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Ethics as Therapy: Philosophical Counseling and Psychological Health

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ABSTRACT: From the inception of philosophical counseling an attempt was made to distinguish it from (psychological) therapy by insisting that therapy could not be more misleading. It is true that philosophical counselors should not pretend to be able to heal major mental illness; nevertheless they do contribute to positive health—health understood as something more than the absence of mental disease. This thesis is developed by critiquing Lou Marinoff's book, Plato not Prozac!, but also by ranging more widely in the literature on philosophical counseling. I also interpret philosophical counseling as a form of philosophical ethics.

Philosophical counseling is the application of ethics, critical thinking, and other philosophical resources in helping individuals cope with problems and pursue meaningful lives. Still a fledgling movement, it began officially in 1981 when Gerd B. Achenbach opened a private practice in Germany, although it has clear precursors in the Hellenistic philosophies of the Stoics and Epicureans.[1] Unlike these precursors, however, philosophical counselors generally insist they are not doing therapy; instead, they claim to be dealing with moral matters, understood broadly as questions about meaningful life. In doing so, they assume a *morality-therapy dichotomy*: human problems are either about morality or about mental health, but not both, at least not in the same respect. I seek to dissolve this dichotomy, thereby paving the way to explore the therapeutic dimensions of philosophical counseling, in addition to highlighting the

moral aspects of psychological counseling.

In the first section, I argue that most problems brought to counselors of all kinds have interwoven moral and therapeutic aspects. Although the primary task of philosophical counselors is not to cure mental illness, their services do tend to promote positive mental health, that is, psychological wellbeing beyond the mere absence of mental illness. In the second section, I discuss how philosophical counseling contributes to positive mental health, even when health is not adopted as an explicit goal. I also challenge some over-drawn contrasts, for example that psychotherapists deal with causes, whereas philosophical counselors deal with reasons. In the third section, I explore how philosophical counseling relates to philosophical ethics, in light of the overlap between morality and mental health. Although I draw widely from the literature on philosophical counseling, I devote special attention to *Plato, Not Prozac!*, a recent book by Lou Marinoff, current President of the American Philosophical Practitioners Association.

Diagnosing Problems: Morality and Mental Health

From the outset, philosophical counselors sought to distinguish their work from psychotherapy. In doing so, they portrayed psychotherapy as concerned with health and sickness, whereas philosophical counseling explores moral and other values that give life meaning. Psychotherapists seek to cure "patients," relying on a medical model that distinguishes normality from abnormality. Philosophical counselors help "counselees" pursue meaningful lives and resolve personal problems by using philosophical techniques, such as clarifying concepts, reasoning about values, and exploring worldviews. Roger Paden puts the point baldly:

Philosophical counselors "must reject 'health' as a normative ideal. The goal of philosophical counseling cannot be to return its clients to some minimal socially (or biologically) defined level of functioning; nor can it be to treat deviancy. Philosophical counseling cannot be a normalizing discipline."[2] Notice that Paden assumes that adopting health as a guiding ideal means setting out to cure sickness or social deviancy. This assumption overlooks the possibility that philosophical counselors might adopt positive health as at least a supplemental goal of philosophical counseling, where positive health encompasses more than the mere absence of mental illness. Paden also assumes a version of the morality-therapy dichotomy: philosophical counseling is either about morality or about health, but not both.

Lou Marinoff offers a murkier, although potentially more accurate, picture of how philosophical counseling is related to health. On the one hand, he inveighs against the therapeutic preoccupations in our society and challenges psychotherapy as commonly practiced: "too much of psychology and psychiatry have been aimed at 'disease-ifying' (that is, medicalizing) everyone and everything in sight, looking to diagnose each person who walks in the door and find what syndrome or disorder could be the cause of their problems" (11).[3] In places, he sympathetically cites Thomas Szasz's radical view that mental illness is a sheer myth, that the only genuine mental disorders are biological rather than psychological in origin (16, 27-28). And he mocks the psychiatrists' *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which, by listing nearly 400 disorders, effectively pathologizes most seriously undesirable behaviors, emotional disturbances, and character flaws ("personality disorders") (18). The vast majority of people who seek counseling need moral reflection, not healing; they "need dialogue, not diagnosis," "contemplation, not medication" (4, 6). Most problems brought to

psychotherapists concern moral values, for example, decisions about whether to stay in a love relationship, how to cope with a divorce, overcoming unhappiness with one's job, whether to blow the whistle on a corrupt employer, working through a religious crisis, resolving fights with in-laws, accepting one's sexuality, and in general struggling to find meaning (3).

On the other hand, Marinoff frequently uses therapeutic language in characterizing philosophical counseling. Without explanation, and contrary to the anti-therapeutic bent of most of his book, he calls philosophical counseling a form of "talk therapy" and speaks of philosophical counselors "healing" depression (33). He insists that philosophical counselors have the same claim for reimbursement for their services from health insurance companies as do psychotherapists (24). He acknowledges that psychologists occasionally help people with what, by his own account, are value questions, although he does not explain how that is possible given their health-orientation. And he concurs with Peter March, a Canadian colleague, that philosophical counseling is "therapy for the sane" (11). This interesting expression poses a dilemma, which Marinoff leaves unexplored. If "sane" means completely healthy, then the term "therapy" is inappropriate. If "sane" means "not insane," then most psychotherapy also qualifies as therapy for the sane, and the phrase does not distinguish philosophical counseling from psychotherapy.

Is Marinoff trying to have it both ways? Is he denying that philosophical counselors engage in therapy, when he wants to distinguish them from psychotherapists, and yet affirming that philosophical counselors engage in therapy, when he celebrates their contributions? I believe his view can be rendered consistent, and the work of philosophical counselors illuminated, by embracing a conception of positive mental health.

To show this, and to show how the problems brought to philosophical counselors frequently have both moral and health dimensions, it will be helpful to use depression as an example. Not only does depression take many forms, ranging from major pathology to everyday "blues," but because all types of counselors encounter depression frequently in their daily work. Indeed, according to one observer, "depression has overtaken anxiety as our presiding discontent."[4] Marinoff borrows a case study of depression from his colleague Ben Mijuskovic. I will quote directly from Mijuskovic's description of the case, noting places where Marinoff alters a few details.

