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A table of contents for *Theological Students Fellowship* (TSF) *Bulletin* can be found here:

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which she did not normally speak, though would hear often.

Before this is taken as immediate damnation of Pentecostalism, it should be noted that the similarities with Christian glossolalia consist only in that the speaker is not using his own language. Some of the characteristics of Christian glossolalia we noted earlier; other points of significance are that the speaker's voice is not different from his normal (praying) voice, and that the language is not (normally) one which he might be expected to have come into contact with in a secular situation (unlike the three instances cited above). Nor of course does the speaker belong to a particular guild of cultic functionaries. The standard reply when non-Christian tongues are brought up in Pentecostal circles (when the question is not rejected as based on unreliable hearsay) is to refer to diabolical counterfeit.

One may provisionally claim that Christian tongues are different in quality from the seeming parallels, but that this parallel phenomenon should make one hesitant about accepting tongues as an authentication of the teaching or personal authority of the speaker, taken as a sole criterion. Rather, as always, the criteria for authentic Christianity are moral, as set forth in John's First Letter, and doctrinal. Above all, as Paul states in a 'Pentecostal' context in 1 Corinthians 13, love for fellow-Christians must be the greatest 'sign following', for all belong to the one body of Christ, whatever their gifts or lack of them.

'If this (or any) form of devotion can be accounted for by psychological or sociological factors, does this affect its validity?' In worship, as in so much of life, we employ faculties, feel sensations, which in a non-worship context would symbolize other things to us, or the person to whom they are directed. This is bound to be so, because of human physical limitations. (C. S. Lewis noted that intense anger and intense love are accompanied by the same sensation.) So if some one suggests that there is no peculiar sensation of 'belief'[23] or conversely that particular elements of worship can be given other psychological or social significance, they do not invalidate the belief or worship. Provided that the character of the worship and the character of the worshipper do not deny either God's holiness or the redemption through which worship is possible, that worship is valid, because validity in worship depends not on the mechanism involved in the human activity but on God who takes and uses the activity to glorify Himself.

As Christians we rejoice to have been met by God in Christ, and that individually *and in community* we experience Him. We worship Him because He is Truth, and has sovereign claims over us, not just because it makes us feel good. Specifically Pentecostal experience, while not to be pressed upon all, is one of the 'signs following' which point towards Him.

[23] These thoughts are in reaction to R. Needham, *Belief, Language and Experience* (a forthcoming book, based on lectures in the Institute of Social Anthropology, Oxford).

CORRECTION

In the first part of this article it was stated that Samuel Chadwick 'nowhere refers to tongues in his writings'. What the author intended to say was that Chadwick never refers to having had experience of the gift of tongues himself; he does, however, briefly refer to the gift in his book *The Way to Pentecost* (Hodder and Stoughton, 1932), p. 93.

Clinical Theology: an Assessment

F J Roberts

We are grateful to Dr Roberts and the editor of Fraternal *for permission to republish this article on a subject which is clearly of great interest among ministers as well as medical practitioners. Dr Roberts notes that Dr Lake's work has aroused various reactions, and readers may like to refer also to a paper on the theme by M. A. H. Melinsky in the volume of essays which he edited*: Religion and Medicine — a Discussion *(SCM, 1970), pp. 117-131.*

The Clinical Theological Association is now a well established movement in Great Britain. Like other young and vigorous movements, mention of its name tends to invoke a strong reaction, either for or against, in medical men and clergymen. This reaction can quickly lead any discussion of clinical theology into a discussion of its founder and mainspring, Dr Frank Lake. Although some knowledge of Frank Lake is necessary to help us to understand the origins and development of the movement, we must also consider some other historical factors which have made clinical theology what it is today.

It is now nearly twenty years since Dr Lake returned to England from India where he had been working as a medical missionary. While in India he had worked both as a parasitologist and as the medical superintendent of a large hospital. On returning to England a number of factors conspired to-

gether to make psychiatry the next avenue for him. During the early days of his psychiatric training he began to develop those ideas which are now incorporated in clinical theology. In his training, particularly in a mental hospital, Dr Lake met hundreds of people who were to all intents and purposes removed from the direct influence of the gospel. It was from this kind of observation that the idea arose that there should be a technique for those who cared which would enable them to take the gospel to this group of people—hence the title, clinical theology.

