic Pertaining to a method or theory that leads to the discovery of new information.

Hierarchy of needs A major concept in the work of Maslow which refers to the realization that needs are ordered in such a manner that those on a lower level must be satisfied before higher level needs become activated.

Holistic-dynamic Maslow's theory of personality, which stresses both the unity of the organism and the motivational aspects of personality.

Humanistic psychology Ill-defined term referring to those theories and systems of psychology which, in general, emphasize the power of the individual to make conscious rational decisions and which stress the primacy of humans to other beings.

Hyperintention In Franklian psychology, attempts to escape the existential vacuum by focusing on the pursuit of pleasure. The direct attention on pleasure defeats itself. "The more an individual aims at pleasure, the more he misses the aim."

Hysteria A Freudian term used to refer to a mental disorder characterized by conversion of repressed psychical elements into somatic symptoms such as impotency, paralysis, or blindness, where no physiological bases for these symptoms exist.

Id A key term in Freudian psychoanalytic theory which refers to that region of personality which is alien to the ego in that it includes experiences that have never been owned by the person. The id is the home base for all the instincts and its sole function is to seek pleasure,

regardless of consequences.

Ideal self A Rogerian term used for one's view of self as one would like to be.

Idealization An Adlerian safeguarding tendency whereby the individual, in order to maintain exaggerated feelings of inferiority, sets up an ideal model so that any real person, by comparison, will inevitably fall short and thus be depreciated.

Incongruence A term used by Rogers to suggest the perception of discrepancies between organism self, self-concept, and ideal self.

Individual Psychology Theory of personality and approach to psychotherapy founded by Alfred Adler.

Individuation Jung's term for the process of becoming a whole person, that is, an individual with a high level of psychic development. Similar to Maslow's concept of self-actualization.

Inductive method Approach to factor analytic theories of personality that gathers data with no preconceived hypotheses or theory in mind. Reasoning from the particular to the general.

Infantile state Freud's term for the first four or five years of life characterized by autoerotic or pleasure-seeking behavior and consisting of the oral, anal, and phallic substages.

Inferiority complex A term used by Adler to suggest the exaggerated or abnormally strong feelings of inferiority, which usually interfere with socially useful solutions to life's problems.

Instinct From the German *trieb* meaning drive or impulse;

Freud used this term to refer to an internal stimulus that impels action or thought. The two primary instincts are sex and aggression.

Instinctoid needs Maslow developed this term to mean the needs that are innately determined, but can be modified through learning. The frustration of instinctoid needs leads to pathology. The use of the word "instinctual" would have served his system better as there was always confusion regarding this term.

Intimacy Sullivan used this term to refer to the conjunctive dynamism characterized by a close personal relationship with another person who is more or less of equal status.

Introversion Jung used this term to apply to an attitude or type characterized by the turning inward of psychic energy with an orientation toward the subjective.

Intuition Jung used this term to apply to an irrational function that involves perception of elementary data that are beyond our awareness. Intuitive people "know" something without understanding how they know.

Irrational functions Methods of dealing with the world without evaluation or thinking. Sensing and intuiting are the two irrational functions.

Isolation A Freudian term used to characterize a defense mechanism; also a type of repression whereby the ego attempts to isolate an experience by establishing a period of black-out effect immediately following that experience.

Latent dream content A term used by Freud for the underlying, unconscious meaning of a dream. Freud held that the latent content,

which can only be revealed through dream interpretation, was more important than the surface, or manifest, dream content.

Libido Freud used this term to refer to the psychic energy of the life instinct; sexual drive or energy.

Life instinct Freud used this term for one or two primary drives or impulses, the life instinct is also called Eros or sex.

Logotherapy According to Frankl, "focuses on the meaning of human existence as well as on man's search for such a meaning… the striving to find a meaning in one's life is the primary motivational force in man… It is a psychotherapy which not only recognizes man's spirit, but actually starts from it."

Lust A term used by Sullivan for the isolating dynamism characterized by impersonal sexual interest in another.

Maintenance needs A Rogerian term for those basic needs which protect the status quo. They may be either physiological (e.g., food), or interpersonal (e.g., the need to maintain the current self-concept).