A thirty-seven year old man, who had been a monk since he was seventeen (Marinoff says since ten years earlier), sought Mijuskovic's help because he was experiencing "'symptoms of major depression,' fatigue, sleeping problems, feelings of hopelessness, helplessness, and suicidal ideation."[5] Despite the severity of the symptoms, Mijuskovic judges that the monk's depression is not a pathological ("clinical") depression, nor in other ways a health issue. Instead, the monk suffered from a value conflict "created by a revived self-awareness that he had spent two decades of his life committed to a religious life, which included helping strangers at his monastery, but excluded sexual intimacy and the formation of a biological family to which he could belong." It became clear that the man was faced with a choice between re-affirming his vows as a priest or abandoning them in order to begin a new life outside the monastery: "His crisis was a religious and intellectual one. Its very core was a dilemma between two attractive value systems. But it was not a psychiatric problem. Medication and psychotherapy [which he had already tried], with its focus on the past, could not resolve the crisis." During six months of counseling, Mijuskovic and the monk discussed a variety of writings, especially concerning religious conversions as

discussed by St. Augustine and Soren Kierkegaard. Marinoff adds, apparently based on conversations with Mijuskovic, that a turning point came when Mijuskovic asked the monk "whether it was possible that loss of meaning could be causing his feelings of depression, rather than the other way around," and the monk immediately affirmed the former possibility (218). Marinoff also says the monk resolved his crisis by leaving the monastery while maintaining his religious faith.

Judging from what we are told, the philosophical counseling is successful, and more generally I concur that philosophical counselors often help people who are depressed. However, I challenge the claim that because values were the crux of the monk's problems that mental health and healing were not involved. That is, I reject a morality-therapy dichotomy that says health issues are irrelevant simply because moral and religious values are at stake (and vice versa).[6] Common sense tells us that persons suffering from "'symptoms of major depression,' fatigue, sleeping problems, feelings of hopelessness, helplessness, and suicidal ideation," with a severity that sends them to seek professional help, are not in peak mental health.

Of course, common sense can be mistaken. How do we determine whether a particular depression is pathological, or at least unhealthy in some broader sense? Marinoff suggests the answer lies in its origin, its "root cause." He distinguishes four types of depression, depending on whether the "underlying problem" is (1) a genetic brain abnormality, (2) an induced brain abnormality due, for example, to drug or alcohol abuse, (3) an unresolved childhood trauma or other problem in the past, or (4) "an acute happening in one's current life . . . [that] might be a professional crisis, an impending personal or financial problem like divorce or bankruptcy, or a moral or ethical dilemma" (33). According to Marinoff, the first type of depression is a physical

illness requiring the help of psychiatrists or other physicians. The second type is "a physical or psychological dependency" that also requires medical attention. The last two types of depression can benefit from "talk therapy." Specifically, the third type can benefit from psychology and sometimes from philosophical counseling. "But in the fourth scenario--by far the most common one brought to counselors of all kinds--philosophy would be the most direct route to healing" (33).

This last claim is an empirical hypothesis for which Marinoff provides no support. It is a dangerous assertion, in that it might discourage sick individuals from seeking therapy, and it is at odds with contemporary psychiatry. Psychiatrists define pathological depression in terms of patterns of behavior, belief, and emotion, not in terms of causal origins. The DSM sorts out several different types of pathological depression, but all make reference to mood and behavior disturbances characterized using non-etiological criteria of this sort: "depressed mood most of the day, nearly every day," "markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day," "insomnia or hypersomnia nearly every day," "fatigue or loss of energy nearly every day," "feelings of worthlessness or excessive or inappropriate guilt . . . nearly every day."[7] Using such criteria, it is not at all uncommon for "an acute happening in one's current life" to generate a pathological depression, including what is called a Major Depressive Disorder. Quite possibly that was true in the case of the monk.

For his part, Mijuskovic, who works within a health care clinic, wisely cautions that "philosophical counselors should be trained in psychiatric disorders, or terrible mistakes could happen, albeit unintentionally."[8] Karl Pfeifer, a philosopher and a former welfare worker, also warns that traditional training in philosophy programs, by itself, is usually not an adequate

preparation to help clients suffering from depression, anxiety, anger, and a host of other emotional disturbances that might be linked to their values.[9] Although there are naturally gifted therapists, including some philosophical counselors, any profession must assure quality control beyond the gifted individual. My concern here, however, is not with the training and credentialing of philosophical counselors. It is to insist that neither Marinoff nor Mijuskovic provide grounds for denying that the monk faced a significant health problem, as well as a moral and spiritual crisis. Moreover, the health and value dimensions of his difficulty were interwoven, rather than neatly separable.

For the sake of argument, however, let us assume that the monk was not clinically depressed, that he did not fully meet the criteria in the DSM. Would it follow that his depression was not a health concern? No, for there are intermediary states between full-blown clinical depression and entirely healthy states of depression. In general, full-blown mental disorders and optimum health are not exhaustive categories. Intermediary states include some instances of significant depression, anxiety, rage, difficulties in relating to people, and lack of self-control. They also include unhealthy habits, such as smoking, drinking immoderately, and driving without a seatbelt. Persons engaging in these risky behaviors might not be sick but nor are they optimally healthy.

To make sense of these intermediary states we need to embrace a positive rather than a negative conception of health. Negatively conceived, health is the mere absence of major maladies (sickness, disease, injury, and infirmity). Hence, using negative definitions, health and major maladies are mutually exhaustive: If one is free of major maladies, one is completely healthy. As positively conceived, however, health includes states of wellbeing beyond the mere

absence of disease. Lacking major maladies, one can still be less than optimally healthy. A positive concept of health allows us to say that even if the monk was not clinically depressed he was not in optimal psychological health at the time he sought help.

