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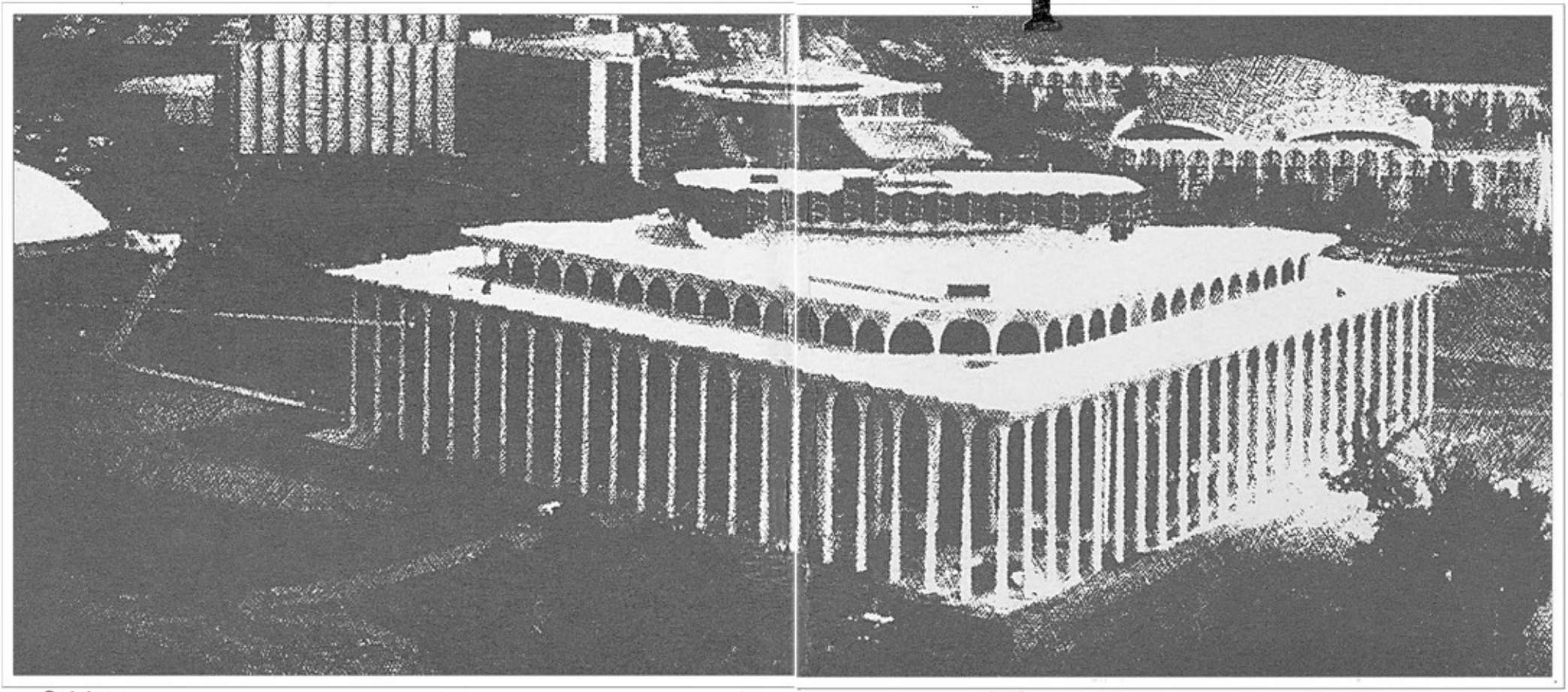

Spiritus
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Tulsa, OK 74171

The Journal of the School of Theology

Volume 1, Number 1
Winter 1985

Integrating the Problem-Solving Task and Divergent Professional Values: The Essence of a Cross-Pollinated Approach to Healing

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In the cross-pollinated approach to healing, implicit and underlying value structures of the "healers" need to be made explicit and correlated with the task at hand. A theoretical model and an example are presented that clarify the professional roles and associates values; further, the complementarity needed in a coordinated healing effort is explicated.