The idea that a special technique was required to take the gospel to psychiatric patients was supported by the practice of the church and its missions of offering the gospel in a formal verbal or written manner, and by the opinions which have been expressed, in doctor/clergy groups and discussion groups with clergyman with which I have been associated, that this form of presentation is appropriate only to those who are psychologically whole. This view raises some very important issues: Is the gospel presentable only in a formal way, are we dependent on technique, and do we require psychological understanding in order to communicate with those who are psychologically disturbed? We shall be addressing ourselves to problems of this kind as we look in more detail at what clinical theology teaches and does.

At the time when Dr Lake was beginning to formulate his ideas and to interest others in them there were few psychiatrists in Great Britain who would have admitted that the gospel had any relevance for the patients under their care. The 1950s saw a psychiatry which was optimistic and successful. It was inundated with well-qualified applicants who wished to be associated with this promisingly powerful branch of medicine. This image of psychiatry was derived from some real achievements in the field of social policy within hospitals with the use of 'open doors' and therapeutic community ideas. Also there were now available for the first time a number of drugs which seemed to be able to control, in a specific way, symptoms and signs which previously had been resistant to treatment. The clerical profession, in contrast, was beginning a period of uncertainty and disillusionment which showed itself in the flight of abler men from the profession and the avoidance of the church as a career by many who could have contributed a great deal to its life. The reasons for all this are obscure but the vagueness some felt about the clergyman's role, and the comparative impotence of the church when compared with medicine, played their part.

It was through clinical theology that many clergymen, particularly within the Anglican communion, saw a new and vital role for themselves which may well have derived strength by basking in the light of an optimistic psychiatry. It was as if this tense and fertile scene were waiting for an enthusiast with the appropriate message. Frank Lake rose to the occasion and by dint of dedication and enthusiasm was able to conceive a movement which gave some clergymen not only a new skill but a new reason for being. This was achieved at first by Frank Lake almost single-handed, and then gradually with the help of an increasing band of associates via seminars and lectures which were arranged throughout the length and breadth of Great Britain. In most instances these were arranged with the help and blessing of the various dioceses. In the beginning the main purpose of the seminars was to introduce the clergymen to a psychiatric way of thinking and to an understanding of those of the clergyman's flock who were psychologically disturbed. It soon became apparent that this type of activity brought individual students face to face with their own personal problems in a way which led them to look for personal help from the movement.

The standard form of training is by seminars, each lasting for three hours and occurring twenty-four times in two years. On the successful completion of this course it is possible for individuals to progress by further training to become tutors who are then held to be competent to run seminars.

During the first year students are introduced to contemporary views on neurotic and psychotic disorders. The Association has produced a number of publications in booklet form to aid these studies; these are of a very high standard and would be found useful by medical students and aspiring psychiatrists. The second year of training 'takes up rather more complex study of human personalities as they interact in small groups. Critical transitional periods of human life are observed in which profound changes of adjustment are required of the individual in physical, social and spiritual life.'[1] Behind all this work is the massive textbook *Clinical Theology* which was written by Frank Lake.[2]

Some idea of the extent and competence of the organisation and effort invested can be seen in the fact that between 1959 and 1966 the Association's two-year courses were attended by 3,500 clergymen and between 300 and 400 lay people. If we compare this number of trained people with the number of graduates from British medical schools who during the same period went on and specialized in psychiatry, we find that clinical theology's total is three times as large as the number of doctors embarking on psychiatry.

It may well be asked in the light of this effort, Where is clinical theology going? Lake and Harman (*op. cit.*) write 'A present day interpretation of these objectives would be (1) to equip the clergy, allied professional helpers and lay members with an ade-

[1] B. Lake and L. W. Harman, *An Assessment of Clinical Theological Training* (Clinical Theological Association, Nottingham, 1968).

[2] F. Lake, *Clinical Theology* (Darton, Longman & Todd, London, 1966).

quate knowledge of the psychodynamics of interpersonal relationships to make them useful in the field of mental health and to relate this knowledge to the theological understanding of men; (2) to enable the student to learn the role of his own personality in pastoral relationships and to deal creatively with his own anxieties in accepting pastoral responsibility; (3) to provide a clearer recognition and a knowledge of the proper indications and methods of referral; (4) to provide a deeper understanding of the problems involved in individual, group and communal relationships and to enable the student to gain familiarity with the wider body of experience available to those who work in the community services.'