Among health care professionals, the most famous conception of positive health was promulgated by the United Nations World Health Organization (WHO): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[10] Positive definitions were also set forth by humanistic psychologists such as Erich Fromm and Abraham Maslow, who viewed mental health and moral values as interwoven. Among philosophers, the most famous conception is the explicitly-moral one developed by Plato in the *Republic*: "It appears, then, that virtue is as it were the health and comeliness and well-being of the soul, as wickedness is disease, deformity, and weakness."[11] With this in mind, there is considerable irony in Marinoff's title, *Plato, Not Prozac!*, for it implies a dichotomy between ethics and therapy that Plato himself renounced. The title also clashes with the occasional, and undeveloped, passage where Marinoff comes close to abandoning a morality-therapy dichotomy; for example, "Some may need Prozac first, then Plato later, or Prozac and Plato together" (10). Compounding the irony, positive conceptions of mental health were also standardly embraced by the Epicureans and Stoics, whom philosophical counselors frequently cite as their predecessors. Witness Epicurus: "Empty is that philosopher's argument by which no human suffering is therapeutically treated."[12]

This is not the place to argue for any one positive conception of health. Briefly, I believe that all six elements identified long ago by Marie Jahoda play a role in good health: positive attitudes toward oneself (self-esteem), accurate perception of reality (realistic cognition), environmental

mastery (functional fitness, ability to cope socially), personal integration, autonomy (rational self-governance), and ongoing self-growth.[13] Taken together, these elements favor the holistic, biopsychosocial spirit of the WHO definition, although the idea of "complete" well-being is too idealistic to be of much practical use. It is better replaced by the looser idea of satisfactory or "adequate" fitness and function, where the criteria for adequacy are partly subjective (what one desires for oneself) and partly assessed by rational observers. I agree with Plato in seeing a wide overlap between basic moral responsibility and mental health, although he goes too far in equating morality and mental health.[14] An isolated act of poor moral judgment or weakness of will is not a sign of poor mental health, and severe mental disorders such as Alzheimer's Disease have nothing to do with the absence of virtue. Especially insightful is Lawrence Becker's neo-Stoic definition of health as including "effective powers of deliberation and choice, and the disposition to use them," and as excluding an array of specific dispositions that undermine effective agency--including severe depression.[15]

Philosophical counselors need not share any one of these or other detailed conceptions of positive health, any more than psychotherapists do. It is important, however, that they acknowledge the interconnections between moral values and positive mental health, thereby dissolving the morality-therapy dichotomy. The same is true of negative definitions of health, for even mental disorders are defined in part by using moral criteria. As Rem Edwards notes, "Most philosophically minded thinkers who have looked critically at the concepts of 'mental health' and 'mental illness' have found them to be inherently value-laden. This means that evaluative components as well as descriptive elements are inescapably a part of their meaning. We pack our value preferences and aversions into these notions. 'Mental illness' includes things regarded as

highly undesirable; and 'mental health' includes things judged to be highly desirable."[16]

Critics, including Edwards himself, object that positive concepts of health lead to the expansive pathologizing that alarms Marinoff and others. Yet, although positive concepts do greatly broaden what counts as health matters, they do not by themselves increase what counts as mental illness. Unquestionably, our culture has been shaped dramatically by a *therapeutic trend*: the tendency to adopt health-oriented approaches to issues traditionally viewed as moral matters. As just a few examples, the DSM lists drug abuse, alcohol dependence, impulse control disorders, and a variety of personality disorders that in the past were discussed as character flaws. Critics of the therapeutic trend, however, fail to distinguish two interpretations of it, or rather two different components of it: a replacement project and an integrative project.

The *replacement project* seeks to replace morality with therapeutic outlooks.[17] I agree that the replacement project should be rejected as a general threat to morality.[18] It is also muddled, insofar as it assumes therapy is morally neutral. And it is dangerous, insofar as it creates the "medical tyranny" of therapists who are implicitly given power in moral matters, under the guise of morally neutral science. Both advocates and critics of replacement projects think in terms of a morality-therapy dichotomy, such that regarding a problem as a health matter automatically places it outside the realm of moral values. In contrast, the therapeutic trend contains an *integrative project*, the project of integrating moral and therapeutic perspectives. Far from assuming a morality-therapy dichotomy, it seeks to link moral and therapeutic outlooks. Philosophical counseling is best viewed as part of an integrative project that views therapeutic outlooks as resources, rather than as threats.

Of course, the details about this integration matter greatly. A sound integrative project will

link *justified* moral perspectives with *sound* therapeutic perspectives, and identifying those perspectives is a matter of considerable controversy. Nevertheless, a careful integrative project opens up new ways of thinking about many human problems as having both moral and health dimensions. Certainly that is true of drug abuse, alcohol dependency, impulse control disorders (loss of rational self-control), and depression. It also enables us to rethink philosophical counseling as frequently dealing with problems having both moral and health dimensions, as in the case of the monk.

I should add that psychotherapists also stand to benefit from an integrated, moral-therapeutic outlook. Many psychology-based counselors work with a morality-therapy dichotomy, either by renouncing moral matters as irrelevant to their work (as Marinoff notes) or by renouncing health as their goal (as Marinoff fails to note). Influenced by Szasz, the latter group think of their work as helping people with "problems in living," rather than as health matters. They would benefit from a positive conception of mental health that highlights psychological health beyond the absence of mental illness. Also, in a recent general textbook on all forms of counseling, *The Virtuous Therapist*, Elliot D. Cohen (himself a philosophical counselor) and Gale Spieler Cohen bypass the entire topic of mental health by characterizing all counseling as aimed at promoting clients' welfare, understood as promoting their pleasure and alleviating their pain.[19] I find the Cohens' approach helpful as a corrective to what Marinoff calls the excessive diseasifying of human behavior, although their approach would be strengthened even more by additional emphasis on how morality, personal welfare, and positive health are blended at numerous junctures.