An important element in an effective cross-pollinated (interdisciplinary) approach to the ministry of healing is an appreciation for individual differences in problem-solving styles. A cross-pollinated aggregate of individuals is faced not only with the needs of a patient, but also with the complexity of human values which inform those problem-solving styles. Concomitant with the central healing goals found in a group of professionals, there is an underlying heterogeneity of roles, experiences, observations, conceptualizations, and preferred methods of data processing. Therefore, it hardly seems surprising that the various idiosyncratic values implicit in the decisions and activities of the individuals are brought into tension with one another.

Concerning the nature of this tension, Ernest Becker offers some theoretical clues as to the interrelationship of personality identity, cultural involvement, and functional roles.[1] Analogously using his conceptual framework, one can suggest that the persons in the care-giving roles are trained primarily as performers. Practitioners, theorists, and researchers individually reflect as part of their identity and resultant value system the very nature of their performance as it touches the human need of healing. To put it more succinctly, Becker believes that the "self" is not physical but symbolic; self-image and value structures are often inseparable from the sum total of a person's possessions, including the work and the reputation of that person.

The initial issue at hand is this: People who come together as a cross-pollinated team may collectively focus upon the critical issues of

healing, but all enter the task at different points and with individualistic values conditioned by past training, personality style, and role identification. When subtle or even overt interpersonal tension arises in the context of ministry groups, it is suggested here that some amount of the conflict is most likely informed by nonrational assumptive sources — namely, inherent and often unlabeled values.

A methodology is proposed in this article as a model for dealing with the "healing of the healers." It includes borrowing from the behavioral sciences an experiential learning model to be used as a metaphor for cross-pollinated group integration. The general focus is on the clarification of the steps involved in the evolution of knowledge and practice as they relate to the needs of a patient. The model is necessarily limited in application to those institutional settings where all of the following processes are possible and encouraged: patient contact (in the form of a "practitioner"), abstract conceptualization (in the form of academic theory), phenomenological observations (a reflection upon experiences that may or may not fit established categories of knowledge), and empirical research. The model also correlates the various steps in the evolution of knowledge and practice with the proposed values inherent in the divergent roles in the healing effort.

The basic assumption of this article is that an identification and an appreciation of the various value-laden contexts of ministry are necessary for the ministers of healing before the best health care can be offered to the patient.

The Evolution of Knowledge with Associated Value-Invested Roles

The phrase "evolution of knowledge and practice" is used here in the context of describing the stages in a problem-solving sequence. Take for instance the issue of patient anxiety as a broad topic to be addressed by the healing community. How does one get from the personal understanding and the articulation of the patient's emotions to the intervention stage where an informed and potentially effective treatment is implemented? In the evolution of the knowledge about the problem and about the various possible solutions or remedial techniques, seven stages are proposed in Table 1. However, before considering the specific problem-solving sequence, some further background issues need to be explicated concerning individual dynamics and group involvement.

In his work resulting in the publication of the *Learning Styles Inventory,* Kolb identified two major dimensions of cognitive growth and learning for the individual.[2] One dimension has as polar opposites the preferred approaches of being either more active or more reflective. "Active" people in a group working on a common task will find themselves wanting to test or experiment on the implications of a proposed hypothesis; thus, tension may be created with the more "reflective" people who possess the propensity for observing and reflectively interpreting experiences or data already collected.

The concrete-abstract polarity is the second dimension described by Kolb's inventory. On the one end, some persons prefer to approach a problem with a concrete or "hands-on" experience. Such persons might feel impatient with those who prefer abstraction, especially if it is suggested that team resources, time, and effort be invested in conceptualization and theorizing as an approach to a patient's "concrete" needs. Attitudinal conflicts may arise over the perceived importance of individual cognitive styles of thinking about the world.

Kolb reflects the view of many cognitive psychologists (e.g., Bruner, 1966; Flavell, 1963; Harvey, Hunt and Schroeder, 1961) that:

> Over time, accentuation forces operate on individuals in such a way that the dialectic tensions between these dimensions are consistently resolved in a characteristic fashion. As a result of our hereditary equipment, our particular past life experience, and the demands of our present environment, most people develop learning styles that *emphasize some learning abilities over others* (emphasis mine).[3]

Kolb labels these individual learning styles as divergence, assimilation, convergence, and accommodation. The original description and data applied to these styles can be found in the *Learning Styles Inventory Technical Manual.*[4] For our present purpose, however, the derived labels for these individual approaches and the developmental rationale supporting their emergence will be borrowed from Kolb's system and applied to the issue of integrated healing efforts along the seven stages in the evolution of knowledge and practice. Figure 1 displays the four