Malevolence Sullivan's term for those destructive behavior patterns characterized by the attitude that people are evil and harmful and that the world is a bad place in which to live.

Mandala A symbol, says Jung, that represents the striving for unity and completion. It is often seen as a circle within a square or a square within a circle.

Manifest dream content A central Freudian concept referring to the surface or conscious meaning of a dream. The manifest content of a dream is the story the dreamer can describe to others. Freud believed

that the manifest level of a dream has no deep psychological significance and that the unconscious or latent level holds the key to the dream's true meaning.

Masculine protest Adler's term for the neurotic and erroneous belief held by some men and women that males are superior to females.

Maturity Freud used this term to mean the final psychosexual state following infancy, latency, and the genital period. Maturity would be characterized by a strong ego in control of the id and superego, and by an ever-expanding realm of consciousness. Though we all strive for maturity, Freud believed that only a very few individuals ever reach it.

Metamotivation Maslow's terms for the motives of self-actualizing people including, especially, the B-values.

Metapathology Maslow's terms for the illness characterized by absence of values, lack of fulfillment, and loss of meaning of life, and resulting from deprivation of self-actualization needs.

Moving backward Adler used this term to apply to the safeguarding of inflated feelings of superiority by reverting to a more secure period of life.

Neurasthenia Neurotic condition characterized by excessive fatigue, chronic aches and pains, and low motivational level.

Neurosis A term signifying mild personality disorders, as opposed to the more severe psychotic reactions. Neuroses are generally characterized by one or more of the following: anxiety, hysteria, phobias, obsessive-compulsive reactions, depression, chronic fatigue, and hypochondriacal reactions.

Noetic dimension The dimension of the human spirit containing our healthy core, where can be found such uniquely human attributes as will to meaning, ideas and ideals, creativity, etc.

Noogenic A logotherapeutic term which refers to anything having to do with the "spiritual" core of one's personality. The word spiritual does not mean religious, rather it refers to the specifically human dimension of being human. Noetic phenomena are a dimension above the somatic and psychic.

Oedipus complex The classic concept in Freudian psychoanalysis used to indicate the situation where the child of either sex develops feelings of love and/or hostility for the parent. In the simple male Oedipus complex, the boy has incestuous feelings of love for the mother and hostility toward the father. The simple female Oedipus complex exists when the girl feels hostility for the mother and sexual love for the father.

Operational definition A definition of a concept in terms of specific operations to be carried out by the observer.

Oral phase Freud used this term to refer to the earliest phase of the infantile period. This stage is characterized by attempts to gain pleasure through the activity of the mouth, especially sucking, eating, and biting; corresponds roughly to the first 12-18 months of life.

Organ dialect Adlerian term referring to the expression of a person's underlying intentions or style of life through a diseased or dysfunctional bodily organ.

Organismic self Rogers used this concept as a more general term than self-concept; the organismic self includes the entire person, along with those aspects of existence beyond awareness.

Paradoxical intention In Franklian terms, it "means that the patient is encouraged to do, or wish to happen, the very things he fears. …It lends itself to the short-term treatment of obsessive-compulsive and phobic patients."

Paranoia Mental disorder characterized by unrealistic feelings of persecution, grandiosity, and suspicious attitude toward others.

Parataxic Sullivan's terms for the mode of cognition characterized by attribution of cause and effect when none is present; private language not consensually validated (i.e., not able to be accurately communicated to others).

Parsimony Criterion of a useful theory which states that when two theories are equal on other criteria, the simpler one is preferred.

Pastoral Care Understood to be the spiritual and emotional nurture traditionally provided by the ordained clergy without specific reference to, or utilization of, modern psychological insights and training.

Pastoral Counseling The study and treatment of dysfunctions in interpersonal relationships based on a psychological understanding of the human person within the context of a spiritual worldview and ethos, providing a values-based framework for analysis and therapy conducted by a professionally-trained individual. Such an individual within the context of this study is understood to be an ordained minister serving a faith community.

Pastoral Logotherapy The application of logotherapeutic analysis and treatment within the context of a spiritual understanding of the human situation and its relevance to mental health. Though not specifically faith-based, pastoral logotherapy is practiced within the

context of a spiritual awareness of self-transcendent reality.