Finally, in urging that the problems brought to philosophical counselors often have

therapeutic dimensions, I am not suggesting they always do. Some clients just want to study philosophy outside university settings, and for them philosophical counselors function much like private tutors. Other clients seek moral advice, for example about whether to have an abortion or how to implement justice at the workplace, and philosophical counselors might be willing to offer that advice or at least function as sounding boards (3, 194-198). Even in such cases, however, health matters might be involved somewhat, especially where major anxiety, excessive self-doubt, depression, and other psychological states disrupt the ability to make decisions.

Helping: Methods and Results

I have argued that many problems have both moral and mental health dimensions, and hence we should renounce any morality-therapy dichotomy with regard to the aims of philosophical counselors and psychotherapists. In this section I argue that the same is true regarding the methods (techniques, approaches) and results of counselors and therapists, contrary to the contrasts frequently drawn in the literature on philosophical counseling. I begin by asking how it is possible for philosophical counselors to disavow health as an aim and yet to succeed in moving clients toward greater health. For example, how was it possible for value inquiries and philosophical dialogue to help alleviate the monk's depression? It was possible for two reasons.

First, as already noted, morality and mental health are interwoven. They are interwoven conceptually: Mental health is partly defined in terms of moral values used in affirming particular psychological conditions as desirable and others as undesirable. They are also interwoven causally, in that moral transformations frequently carry with them changes in mental wellbeing. Consider affirmative attitudes toward oneself, which Jahoda identified as one of the criteria for

positive health long before it became a contemporary preoccupation of therapists and authors of self-help books. Fostering these attitudes is an important part of both psychotherapy and philosophical counseling, especially in responding to depression. Psychotherapists construe these positive attitudes as self-esteem, whereas philosophical counselors are more likely to understand them as the moral virtue of self-respect. Yet, self-esteem and self-respect are connected. As used by psychotherapists, "self-esteem" is in part a quasi-moral concept that refers to "appropriate" self-affirmation, ruling out the extremes of masochism and narcissism.

Mental health and moral character are also connected causally, albeit in complex ways. Consider moral integrity and psychological integration. They are not the same thing, nor does the one always lead to the other. Nevertheless, psychological integration and mental health are very often promoted by bringing greater clarity, consistency, and reasonableness to the values that guide conduct and structure emotions. Human wellbeing in all its dimensions, including mental health, is largely shaped by moral values. Confused, contradictory, and irrational values can foster poor mental health, just as much as genetics and unfavorable social conditions can. At one point, Marinoff comes close to admitting as much, although without elaboration and with the defusing insertion of inverted commas: "philosophical practitioners can help restore moral order--and with it 'mental health'. . . . Moral order isn't a drug, but it does have wonderful side effects" (21).

The second basic way in which philosophical counseling promotes positive mental health has little to do with the philosophical techniques and aims that set it apart from psychology-based therapies. Instead, it concerns what philosophical counseling has in common with psychotherapy: Both are forms of counseling. Counseling is a human interaction centering on

help-oriented dialogue. How is it possible that literally hundreds of different kinds of counseling and psychotherapies all manage to help some individuals? Some psychologists hypothesize that there are structural factors common to these different therapies, or at least recurring and overlapping factors that have therapeutic effects, usually far more than the efficacy of specific theories and techniques.

For example, the humanistic psychologist Carl Rogers was one of the first to identify and emphasize common elements in effective counseling. He concluded there are three interwoven elements: genuineness, caring, and empathetic understanding. Genuineness (or "congruence") means that therapists present themselves to clients openly and "without facade."[20] That does not mean therapists should express all their feeling to clients, for that could disrupt therapy. Instead, it means therapists should monitor their feelings about clients and be willing to express persistent feelings when doing so is consistent with caring and empathy. Caring, or what Rogers calls unconditional positive regard, means conveying to clients a deep concern for them as individuals. It also means suspending most moral judgments about them, although Rogers allows a few exceptions such as the extremely immature client who can benefit from some direct moral guidance. Empathy means accurately understanding what clients are experiencing, together with skillfully communicating that understanding to the clients. Rogers hypothesized that these three features are catalysts for promoting personal growth, regardless of the particular theoretical framework or specific techniques adopted by a therapist. They do so by providing a context of concerned support, trust, and insight that enables clients to explore their emotions and problems, and especially by moving clients toward greater self-acceptance and openness to experience.

Empirical studies have not confirmed all aspects of Rogers' hypothesis, but his basic idea of a

"common factors approach" to helping has considerable plausibility. Jerome Frank conducted studies suggesting that specific doctrines and techniques often matter little. In his view, therapies succeed because of four features: (1) an emotionally-charged relationship with a caring therapist, (2) a healing setting in which clients believe the therapist has expertise and feels safe in opening up emotionally, (3) a rationale that provides a plausible explanation of the patient's symptoms, and (4) a procedure both the therapist and client believes will lead to healing.[21] Citing Frank's research, David A. Jopling argues that at least much of the effectiveness of philosophical counseling resides in such common factors.[22]

If Jopling is correct, and I believe he is, should we reject Marinoff's claim that the techniques of philosophical counselors have unique power? In fact, at one point Marinoff expresses substantial agreement with Jopling's view:

> A good therapist of any stripe will provide sympathy, empathy, and moral support, which can go a long way toward healing. Something as simple as dialogue with another caring individual is a balm in many cases. It isn't expertise that makes a good counselor; expertise isn't even necessary. More important is the ability to listen, to emphasize, to understand what another person is saying, to offer some new way of looking at it, and to proffer solutions or hope (34).

Actually, Marinoff overstates the case. It is true that sometimes the common factors suffice to help, regardless of the specific tools used. But if expertise were irrelevant, there would be no need for Marinoff to write his book making claims on behalf of the distinctive benefits of

philosophical counseling. Nevertheless, the conclusion stands: Philosophical counseling can promote mental health simply by virtue of sharing generic features with other forms of counseling, and not just because of its specific techniques.