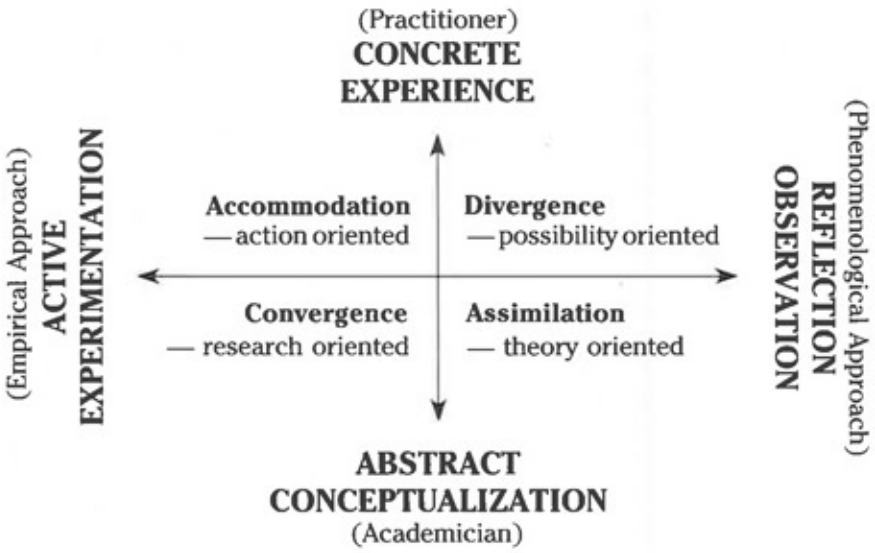

Figure 1 Cognitive dimensions, problem-approach styles, and roles.

characteristic styles in relation to the two cognitive dimensions proposed by Kolb.

It is important to remember that the axes in Figure 1 represent continua. It is not suggested that the practitioner, for example, has no interest in the conceptual framework corresponding to the daily contact with the patient. Indeed, a particular practitioner could be "located" anywhere along the concrete-abstract dimensional axis with more or less attention or investment given to abstractions concerning the delivery of patient care. (Within the university setting, in fact, many academic professors find themselves engaged in therapeutic relationships with patients.) Nonetheless, given one's developmental history, educational experiences, socialization of professional roles, and especially the culturally defined and expected role in the immediate context of a healing community, it is implied that persons approach the healing task with an *a priori* orientation usually in the direction indicated in Figure 1. The exception, of course, would be in reference to a person who in a Jungian sense has developed the highest level of self-integration and expresses nondominant modes of dealing with the world.[5]

The problem-approach styles are likewise more or less definitive for a particular person depending on how far the person is located in the quadrant away from the center of the axes. Research data (e.g., Hudson, 1966; Grochow, 1973; Stabell, 1973; Strasmore, 1973) indicate significant evidence that the problem-approach styles are correlated with personally valued cognitive dimensions. For example, the diverger person values a mixture of concrete experience and reflective observation. The assimilator values reflective observation and abstract conceptualization. The converger is a polar opposite of the diverger and values abstraction and active experimentation. Similarly, the accommodator is a polar opposite of the assimilator and tends to place emphasis on active experimentation and concrete experience.

Thus, divergers, assimilators, convergers, and accommodators (as defined elsewhere by Kolb), all carry individual values, many of which are by nature at the polar end of those held by others involved in the same task.[6] Perhaps if the institutions supporting the healing community efforts could offer unlimited financial and space resources, time commitments, and programming possibilities, then interpersonal tension among the health-care stakeholders would be ameliorated. But the very absurdity of such a suggestion of unlimited resources illustrates the demand that the personal and political realities involved in a cross-pollinated healing effort be taken seriously.

The personal and political realities that must be examined by serious members of a cross-pollinated healing community are implicated in Table 1.

The personal reality evident from both Table 1 and Figure 1 involves the necessity of being empathic to the value-laden orientation opposite of one's own preferred mode. This empathic stance first requires self-assessment of implicit values (such as with the Learning Styles Inventory or by self-reflection). And second, it requires a willingness to encounter one's own nondominant mode of learning and experiencing; this can be accomplished by a working relationship with another person.