Having trained several thousand students during a decade the organization of the training and the objectives are now well established. The theoretical basis of clinical theology is by comparison far less amenable to description and discussion, and it is in this area that I find myself so antagonistic to the movement. I am antagonistic because many who seek training do so in the naive belief that what they are taught will be sound both theoretically and pragmatically. For a number of reasons I do not think that the theoretical basis is sound, and although some students do empirically develop some competence when faced by disturbed individuals this is largely due to unacknowledged processes rather than the declared reasons. For some the short-fall between the teaching and their practical experience leads to a sense of failure in themselves, to some disillusionment and to others confusion.

The theoretical basis is set out at length in Frank Lake's book *Clinical Theology* which was published in 1966. This has been described by someone within the Association as a 'brilliant synthesis',[3] and by reviewers as 'treasure in a large earthen vessel'[4] and ' . . . an ill-conceived . . . misleading book . . . marred by circular arguments'.[5]

There are three specific points which I will make in order to show my own dissatisfaction with this work. Firstly Dr Lake espouses a branch of psychology which leans heavily on the idea that antenatal events, birth and the experiences of the first few months of life are crucial in the formation of enduring personality characteristics. Clearly in some senses this must be true — for example, brain damage or no brain damage — but there is no hard evidence that the subtleties of personality in health or disease are related to these events. Another set of ideas which Dr Lake uses are those which were formulated by Pavlov and expounded by William Sargant (1957).[6] Pavlov was able to demonstrate with dogs in a laboratory certain responses to certain stimuli, the like of which could not have been deduced beforehand and apart from some kind of learning process seemed nonsensical. For example, some dogs learnt to salivate when a bell rang.

Pavlov formulated a general theory for cerebral function in which he postulated excitatory and inhibitory processes to account for the observations he had made. These observations are still regarded as being an important part of the history of experimental psychology but Pavlov's theoretical explanation and Sargant's exposition of them is now largely discredited, Zangwill (1958),[7] Ramage (1967),[8] and Storms and Seigal (1958).[9] The processes of excitation and inhibition as conceived by Pavlov can now only be accepted in a metaphorical sense. Despite this, Dr Lake and others, *e.g.* Eysenck (1960),[10] try and account for behaviour in these terms.

Dr Lake brings the idea of the importance of perinatal experiences as determinants of later behaviour and the Pavlovian theory together in the discussion of his use of LSD (an hallucinogenic drug) in the treatment of certain conditions. The value of this kind of technique is highly debatable. Bennet (1969)[11] points out there is in the written reports of the use of this drug an enthusiasm on both the taker's and the giver's part which makes objective assessment impossible. He goes on to say ' . . . the observer's expectation of effects (as well as the subject's) will to a great extent determine what happens . . .'.

Here, then, are three rather technical aspects of Dr Lake's exposition of clinical theology which I believe are open to criticism. Whatever the value of an attempt of this kind to bring together such disparate ideas for discussion by those who are already familiar with the backgrounds of these very complex issues, I think there are good reasons for doubting the wisdom of offering to the unsophisticated — in a psychopathological sense — this amalgam.

Dr Lake is attempting, like all who work in this area, to find a satisfactory way of talking about behaviour when none of the ways of talking about the subject are adequate over-all. This is a reflection of the age-old problem of bringing together the things we can say about the body on one hand and the mind on the other. Each of these areas has its own language and in a technical sense is a category in its own right. Hence if we try to mix the categories, as Dr Lake does, then we end up in a logical pickle. If there were a one-to-one correlation between a physio-

[3] Clinical Theological Association, *News Letter No. 9.*

[4] R. A. Lambourne, book review, *New Christian* (December, 1966).

[5] R. E. D. Markille, book review, *In Service of Medicine* (CMF, 1967).

[6] W. Sargant, *Battle for the Mind* (Heinemann, 1957).

[7] O. Zangwill, *Review of Battle for the Mind* (*Brit. J. Med. Psychol.*, 1958).

[8] I. Ramage, *Battle for the Free Mind* (George Allen & Unwin, 1968).

[9] L. H. Storms & J. H. Seigal, *Review of The Dynamics of Anxiety and Hysteria* (*Brit. J. Med. Psychol.*, 1958, 31), 228.

[10] H. Eysenck (ed.) *Behaviour Therapy and the Neuroses* (Pergamon Press, 1960), chapter 1.