Peak experience A classic concept of Maslow used to refer to an intense, mystical experience often characteristic of self-actualizing people, but not limited to them.

Perceptual-conscious In Freud's thought, the system that perceives external stimuli through sight, sound, taste, etc., and communicates them to the conscious system.

Person of tomorrow Rogers used this phrase to refer to the psychologically healthy individual in the process of evolving into all that he or she can become.

Person-centered The theory of personality founded by Carl Rogers as an outgrowth of his client-centered psychotherapy.

Persona Jungian archetype that represents that side of personality one shows to the rest of the world. Also, the mask worn by actors in ancient Greek and Roman theater, and thus the root of the word "personality."

Personal unconscious Jung's term for those repressed experiences which pertain exclusively to one particular individual; opposed to the collective unconscious which pertains to unconscious experiences that originate with repeated experiences of our ancestors.

Personality A universal concept referring to all those relatively permanent traits, dispositions, or characteristics within the individual, which give some degree of consistency to that person's behavior. Traits may be unique, common to some groups or culture, or shared by the entire species. At present, no one definition of personality is accepted universally and every major school of psychotherapy has

produced its own.

Personifications Sullivan used this term to apply to images a person has of self or others, such as "good-mother," "bad-mother," "good-me," and "bad-me."

Phallic phase Freud's term for the third and latest stage of the infantile period, this period is characterized by the Oedipus complex. Though anatomical differences between the sexes are responsible for important differences in the male and female Oedipal periods, Freud used the term phallic phase to signify both the male and the female developmental stage. He has been roundly criticized by feminist psychoanalysts.

Pleasure principle Freud used this term to refer to the motivation of the id to seek immediate reduction of tension through the gratification of instinctual drives.

Positive regard Rogers used this term to refer to the need to be loved, liked, or accepted by another.

Positive reinforcer Any stimulus which, when added to a situation, increases the probability that a given behavior will occur.

Preconscious Freud meant by this term those mental elements which are currently not in awareness, but which can become conscious with varying degrees of difficulty.

Primary narcissism Freud meant the infant's investment of libido upon its own ego; self-love or autoerotic behavior of the infant.

Primary process Freud's term which refers to the id, which houses the primary motivators of behavior called instincts.

Progression Jung's term for the forward flow of psychic energy. Involves the extroverted attitude and movement toward adaptation to the external world.

Projection A defense mechanism whereby the ego reduces anxiety by attributing an unwanted impulse to another person or object.

Phototoxic Primitive, presymbolic, undifferentiated mode of experience which cannot be communicated to others.

Psychoanalysis Theory of personality developed by Freud and the Freudian school called by this name, and a recognized mode of psychotherapy.

Psychodynamic Loosely defined term usually referring to those psychological theories which heavily emphasize unconscious motivation. The theories of Freud, Adler, Jung, and Sullivan are usually considered to be psychodynamic.

Psychoid unconscious Jung's term for those elements in the unconscious which are not capable of becoming conscious.

Psychopathology General term referring to various levels and types of mental disturbances or behavior disorders, including neuroses, psychoses, and psychosomatic ailments.

Psychosis Severe personality disorders, as opposed to the more mild neurotic reactions. Psychoses interfere seriously with the usual functions of life and include both organic brain dysfunctions and functional or learned conditions.

Psychotherapy The analysis and treatment of mental and emotional disorders through the use of psychological insights and techniques,

both palliative and curative, designed to deepen the client's self-understanding through personal growth while nurturing the development of skills in interpersonal relationships.

Quaternary A Jungian term used to refer to an archetype symbolized by figures with four equal dies, or four elements.

Rational functions Jung's term for the methods of dealing with the world which involve thinking and feeling, i.e., valuing.

Reaction formation A defense mechanism characterized by the repression of one impulse and the adoption of the exact opposite form of behavior. Reactive behavior is ordinarily exaggerated and ostentatious.

Reality principle Freudian term used to refer to the ego, which must realistically arbitrate the conflicting demands of the id, the superego, and the external world.

Regression 1. Freud's term for a defense mechanism whereby the person returns to a stage previously characterized by libido in order to protect the ego against anxiety; return to an earlier time in life, usually childhood.