The political reality mentioned above involves two issues. The first issue

TABLE 1

Evolution Of Knowledge Related To Integrated Healing Effort

Problem-Solving Style	Stages of Problem Solving	Input into Healing Effort
Diverger (CE + RO)	1. Contextually sensitive to issues. 2. Formally identifies problem areas.	1. Empathic with patient needs; idea generation. 2. Articulate and communicate the patient needs from various perspectives.
Assimilator (AC + RO)	3. Conceptualizes the problem areas into research questions. 4. Suggests alternative solutions.	3. Create or identify the theoretical models into which the patient needs fit. 4. Bring together dissimilar observations from the healing community into an integrated explanation.
Converger (AC + AE)	5. Empirically tests consequences of alternate solutions. 6. Deductively selects a solution.	5. Identify and validate the causal relationships involved in the healing related variables. 6. Interpret the research data in terms of original patient needs.
Accommodator (AE + CE)	7. Executes the solution.	7. Put into practice the findings — carry out the intervention with the patient.

note: CE = concrete experience RO = reflective observation
AC = abstract conceptualization AE = active experimentation

is important to the community of ministers, but of less importance to the thesis of this article; namely, in the midst of limited resources, culture as well as institutional priorities (related to goals, development tasks, survival, etc.) has a tendency to value on a cost-benefit basis some orientations more than others. However, the second political issue to be recognized is that from the standpoint of maximum patient benefit, none of the four approaches to the healing problem can be omitted or depreciated. Input from all perspectives is essential for the fullest development of knowledge in the seven stages as outlined in Table 1. One is reminded by analogy of the body of Christ; each member is different, but all are valued as a part of the functioning whole even though some are more visible. The cross-pollinated approach to healing seems to fit the biblical command to operate in the name of Jesus Christ as one body. It also may elicit the interpersonal tensions inherent in a dialectic group process in which no person is self-sufficient.

The various inputs into the healing effort as summarized in Table 1 are represented in typological terms. Thus the "diverger" who tends to be possibility-oriented would be most comfortable with idea generation arising from patient contact. Most likely reflection, amplification, and synthesis would be considered very valuable. The "assimilator" would be less likely to *sit in* the data as would the diverger, but more likely to *set on* the data (or experiences) a conceptual or theoretical frame of reference. Alternate theoretical positions might be suggested by the assimilator in light of more nomothetic perceptions of the data. The "converger" is most analogous to the researcher who is seen as having a propensity for solutions. The "accommodator" may be the ideal person to carry out the solutions and risk himself or herself in new experiences or approaches with the patient.

The idea that the above "types" of problem-approach styles are not hierarchical in importance in the generation of knowledge or problem-solving is of key importance. To allow a sense of self-importance apart from being in direct relation with all other types would foster professional jealousy, constrain cooperation, and separate efforts. In such a case, cross-pollination will probably become a dialogue among professionals rather than a dialectic integration of healing efforts focused upon the patient. Ideologically, it seems advantageous to have the experiential axis of cross-pollination centered upon the patient being related to an integrated healing process as opposed to the axis pivoting around professionals trying to relate to other professionals.

One additional problem arises with the model as proposed. As is the case with most typologies used for the sake of clarity and delineation of values and interpersonal roles, there is the dominant/variant dynamic involved. That is, classifications are usually aimed at the "typical" or average (dominant) unit being assessed. A smaller percentage of persons will naturally vary from any categorization. These persons will justifiably feel constrained and uneasy about an oversimplified schema. For example, in terms of role identification on the practical level of patient contact, who are the divergers? Where do they work? Do they really differ occupationally

from the assimilators or convergers who might themselves be struggling with the daily reality of a hurting humanity?

Although there has been some effort in the past to correlate specific occupations with problem-approach types, a limitation to such findings is the failure to take into account the differing roles within some occupations. Such specificity (if, indeed, it could ever be found in such a broad-based model) risks the danger of overclassifying professionals into types. A better approach to the model is to associate the problem-approach styles with recognized predisposing "attitudes" held by persons toward the problems of healing.