I turn, more briefly, to two overdrawn contrasts between the methodologies of psychotherapists and philosophical counseling. One contrast is that psychotherapists are preoccupied with the distant *causes* of problems, whereas philosophical counselors focus on *reasons* and reasoning about how to solve problems. Thus, Marinoff says that psychotherapists are preoccupied with unconscious causes going back to infancy, and they approach healing by identifying and modifying the impact of past causes (17-18, 26). Similarly, Mijuskovic characterizes psychotherapy as concerned with mental disorders that are "the result of forces beyond the patient's ability to control," such as organic causes and earlier traumas.[23] Philosophical problems, both agree, concern value choices and presuppose the person is able to exercise reflection and make choices. Again, Ran Lahav says that philosophy is about exploring relationships among ideas and values embedded in worldviews, whereas psychotherapy deals "with psychological (affective, cognitive, behavioral) processes or events (e.g., conflicts, experiences, fantasies, thoughts, anxieties, etc.), i.e., processes inside the patient which underlie the predicament (or life) in question . . . especially as causes of behavior."[24]

The view that psychologists focus on causes of problems to the neglect of their current value implications is a false generalization. Most psychological therapists are very interested in their clients' current values, as embedded in attitudes and patterns of conduct and reasoning. Getting at root causes is a means to transformation, not an end in itself. To be sure, there might be general differences in which values are highlighted, with psychologists tending to have greater

interest in issues about valuing oneself. Nevertheless, any sweeping contrast between causes and meaning-giving reasons (or motives) is implausible. Moreover, everything involved in having a worldview--beliefs, values, patterns of attending, reasoning, dilemmas, etc.--are themselves psychological processes and states.

As for causal factors from early infancy, that is a preoccupation only in some psychotherapies, most notably psychoanalysis. Moreover, the emphasis on complete causal determination applies only to some psychotherapies such as psychoanalysis and behaviorism. Because those forms of therapy were dominant just prior to the emergence of philosophical counseling, it is understandable that philosophical counselors tended to be preoccupied with them in establishing their new version of counseling. Today, however, psychoanalysis is rapidly declining in influence, and behaviorism has largely been reworked and linked to cognitive psychology that, like philosophical counseling, underscores the role of reasoning in human psychology. Moreover, because health care insurance now funds only briefer therapy programs, extended exploration of childhood influences on current problems, such as occurred in classical psychoanalysis, is possible only for the wealthy. Many current psychotherapies, and there are now over 400 different ones,[25] set themselves against the deterministic bent of classical behaviorism and psychoanalysis. Today the dominant mode is cognitive and cognitive-behavioral psychotherapy that emphasizes patterns of thinking about problems and, as such, are related to what philosophical counselors do. An example frequently cited is Albert Ellis's Rational Emotive Therapy, which is close kin to the rational dialogue employed by philosophical counselors.

I should add that there is no necessary connection between causes of problems and their cures.

The causes of problems might involve many factors. Even where a current event in a person's life triggers a problem, the event can be connected with an array of other factors, including genetic, brain chemistry, upbringing, and psychology. The complete explanation of why some of us explode in rage in response to a problem at work while others quickly laugh it off might connect with many elements of a life that neither a psychiatrist nor a philosopher can be certain about. Again, regardless of the particular cause of a depression, medication might help, and so might philosophical discussions with a counselor. The claim that only philosophy will help solve a personal crisis where value issues are involved is simply false.

As a second general contrast, Marinoff claims that most psychotherapy never progresses beyond "validating the emotions," whereas philosophical counselors explore the underlying values that structure emotions and cause distress (38). This stereotype of psychotherapy fits some forms but not all. For one thing, by Marinoff's own admission, emotions and the attitudes they express are not separable from values. When therapists explore and affirm particular emotions they thereby explore and affirm particular values. For another thing, it is not true that psychotherapists merely affirm all emotions equally, and leave matters at that. They seek to modify unhealthy emotions and disruptive moods such as excessive depression, guilt, self-hatred, and rage. Doing so is part of helping clients find creative ways to resolve issues involving moral values.

It is true that therapists typically adopt a stance of value-neutrality, but it does not follow that they are uninterested in questions of value and meaning. Philosophical counselors, too, must work largely (though not exclusively) within the framework of their clients' value perspectives. In fact, some psychotherapists adopt what are essentially philosophical approaches aimed at

reasoning about values explicitly. Certainly that is true of existential psychotherapy, which is not surprising given its roots in the writings of Martin Heidegger, Jean-Paul Sartre, and other existentialist philosophers. Existential psychotherapy understands clients' problems as centered in unhealthy responses to anxieties linked to fundamental features of the human condition: for example, death, freedom, isolation, the need for personal responsibility, and the threat of meaninglessness.[26] Because of the strong overlap of approaches, existential psychotherapies can be viewed as forms of philosophical counseling.

From another perspective, Alan C. Tjeltveit suggests that in practice a psychotherapist often functions as an ethicist, in the sense of "a person who reflects on, has convictions about, and/or attempts to influence others about ethical questions and issues."[27] As Tjeltveit explains, several considerations make it is easy for psychotherapists to be unaware of their role as ethicists. Their professional code of ethics requires them to avoid imposing their personal values on clients, to function non-judgmentally and without blaming. Nevertheless, short of imposing values, therapists exercise many forms of tacit influence on clients (157). In addition, there are limits, and sometimes an explicit goal is to change the behavior of a child molester, as part of court-ordered therapy. Most important, the fact that therapists work primarily within the client's value perspective does not mean that psychotherapy is value-free. For, doing so is required by fundamental moral values governing psychotherapy: respect for autonomy, caring (beneficent helping), and a framework of basic moral decency embedded in the psychotherapeutic goals such as improving mental health and personal growth.

Philosophical Counseling as Ethics

Do the therapeutic dimensions of philosophical counseling imply that it is actually a new form of psychotherapy? If so, would it follow that philosophical counseling is not a branch of philosophical ethics?