[11] Glin Bennet, *LSD 1967* (*Brit. J. Psychiat.*, 1968, 114), p. 1219.

logical account of behaviour and a psychological one, then there would be no problem. The situation is made even more complex by the fact that there are in both the psychological and physiological areas subdivisions which again seem to be in separate categories. For example, we can talk about intrapsychic phenomena as we suppose them to be revealed in an ordinary interview situation. We could also talk about the interview in terms of the roles which each participant played; these two accounts are very difficult to bring together other than in a loose way.

The reaction of many when faced by this kind of mixing of categories is to become confused. Unfortunately, Dr Lake sees no problem with this kind of procedure as is shown when he brings together theological and psychological ideas: '. . . since the origin of the model is Christ and a Christian is by definition to be a man in whom Christ dwells, no awkward transition has to be made in the language of communication when we move from the "psychological" to "spirituality" of the man of God'. And again: 'there is no other way of arriving at the proper spiritual treatment of any depressed person . . . except by way of diagnosis . . . through a thorough history taking' (Frank Lake, *op. cit.*).

Bearing in mind that Dr Lake finds no problem in handling different categories as if they logically belonged together, it is not surprising that he suggests that the treatment for certain abnormal psychological conditions is to get right with God. (Presumably, in view of Dr Lake's theological position, this means in a traditional evangelical sense.) It may well be that we can legitimately see in a patient's recovery that he has in a theological sense got right with God and yet at the same time in psychological terms we would equate recovery with a change in behaviour. The error I believe lies in the mixing of logical categories which in this instance leads on to such ideas as conversion will cure people or the parson should see the patient three times a day after meals. It is just as nonsensical to ask the question, 'Is this a theological or a psychological matter?' as it is to ask about a piece of iron which has been in a fire, 'Is the iron hot or red?'

Many who come to clinical theology as students hope to find the secret of power and control which they believe is shared by members of the medical profession. The confusion which is created in them by the above-mentioned mixing of categories is interpreted by some as an indication of their failure to acquire the secret. The adoption of the medical paraphernalia of consulting room, appointments, interview technique, notes, histories, diagnoses, and talk of clients, does not work the magic for which they hoped. When this happens it would seem that clinical theology has gone sadly astray from its original intention of bringing the gospel to those with psychiatric problems.

To bring the gospel to psychiatric patients was the starting-point for the movement and yet some of its teaching would seem to deny this or at least to make this statement only applicable within certain limits. This I believe is demonstrated by the way in which the students are taught to recognize the stage at which they should refer a client to a psychiatrist once they have recognized a real psychiatric condition. The implication is that once the psychiatrist has successfully treated the case, the clinical theologian can take over again. This puts clinical theology into the same category as clinical psychiatry with the demarcation issue being decided by the severity of the condition. I wonder what the psalmist who wrote, 'If I make my bed in hell, thou art there' would have made of this practice.

The idea that a clergyman should opt out of the relationship he has with someone who is sick at some quite arbitrary stage is most unsatisfactory. It implies amongst other things that *all* a clergyman has to offer is the same set of skills as a psychiatrist but in a less effective or competent way and that he is using techniques which really belong to someone else. By adopting this stance the clergyman is denying the value of the relationship which he has to offer. Perhaps it is time to say quite clearly that from a psychological point of view what he has to offer is his relationship, no more and no less, with or without certain skills, and that this he does in the name of and as a route to the fellowship of the church. This places the clergyman in a much more powerful and enduring position than ever a psychiatrist can be in because the psychiatrist is continually limited by the ideas in our society which attend sickness and treatment.

Many of the comments which are made above are frankly critical of clinical theology. There is plenty of evidence from within the Association — particularly at its centre — to indicate that there is an awareness that all is not well. Further there are signs that efforts are being made to modify and strengthen the theoretical basis and to improve the practice. Clinical theology has survived its honeymoon period and like many other new movements it has tended to be exclusive and to feel that it alone understood what the problems really were. In the first instance this exclusiveness and 'rightness' is protective and enables the movement to survive, but the time has now come to return to the workaday world and begin to put the ideas and practice in the market place and to subject them to the rigours of some rough handling. If they survive in a modified form, then we shall be delighted and we shall be able to live together.