An Illustrated Need for Cross-Pollination in Healing — Pastoral Care

One can look to the field of pastoral counseling and its current healing efforts to illustrate the need for a cross-pollinated approach. The progression of information regarding patient needs and healing techniques seems to be blocked to some extent between the experimental verification and concrete application processes. It is postulated that this "block" accounts for the incongruity between what some pastoral psychologists have called for and what has been produced in the way of research over the past two decades.

One needs only to look in journals such as *The Journal for the Scientific Study of Religion, The Journal of Psychology and Theology,* and *The Review of Religious Research* (or others), to be convinced that over the past two decades the publications related to pastoral psychology are indeed increasingly empirical in format. Likewise, there are theorists who are providing "categories" to place on observed data. However, something is missing. In pastoral psychology the result of combining the idiographic data from personal experience with the nomothetic data from experimental efforts is not more than the sum of its parts. The union of induction and deduction has not effectively become the union of theory and practice. In other words, the intended usefulness of the experimental/empirical effort seems to be rather disappointing if evaluated in light of how little of the findings seem to be stylized in actual clinical practice (much less "guiding" practice).

The "something missing" or the lack of "gestalt" in the current interrelationship between the practitioners and the researchers lies precisely in the lack of communication and application of findings. On the one hand, with what clarity has the practitioner expressed to the researcher the values or issues most important in terms of day-to-day contact with "the real world"? On the other hand, how much has the researcher allowed external validity concerns about generalization guide the research as compared to past emphasis on internal validity and reliability? And finally, in what settings, and by what systematic, conscientious efforts are the painstaking results of the researcher tested in applied ways?

Seward Hiltner, as one of the leaders in the pastoral-care field, identified the problem of accommodating empirical findings quite clearly in reference to his own work:

> With very minor exceptions, however, it is still true that the findings of experimental studies in the behavioral sciences have had little effect upon pastoral care and counseling. Many pastors know something about Carl Rogers's theory of the fully functioning person without having a glimmer about the experimental studies done by him and his students. Indeed, I am often embarrassed by ministers who know my theory of pastoral care but have never bothered to pursue my semiexperimental study with Lowell G. Colston. I believe that even my own theory has to be checked up more precisely. But a lot of ministers apparently think they need only reflect on it.[7]

Although Hiltner argued 15 years ago for a better working relationship between the experimental branch of the behavioral sciences and pastoral care, it is reasonable to assume that the problem of uncoordinated efforts remains. This is especially true when the typical empirical study can be evaluated as more heuristically oriented in identifying the next experimental project than it is contemporaneously relevant in a concrete setting.

Understanding the process of knowledge through the "attitudes" of divergence, assimilation, convergence, and accommodation, makes all those involved in pastoral care responsible for contributing to the process. For example, those involved in pastoral counseling can continue unfortunately to depend on "hunchy" categories and theories (as Hiltner claimed is happening)[8] or they can increasingly pay attention to solutions arrived at more objectively. The former alternative would be analogous to the accommodator relying more on the diverger's reflections than the converger's actively sought solutions which need a trial run "outside the lab."

However, to be fair to the care-giver mentioned above, those involved in empirical/experimental work must not be more influenced by publishing, dissertation, and methodology constraints than they are by the questions elicited from practitioners. And, to be fair to the active experimenters, those with the gift of conceptualization, problem identification, and clarification of the divergent ideas, need to mediate between the practitioner and the researcher. Thus, this necessary interaction among all involved in pastoral care needs to be instrumentally promoted and carefully guarded against the formation of compartmentalized professional-interest groups.

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program that emphasizes research in clinical psychology as well as in religious and theological studies.

Notes

[1]Ernest Becker, *The Birth and Death of Meaning* (New York and London: The Free Press, 1971).

[2]David A. Kolb, *Learning Style Inventory Technical Manual* (Boston: McBer & Company, 1976).

[3]Kolb, p. 4.

[4]Kolb, pp. 4-6.

[5]C. G. Jung, *Psychological Types* (London: Pantheon Books, 1923).

[6]Kolb, pp. 4-6.

[7]Seward Hiltner, "The Contribution of the Behavioral Sciences to Pastoral Care and Counseling," *Ministry Studies,* Vol. 3, No. 2, August 1969, 10-17.

[8]Hiltner, p. 13.