2. Jung's term for the backward flow of psychic energy. Regression involves the introverted attitude and movement toward adaptation to the internal world.

Repetition compulsion Freud used this concept to refer to the tendency of the instinct, especially the death instinct, to repeat or recreate an earlier condition, particularly one that was frightening or anxiety-arousing.

Repression Freud's term for the forcing of unwanted, anxiety-laden experiences into the unconscious in order to defend the person

against the pain of that anxiety.

Resacralization Maslow developed this concept for the process of returning respect, joy, awe, rapture, etc., to an experience in order that the experience is more subjective and personal.

Sadistic-anal phase Freud used this concept to refer to the anal phase, this is the second stage of the infantile period and is characterized by attempts to gain pleasure from the excretory function and such related behaviors as destroying or losing objects, stubbornness, neatness, and miserliness. Corresponds roughly to the second year of life.

Safeguarding tendencies A dominant concept in Adlerian psychology, this term is used to refer to the protective mechanisms such as aggression, withdrawal, etc., which maintain exaggerated feelings of superiority.

Schizophrenia Psychotic disorder characterized by fundamental disturbances in perception of reality, severe apathy, and loss of affect.

Secondary narcissism Freudian concept referring to self-love or autoerotic behavior in an adolescent.

Secondary reinforcement Learned reinforcement. If a previously ineffective event, for example money, increases the likelihood that learning will take place, then that event is a secondary reinforcer.

Selective inattention A classic term developed by Sullivan to refer to the control of focal awareness, which involves a refusal to see those things one does not wish to see or a refusal to hear things wishes not to hear.

Self In Jungian psychology, the most comprehensive of all archetypes, including the whole of personality, though it is mostly unconscious. The self is often symbolized by the mandala motif.

Self-accusation Adlerian safeguarding tendency whereby the person aggresses indirectly against others through self-torture and guilt.

Self-actualization Maslow's classic concept referring to the highest level of human motivation characterized by full development of all one's capacities.

Self-regard Rogers developed this term to refer to the need to accept, like, or love oneself.

Self-system Sullivan's term for the complex of dynamisms that protect the person from anxiety and maintain interpersonal security.

Self-transcendence In Franklian psychology, "self-transcendence is our ability to reach beyond ourselves to people we love or to causes that are important to us (Lukas)." "Self-transcendence is the essence of existence. Being human is being directed to something other than itself," according to Frankl.

Shadow Jungian archetype representing the inferior or dark side of personality.

Social interest An Adlerian term for the translation of the German, *Gemeinschaftsgefuhl*, meaning a community feeling or a sense of feeling at one with all human beings.

Social Psychotherapy The study of interpersonal relationships with particular attention to clinical issues related to interactive

dysfunctions, including self-image and social skills and the treatment of those dysfunctions.

Social Psychology Defined by William James, the father of modern psychology, as the "discipline that attempts to understand and explain how the thought, feeling or behavior of individuals are influenced by the actual, imagined or implied presence of others."

Social Psychiatry Defined by Harry Stack Sullivan, the father of American psychiatry, as "the study of processes that involve or go on between people. The field of psychiatry," he explains, "is the field of interpersonal relations, under any and all circumstances in which these relations exist."

Solicitude Adlerian safeguarding tendency whereby the individual depreciates others and receives an inflated feeling of superiority by acting as if other people are incapable of caring form themselves.

Somnolent detachment Sullivan's term for the dynamism that protects the person from increasingly strong and painful effects of severe anxiety.

Standing still Adlerian term for the safeguarding tendency characterized by lack of action as a means of avoiding failure.

Stereotypes Sullivan used this term to refer to imaginary traits attributed to a group of people.

Style of life Adler's terms for a person's individuality expressing itself in any circumstance or environment; the "flavor" of a person's life.

Subception A term developed by Rogers to refer to the process of perceiving stimuli without an awareness of the perception.

Sublimation A defense mechanism that involves the repression of the genital aim of Eros and its substitution by a cultural or social aim.

Successive approximations Procedure used to shape an organism's behavior; entails the rewarding of behaviors as they become closer and closer to the target behavior.