The answer to the first question, Is philosophical counseling a form of psychotherapy?, turns on how we define psychotherapy. If psychotherapy means psychology-based and psychiatric-based counseling, then of course philosophical counseling is not psychotherapy. Philosophical counseling is a new form of counseling centered on philosophical approaches, skills, ideas, perspectives, and hence training in philosophy. If, however, psychotherapy is understood more broadly as mental or *psyche*-therapy--as therapy for a person-as-mental-being who pursues meaning, engages in reasoning about values, and seeks positive health beyond the mere absence of mental illness--then philosophical counseling is a form of psychotherapy.

Viewing philosophical counseling as a new version of psychotherapy does not threaten its distinctiveness. Philosophical counseling remains distinctive insofar as it makes philosophical methods and perspectives central, together with devoting more explicit attention to values than is common in most psychotherapy. Philosophical skills include clarifying concepts, identifying hidden assumptions, drawing relevant distinctions, engaging in cogent reasoning, examining worldviews (general perspectives). Philosophical resources include readings, insights, and perspectives from the history of philosophy that express the substantive views of philosophical thinkers. And philosophical interests include a search for important truths, justified values, solution of conceptual perplexities, exploration of worldviews. Together, these features of philosophical counseling open up fresh approaches in counseling, approaches that might

eventually influence and blend with other types of counseling and therapy.

The answer to the second question, Is philosophical counseling a form of philosophical ethics?, deserves fuller comment. Eckart Ruschmann suggested that in establishing their new profession, philosophical counselors have had to fight on two fronts: "first against psychotherapists who force upon their clients a rigid diagnostic and therapeutic system, and second against academic philosophers who overlook the problems of daily life (and thus at the same time the special needs of the philosophical practitioner)."[28] Philosophical counselors have sometimes exacerbated tensions by adopting a dismissive attitude toward mainstream academic philosophy. Marinoff, for example, is both unfair and gratuitously antagonistic when he dismisses academic philosophy as "rarely applicable to life," as "mental gymnastic having nothing to do with life" (8). Ran Lahav is slightly more generous in acknowledging applied ethics, but he still objects that all academic ethics is more theory than practice and that philosophical counseling is a more direct route to philosophical self-understanding.[29]

In reply, applied (or practical) ethics, which has flourished for several decades in academia, is very much applicable to life. It tackles topics as earthy as sex and love, guilt and forgiveness, happiness and virtue, work and the professions. Its results provide invaluable resources for philosophical counselors to draw upon, just as counselors provide applied ethicists with new material for discussion. To be sure, it is true that most theoretical philosophy ignores or discounts what philosophical counselors do, but it also ignores or discounts applied ethics.

As an example, consider William Frankena's delineation of philosophical ethics in his widely read text, Ethics, the second edition of which appeared seven years before Gerd Aschenbach began his work. Frankena urged that even the most abstruse ethical theory is practical insofar as

it concerns how we should live, but he also established rigid limits to ensure that philosophical ethics remains oriented toward general principles. When philosophers discuss practical issues like abortion and violence, they should "stress general principles, careful definition of terms, and logical reasoning, rather than specific cases and detailed answers."[30] Philosophical ethics concerns "general questions about what is good or right" but not trying "to solve particular problems as Socrates was mainly doing in the Crito."[31]

This reference to the Crito is ironical, for Frankena in fact draws on that dialogue to engage his readers at the opening of his book. Socrates's "particular problem" in the Crito was whether to drink the hemlock as punishment for his alleged crimes or to accept the help of friends in escaping to safety. Presumably Frankena was willing to use concrete examples to arouse interest and to illustrate general principles, but not as objects of philosophical inquiry per se. Philosophical counselors reject that approach as inconsistent, and they are right to do so. Philosophical ethics is very much concerned with solving specific problems using philosophical reasoning.

There is no basis for assuming that studying abstract philosophical theory automatically contributes to solving practical personal problems. Wittgenstein, that philosophers' philosopher, once asked rhetorically, "What is the use of studying philosophy if all that it does for you is to enable you to talk with some plausibility about some abstruse questions of logic, etc., and if it does not improve your thinking about the important questions of everyday life."[32] Wittgenstein posed the question in chastising his student, Norman Malcolm, for naively believing the British were too civilized to plot a bombing assassination of Hitler. At the time, Malcolm was studying esoteric issues in logic and the foundations of mathematics, and apparently Wittgenstein simply

assumed that such studies should have a trickle-down benefit in everyday life. Philosophical counselors reject that assumption, but so do applied ("practical") ethicists. To be relevant to our everyday lives, ethics must tackle everyday beliefs, attitudes, and reasoning more directly.

To be sure, there are significant differences between what goes on in universities in studying applied ethics and what occurs in counselors' offices. Academic philosophy, both theoretical and applied, is aimed at teaching and developing a discipline as a branch of the liberal arts. Most professors attempt to connect readings and assignments with students' practical interests, but usually not in response to the specific life problems each student brings to the classroom. Because of these different goals, different techniques employed. Academics assign extended readings on opposing sides of issues, and they grade essays and tests, all with an eye to inculcating high standards in the pursuit of understanding. Most of this does not occur in philosophical counseling, thereby raising questions about whether counseling is genuine philosophy or its simulacrum.

In a way, such doubts are as ancient as Aristotle's critique of Plato's blending of morality and mental health. Although she does not discuss philosophical counseling, Martha Nussbaum's study of Aristotle's critique of Plato in *A Therapy of Desire* bears scrutiny. Nussbaum is sympathetic to the therapeutic orientation of Epicurean, Skeptic, and Stoic philosophies: "The idea of a practical and compassionate philosophy--a philosophy that exists for the sake of human beings, in order to address their deepest needs, confront their most urgent perplexities, and bring them from misery to some greater measure of flourishing--this idea makes the study of Hellenistic ethics riveting for a philosopher who wonders what philosophy has to do with the world."[33] Nevertheless, echoing Aristotle, Nussbaum expresses three reservations about thinking

of ethics as therapeutic. All of them center on whether a practical, therapeutic orientation invariably dilutes the search for truth, thereby raising doubts about whether it is "really" philosophy.