I would like to end on a positive note. It is quite clear that Frank Lake and clinical theology have responded to a very real need within the church and society. They have drawn our attention to the scandalous deficiencies in the training of our ministers. They have attempted to face and meet the need of those in our community who are psychiatrically ill. In so doing they have written another chapter in

the history of the church's caring ministry — as far as impact is concerned it is the first determinedly Christian effort in this direction since the Quakers opened The Retreat in York in September 1777. Individual ministers have been helped to find a role for themselves again by giving them a frame of reference which despite its deficiencies enabled them to tackle situations which previously they would have have found beyond their capabilities.

As well as this, clinical theology has by virtue of its training groups brought together like-minded individuals who were prepared to seek a way together. I believe that it was within the groups that the main benefits were derived as the individuals found support and a mutual sharing of their problems. The Association has published some evidence which underlines the anxiety relieving functions of the seminars.

Clinical theology is changing and seeking to be more effective. It has stimulated the church to look again at the way in which it conducts itself towards that submerged tenth of the population who are enmeshed in psychological difficulties and I sincerely hope that just because of the deficiencies of clinical theology the church will not be content to return to the bad old days of pre-1958 when the Association got under way.

The Theological Journals in 1971

Ralph P Martin

Past experience in this annual task of collecting material from the previous year's publications in the journals would suggest that the chief difficulty is to know what to include and what has to be left out. Not so for 1971. For, unless I have been especially unobservant and more ignorant than I confess, this has been a year of dearth. I say this partly to account for the selectivity of the survey that follows and perhaps partly to excuse an omission of contributions of which I should really have taken cognizance if I had spotted them. All the references which appear presuppose a 1971 date of publication, and special attention has been given to the work of Tyndale Fellowship members.

The Old Testament

Several background studies head the list. In *Westminster Theological Journal* xxxiii. 2, May, pp. 133-152, D. J. Wiseman published the substance of his lecture on 'Archaeology and Scripture' in which he treated three areas in a deft and illuminating way: the text, the literary environment, and the historical situation. Designed for a popular audience, this is an excellent presentation. With a more technical interest in view, P. C. Craigie devoted the 1970 Tyndale Lecture to 'The Poetry of Ugaritic and Israel' (*TB* 22, pp. 3-31). At the fortieth anniversary of the first translation of the Ras Shamra texts, this was an appropriate occasion on which to look back in retrospect and survey the gains of Ugaritic study for the Old Testament interpreter, and to do this especially in the light of three test-cases of Hebrew poetry in the Song of Songs, Psalm 29 and Exodus 15. There are obvious links of correspondence between Hebrew and Ugaritic poetic forms and P. C. Craigie returns to this theme in a discussion, 'A Note on "fixed pairs" in Ugaritic and Early Hebrew Poetry' (*JTS* xxii. 1, April, pp. 140-143). However, the purpose of this note is to raise a question mark against the rule that 'if two synonyms which were commonly coupled in parallelism always occurred in the same sequence in *both* languages (Heb. Ug.), then a common literary tradition may lie behind them' in view of the observation that Hebrew shows greater flexibility in the sequences in which pairs of words are used.

The linguistic field is still being worked, as we see from lexical studies noted during the year. 'Some notes on Second Isaiah' by A. Gelston (*VT* xxi. 5, December, pp. 517-527) considers some problem verses in Isaiah, with a final comment on Isaiah 53: 11 which is rendered: 'He (Yahweh) will deliver his soul from trouble: he will see light and be satisfied. By his humiliation/chastisement will my servant justify the many; and he will bear their iniquities/guilt/penalties.' The whole sweep of the suffering servant passage is surveyed by D. F. Payne (*EQ* 43, pp. 131-143) and full account taken of the most recent linguistic research which may 'alter the traditional understanding of certain elements in the passage' but does not seem 'to have undermined . . . the Christian application of the prophet's words to Jesus of Nazareth'.

L. C. Allen offers a couple of erudite lexical notes including a brief comment on Isaiah 52: 2 in *VT* xxi. 4, October, p. 491, in which the translation preferred is 'straight up', and a longer series of observations (mainly in second Isaiah but also including 2 Ki. 20: 13; Ps. 22: 17; 2 Ch. 5: 9) on the text of the Old Testament published (in *JTS* xxii. 1, April, pp. 143-150) under the intriguing title, 'Cuckoos in the Textual Nest'. The short paragraph by R. Youngblood (in *JBL* 90. 1, March, p. 98) establishes the single point that in Amos 4: 12 the verb *qara' 'eth* means to call upon (your God(s), O Israel), the *'eth*