Superego Freud's classic term for that province of the mind which refers to the moral or ethical processes of personality. The superego has two subsystems – the conscience, which tells us what is wrong, and the ego-ideal, which tells us what is right.

Superiority complex Adler's terms used to refer to the exaggerated and unrealistic feelings of personal superiority as an overcompensation for unusually strong feelings of inferiority.

Suppression The blocking or inhibiting of an activity by either a conscious act of the will or by an outside agent such as parents or other authority figures. Not to be confused with *repression*, which is the unconscious blocking of anxiety-producing experiences.

Syntaxic Sullivan's well-developed concept used to refer to consensually validated experiences. As the highest level of cognition, syntaxic experiences can be accurately communicated to others, usually through language.

Taoist attitude An adapted term developed by Maslow to refer to the non-interfering, passive, receptive attitude that includes awe and wonder toward that which is observed.

Tenderness Sullivan used this term to refer to the tension within the mothering one, which is aroused by the manifest needs of the infant. Within the child tenderness is felt as the need to receive care.

Terror Sullivan's term for the experience of absolute or complete tension.

Theory A scientific theory is a set of related assumptions from which, by logical deductive reasoning, testable hypotheses can be drawn.

Thinking By this term, Jung meant a rational function that tells us the meaning of a sensation that originates either from the external world (extroverted) or from the internal or subjective world (introverted).

Third force Somewhat vague terms referring to those approaches to psychology which have reacted against the psychodynamic and behaviorist theories of Freud, Jung, Adler and Skinner and all those in between them. Rogers and Frankl belong to the Third Force, but some would argue that Erikson and Maslow belong to the psychodynamic school. Since no one pays dues to belong to one or the other, the question is essentially moot.

Threat Rogerian term for the results from the perception of an experience that is inconsistent with one's organismic self.

Transference Freud developed the term but many schools now use it to refer to the strong, underserved feelings the patient develops toward the analyst during the course of treatment. This feeling may be either sexual or hostile and stems from the patient's earlier experiences with parents.

Transformation Psychotherapeutic approach used by Jung wherein the therapist is transformed into a healthy individual who can aid the patient in establishing a philosophy of life.

Types Jung's classification of people based on the two-dimensional scheme of attitudes and functions. The two attitudes of extroversion and introversion and the four functions of thinking, feeling, sensing, and intuiting combine to produce eight possible types.

Unconditional positive regard A Rogerian term for the need to be accepted and prized by another without any restrictions or qualifications. One of three "necessary and sufficient" therapeutic conditions.

Unconscious Freud meant all those mental elements of which a person is unaware. Two levels of the unconscious are the unconscious proper and the preconscious. Unconscious ideas can become conscious only through great resistance and difficulty.

Undoing A Freudian defense mechanism, closely related to repression, involving the ego's attempt to do away with unpleasant experiences and their consequences by an expenditure of energy on compulsive ceremonial activities.

Vulnerable A Rogerian term for a condition that exists when people are unaware of the discrepancy between their organism selves and their experiences. Vulnerable people often behave in ways incomprehensible to themselves and to others.

Will-to-meaning "According to logo therapy," says Frankl, "the striving to find a meaning in one's life is the primary motivational force in man." This is in opposition to the will-to-pleasure in Freudian psychology and the will-to-power in Adler's thought.

Withdrawal Adler's term for safeguarding one's exaggerated sense of superiority by establishing a distance between oneself and one's problems.

E. Bibliographies of the Eight Classical Schools of Psychotherapy

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G. Definitional Parameters of Psychotherapy

John H. Morgan

Clinical Pastoral Psychotherapy is the study and treatment of dysfunctions in interpersonal relationships within the context of a spiritual worldview and ethos which provides a values-based framework for analysis and therapy.

Logotherapy is a type of psychotherapeutic analysis and treatment which focuses on a *will to meaning*. It is founded upon the belief that striving to find meaning in one's life is the primary, most powerful motivating and driving force within the #human experience. Sometimes called existential analysis, it is the Third Viennese School of Psychotherapy founded by Viktor Frankl, the first and second schools were founded by Freud and Adler.

Pastoral Care is understood to be the spiritual and emotional nurture traditionally provided by the ordained clergy without specific reference to or utilization of modern psychological insights and training.