First, Aristotle argued that the virtues (excellences) of medical craft and other health care are aimed at healing, whereas the virtues of ethical inquiry are valued for themselves, as part of the goal of pursuing truth. The danger of thinking of ethics as therapy is that doing so could subsume and distort such key values as clarity of thought, cogency of reasoning, sensitivity and insight into values, and in general commitment to truth. Nussbaum explores how this became a genuine danger in Hellenistic philosophy. Throughout her study, Nussbaum herself is concerned with how a "passion for health" "might subordinate truth and good reasoning to therapeutic efficacy."[34] Despite the rigor of Stoic and Epicurean philosophers, when they applied their skills to healing particular individuals they would be tempted to elevate healing over truth seeking, or more generally practical problem solving over philosophical understanding.

In reply, let us acknowledge that there is indeed a risk of subsuming truth to usefulness, especially in a form of counseling that centers itself in the philosophical pursuit of rationality and moral responsibility. This risk has been discussed in the literature on philosophical counseling, and it should continue to be discussed.[35] Some philosophical counselors, in particular Ron Lahav, make problem solving secondary to the broader search for meaning, "a never-ending search, an endeavour of creative openness to new horizons rather than an attempt to produce solutions and ultimate theories."[36] Perhaps most counselors, however, work with people who seek help with specific problems and who might view the wider pursuit of truth secondary to immediate coping.

Thus, although Marinoff speaks of drawing on "timeless insights" from the history of philosophy, in practice he draws on any philosophical idea he thinks will help his clients solve their problems. He says he functions as "an advocate for my client's interests. My job is to help my clients understand what kind of problem they face and, through dialogue, to disentangle and classify its components and implications. I help them find the best solutions: a philosophical approach compatible with their own belief system yet consonant with time-honored principles of wisdom that help in leading a more virtuous and effective life" (9). Again, "philosophical counselors are like matchmakers: we help our clients find a philosophical interpretation of themselves and their situations that they can live with, and prosper with, over a lifetime" (50). I might add that the danger of subsuming truth to usefulness arises in all areas of life, including writing and teaching academic philosophy within the practical limits imposed by institutions, and that professors too seek to match their students with accessible and engaging texts.

Second, Aristotle pointed out that because medicine has the practical goal of helping (as do other forms of therapy), there is little interest in exploring many different views on ethics. Conceiving of ethics on the medical analogy would tend to discourage the study of alternatives. In contrast, philosophical ethics requires exploring alternatives, if only to counter the influence of blinkers and biases in a search for broader truths. This is a useful caution regarding philosophical counseling. For example, in helping a woman who is excessively self-sacrificing, Marinoff recommends that she read Ayn Rand, an exponent of the view that morality is solely about maximizing self-interest. Even if he only intended Rand as a corrective for a given excess, rather than the basis for a sound ethics, we might fear that when philosophy becomes too narrowly oriented to solving particular problems it compromises its claim for a search for truth.

At the same time, virtually all forms of therapy have a focus in practical problem solving in ways that limit what can be done in a short amount of time. Furthermore, although some philosophy is purely theoretical and has little connection with personal interests, a great deal of philosophy has a highly personal dimension. In addition to much applied ethics, the insights of philosophers like Friedrich Nietzsche, William James, Jean-Paul Sartre, and Martha Nussbaum herself are deeply rooted in their personal experience, and some would argue that the personal is never far from the surface of most philosophers' engagement in their work. Needless to add, in the classroom there are also practical limits on how many opposing perspectives can be explored, whether the limits are owing to finite class time or to the imagination of professors.

Third, medicine and most other therapy is based on a strong asymmetry of roles, with doctors having authority over patients, whereas philosophical ethics requires active involvement of student and teacher. There is also the concern that therapists will pass on their own philosophical biases rather than present clients with ideas and allow them to work out their own responses in the pursuit of truth. Nussbaum concluded that there is indeed "a tension between critical autonomy and causal manipulation" present in the work of Hellenistic philosophers."[37]

In reply, physicians' traditional authority over patients is now widely challenged. All therapy carries the risk of manipulation, which is why psychotherapists developed strong professional norms of respect for client autonomy. If it is objected that even the simple presentation of ideas to clients in therapeutic settings will influence them, we should remind ourselves that clients come to counselors to be influenced, as well as supported in their own efforts by caring and respectful professionals. At present, philosophical counseling is less professionalized, but it has in practice developed in a similar spirit of respect for counselees' values. It should also be noted

that academic philosophers, like all professionals, must confront the same concerns about respect for their students' autonomy. That is what professional distance requires.[38] In short, Aristotle's three objections to linking ethics with therapeutic perspectives express genuine concerns, but they provide cautions rather than insurmountable obstacles.

There is another lesson to be drawn from Aristotle's rejoinder to Plato's link between morality and therapy. The difference in the two thinkers reminds us that the domain, aims, and procedures of philosophical ethics have always been subject to vigorous disagreement within philosophy. These disagreements have greatly contributed to the development of philosophy, at least when accompanied by a willingness to engage alternative views. Philosophical counseling began by setting itself against both the therapeutic trend and much academic ethics. Perhaps, looking to the future, philosophical counseling might enrich academic ethics by restoring Plato's appreciation of how morality and mental health are connected.

Endnotes

1. The expression "philosophical practitioners" was used by Aschenbach to refer to philosophical counseling, although in the U.S. the expression is applied to additional practical uses of philosophy such as facilitating various groups and consulting with organizations. Interestingly, Gerd B. Achenbach has moved toward seeing the relationship between psychotherapy and philosophical counseling as more complex, as a "relationship of cooperation and competition, that is, a dialectic relationship." "Philosophy, Philosophical Practice, and Psychotherapy," in Ran Lahav and Maria da Venza Tillmanns (eds.), *Essays on Philosophical Counseling* (Lanham: University Press of America, 1995), pp. 61-74.

2 . Roger Paden, "Defining Philosophical Counseling," *International Journal of Applied Philosophy*, 12:1 (1998), p. 10.

3. Parenthetical page references are to Lou Marinoff, *Plato, Not Prozac!: Applying Philosophy to Everyday Problems* (New York: HarperColllins, 1999).