Pastoral Counseling is the study and treatment of dysfunctions in interpersonal relationships based on a psychological understanding of the human person within the context of a spiritual worldview and ethos providing a values-based framework for analysis and therapy conducted by a professionally trained individual. Such an individual within the context of this study is understood to be an ordained minister serving a faith community.

Pastoral Logotherapy is the application of logotherapeutic analysis and treatment within the context of a spiritual understanding of the human situation and its relevance to mental health. Though not

specifically faith-based, pastoral logotherapy is practiced within the context of a spiritual awareness of self-transcendent reality.

Psychotherapy is the analysis and treatment of mental and emotional disorders through the use of psychological insights and techniques, both palliative and curative, designed to deepen the client's self-understanding through personal growth while nurturing the development of skills in interpersonal relationships.

Social Psychiatry is defined by Harry Stack Sullivan, the father of American psychiatry, as "the study of processes that involve or go on between people. The field of psychiatry," he explains, "is the field of interpersonal relations, under any and all circumstances in which these relations exist."

Social Psychology is defined by William James, the father of modern psychology, as the "discipline that attempts to understand and explain how the thought, feeling or behavior of individuals are influenced by the actual, imagined or implied presence of others."

Social Psychotherapy is the study of interpersonal relationships with particular attention to clinical issues related to interactive dysfunctions including self-image and social skills and the treatment of those dysfunctions.

H. Medication and Counseling in Psychiatric Practice

Biogenic Psychotherapy (Partnering in the Treatment of Mental Illness)

John H. Morgan

The practice of psychiatry, though a very young specialization within the field of medicine, was historically restricted to practitioners holding the Doctor of Medicine degree. It covered a wide ranging field of interests and clinical practices, including but not restricted to a combination of psychotropic drugs and psychotherapy. Since the coming of Harry Stack Sullivan (1892-1949), psychiatry has been redefined by him and his colleagues at the William Alanson White Institute of Psychiatry in New York City and the Washington School of Psychiatry in D.C. as "the study of processes that involve or go on between people. The field of psychiatry," then, he suggested, "is the field of interpersonal relations, under any and all circumstances in which these relations exist." Not everyone in or out of medical practice agree with Sullivan and his colleagues but the sentiment within the broader counseling professions is that this more expansive and psychogenically-linked definition is now more commonly employed in today's complex world of clinical psychotherapeutic and medical practice than is the old traditional and restricted biogenic definition circumscribed by psychotropic medical intervention.

Medication and counseling, and a varying combination of the two, constitute what today is thought of as the appropriate treatment of mental illness. Based on whether the diagnosis of the presenting mental disorder is biogenic or psychogenic in nature, either psychotropic drugs or psychotherapy must necessarily dictate the treatment prescribed. Psychopharmacology and psychotherapy are both considered appropriate methods of treatment depending, of

course, on the diagnosis. The present state of psychiatry, dominated by the insurance industry's jurisdiction in terms of coverable fee-based treatment, has been somewhat restricted in the use of psychotherapy in deference to psychopharmacological intervention. Within and without the profession there is the general consensus that the practice of psychiatry has suffered from these fiscal constraints and, therefore, a reliance upon social workers trained in counseling has become the normative practice within psychiatric treatment when a psychogenic illness has been diagnosed.

If Sullivan and company's expanded definition of psychiatry is embraced, namely, that this field of medicine deals fundamentally with interpersonal relationships, and the medical community is in agreement that both drugs and counseling are appropriate modalities of treatment, based upon the diagnosis, then a companioning of psychopharmacology and psychotherapy in psychiatric practice seems most reasonable and desirable. Biogenic illnesses are subject to psychopharmacological treatment whereas psychogenic illnesses are the domain of psychotherapy. In the best of all possible worlds, a complimentary relationship of these two modalities of treatment constitutes the ideal situation in any clinical practice. One need not adhere to the extremism of Thomas Szasz to see the value in pursuing a balanced diagnosis and treatment of mental illness using both drugs and counseling. The exploration of both modalities of treatment, pointing out the value of each within their own perimeters of jurisdiction and practice, would constitute a significant contribution to the discussion of the relationship between medication and counseling in the treatment of mental illness and the nurturing of mental health.

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