4. Michael Miller, Foreword to *The Cruelty of Depression: On Melancholy*, by J. Hassoun (Reading, MA: Addison-Wesley, 1997).

5. Ben Mijuskovic, "Some Reflections on Philosophical Counseling and Psychotherapy," in Ran Lahav and Maria da Venza Tillmanns (eds.), *Essays on Philosophical Counseling* (Lanham: University Press of America, 1995), p. 94.

6. I argue this point with regard to depression in "Depression: Illness, Insight, and Identity," *Philosophy, Psychiatry, and Psychology*, 6:4 (1999): 271-286. Also see "Moral Health: Responsibility in Therapeutic Culture," *The Journal of Value Inquiry*, 34 (2000): 27-43; and "Alcoholism as Sickness and Wrongdoing," *Journal for the Theory of Social Behaviour*, 29 (1999): 109-131.

7. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR* (Washington, DC: American Psychiatric Association, 2000), p. 356.

8. Ben Mijuskovic, "Some Reflections on Philosophical Counseling and Psychotherapy," in Ran Lahav and Maria da Venza Tillmanns (eds.), *Essays on Philosophical Counseling*, p. 96.

9. Karl Pfeifer, "Philosophy Outside the Academy: The Role of Philosophy in People-Oriented Professions and the Prospects for Philosophical Counseling," *Inquiry: Critical Thinking Across the Disciplines*, Vol. 14, (1994): 58-69.

10. Preamble to the Constitution of the World Health Organization, Official Record of the World Health Organization, 2, (1946), p. 100.

11. Plato, *Republic*, trans. F.M. Cornford (New York: Oxford, 1945), p. 444e.

12. Epicurus, cited and translated by Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton, NJ: Princeton University Press, 1994), p. 13.

13. Marie Jahoda, *Current Concepts of Mental Health* (New York: Basic Books, 1958).

14. See Mike W. Martin, "Moral Health: Responsibility in Therapeutic Culture," *The Journal of Value Inquiry*, 34 (2000): 27-43.

15. Lawrence C. Becker, *A New Stoicism* (Princeton, N.J.: Princeton University Press, 1998), p. 104.

16. Rem Edwards, "Introduction" to Rem E. Edwards (ed.), *Ethics of Psychiatry* (Amherst, NY: Prometheus Books, 1997), p. 17.

17. E.g., Karl Menninger, *The Crime of Punishment* (New York: Viking Press, 1968); and James Gilligan, Violence (New York: Vintage Books, 1997).

18. Cf. Philip Rieff, *The Triumph of the Therapeutic: Uses of Faith After Freud* (Chicago: University of Chicago Press, 1987 [1966]); Robert Bellah et al., *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985); and James Davison Hunter, *The Death of Character: Moral Education in an Age Without Good or Evil* (New York: Basic Books, 2000).

19. Elliot D. Cohen and Gale Spieler Cohen, *The Virtuous Therapist: Ethical Practice of Counseling and Psychotherapy* (Belmont, CA: Brooks/Cole, 1999), p. 32.

20. Howard Kirschenbaum and Valerie Land Henderson (eds.), *Carl Rogers: Dialogues* (Boston: Houghton Mifflin Company, 1989).

21. Jerome D. Frank and Julia B. Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy*, 3d ed. (Baltimore: Johns Hopkins University Press, 1991), pp. 40-43.

22. David A. Jopling, "'First Do No Harm': Over-Philosophizing and Pseudo-Philosophizing in Philosophical Counseling," *Inquiry: Critical Thinking Across the Disciplines*, Vol. XVII, (1997): 100-112.

23. Ben Mijuskovic, "Some Reflections on Philosophical Counseling and Psychotherapy," in Ran Lahav and Maria da Venza Tillmanns (eds.), *Essays on Philosophical Counseling*.

24. Ran Lahav, "A Conceptual Framework for Philosophical Counseling: Worldview Interpretation," in Ran Lahav and Maria Da Venza Tillmanns (eds.) Essays on Philosophical Counseling, pp. 11-12.

25. Edward Erwin, *Philosophy and Psychotherapy* (London: Sage Publications, 1997), p. ix.

26. See especially, Irvin D. Yalom, *Existential Psychotherapy* (New York: BasicBooks, 1980).

27. Alan C. Tjeltveit, *Ethics and Values in Psychotherapy* (London: Routledge, 1999), p. 35.

28. Eckart Ruschmann, "Foundations of Philosophical Counseling," *Inquiry: Critical Thinking Across the Disciplines* Vol. XVII, No. 3, (1997), p. 24.

29. Ran Lahav, "Philosophical Counseling and Taoism: Wisdom and Lived Philosophical Understanding," *The Journal of Chinese Philosophy*, Vol. 23, No. 3 (1996), p. 266.

30. William K. Frankena, *Ethics*, 2d ed. (Englewood Cliffs, NJ: Prentice-Hall, 1973), p. 13.

31. Ibid., p. 5.

32. Quoted by Norman Malcolm, *Ludwig Wittgenstein: A Memoir* (London: Oxford University Press, 1967), p. 39. Discussed by Mike W. Martin, "Applied and General Ethics: Family Resemblances and Tensions," in Michael Bradie, Thomas W. Attig, and Nicholas Rescher (eds.), *The Applied Turn in Contemporary Philosophy* (Bowling Green, OH: Bowling Green State University, 1983), pp. 34-44.

33. Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics*, p. 3. And see especially pp. 58-75.

34. Ibid., p. 49. Italics removed.

35. David A. Jopling, "Philosophical Counselling, Truth and Self-Interpretation," *Journal of Applied Philosophy*, Vol. 13 (1996): 297-310.

36. Ran Lahav, "What is Philosophical Counseling?," *Journal of Applied Philosophy*, Vol. 13 (1996), p. 268.

37. Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics*, p. 452. Italics removed.

38. See Mike W. Martin, "Professional Distance" and "Advocacy in Education," in *Meaningful Work: Rethinking Professional Ethics* (New York: Oxford University Press, 2000), pp. 82-115.