

Article

“Normalcy” in Behavioral Philosophy and in Spiritual Practice

Aleksandar Fatic

Institute for Philosophy and Social Theory, University of Belgrade, 11 000 Belgrade, Serbia;
aleksandar.fatic@ifdt.bg.ac.rs

Abstract: This paper introduces the concept of behavioral philosophy, discusses its relationship to philosophical counseling and psychotherapy, and focuses on the concept of normalcy as the normative foundation for a broader discussion on pathology versus philosophical dysfunctionality in life. Following the starting definitions, the argument proceeds to considering how normalcy as a normative foundation of both behavioral philosophy and philosophical counseling and of psychotherapy (along with pathology and pathologization) plays a role in the perspective of behavioral self-improvement sought by behavioral philosophy and by psychotherapy (for various reasons, depending on the psychotherapeutic school and methodology). The author concludes that normalcy, rather than pathology or mental disorder, is the focal concept to discuss in order to understand the role of spirituality and spiritual conviction and belief within the context of therapeutic change, whether it is interpreted philosophically or strictly psychotherapeutically.

Keywords: psychotherapy; behavioral philosophy; self-improvement; belief; pathology



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1. Key Concepts

In order to introduce a structured discussion on normalcy in the context of the philosophical and psychotherapeutic depictions of normalcy and explore the spiritual aspect of normalcy both in behavioral philosophy and in psychotherapy, several key definitions at the outset appear to be in order. This, specifically, concerns the distinctions among philosophical counseling, psychotherapy, and behavioral philosophy as an over-arching philosophical perspective on both, as well as what is exactly meant by the “spiritual” dimension of the psychotherapeutic or counseling processes. I will thus focus on the conceptual issues and then move on to developing the argument that posits normalcy at the very foundation of all self-improvement and, at the same time, therapeutic and corrective interventions within behavioral philosophy, where normalcy as the methodological and conceptual focus is capable of factually replacing psychopathology as the focus of discussion.

1.1. Psychotherapy

One of the key discussions in the modern depiction of philosophical counseling as a complement, or even alternative, to traditional psychotherapy revolves around the roles of psychotherapy and philosophical counseling. The most common assumption is that psychotherapy deals with mental pathology, or mental disorders (although this is not always the case), while philosophical counseling is concerned with values, quality of life, and self-development of “healthy” individuals seeking a critical perspective on their life experience (Marinoff 2008; Frunza 2018; Martin 2001). An offshoot of this type of thinking about the distinction between the two is the idea that psychotherapy concerns “cerebral” dysfunctionalities, while philosophical counseling addresses thought patterns, logic, and values. Neither seems convincing enough.

Perhaps one of the best descriptions and, indirectly, definitions of psychotherapy was offered by Otto Kernberg, one of the “fathers” of modern theory and treatment methodology for personality disorders. According to Kernberg, psychotherapy is a relationship marked by two key elements: care by the therapist for the client, to the extent that the therapist

is prepared to undergo unpleasantness and, sometimes, even abuse by the client (when personality disorders are concerned), and a sincerity in the reactions the therapist offers to the client, which can in fact exert a corrective influence on the client (Kernberg et al. 2008). Kernberg describes, in a variety of sources and interviews, his own development towards the point in his life when he decided to become a psychiatrist and says that the key driver for him was his desire to change his own personality. This subsequently led him to explore ways in which psychotherapy can change the personalities of clients and the psychological, existential, and cognitive investments psychotherapists must make into the therapeutic relationship in order to help effect such change in the clients.

The above description is perhaps the most general depiction of psychotherapy that goes beyond the various sectorial approaches that focus on a particular “method”. In fact, it seems that the method is little more than a refuge for therapists with a crisis of intellectual identity, where neither the clients nor the society at large are concerned with the particular method a therapist uses; what they are interested in is the therapist’s skill and the effectiveness of the therapeutic relationships. Empirical surveys have found that the success of therapy crucially depends on the quality of the therapeutic relationship and does not depend almost at all on the particular “school” or ideological self-identification of the therapist (Lewis et al. 2000).

Assuming that psychotherapy in general is seen as a relationship, and not as a “grab bag of techniques” that are chosen based on a “deep understanding of the human condition” (the way it was recently described by an American psychodynamic therapist on social networks), the next questions to consider are what distinguishes the psychotherapeutic relationship from a philosophical counseling relationship and whether in philosophical counseling, the relationship itself has the same prevailing significance.

1.2. Philosophical Counseling as a Dimension of Psychotherapy

Philosophical counseling is an approach that is based on the examination of assumptions, beliefs, and values and, as such, has characterized philosophy from its very inception, at least in its western tradition (Hadot 1995). In fact, there is reason to assume that modern psychotherapy has grown out of what the ancients would have called philosophical counseling, if all of philosophy at the time was not a kind of “philosophical counseling”. The idea is expressed in Epicurus’s proverbial statement that the philosophy that is not capable of curing human suffering is not worth the name of philosophy and in the more recent advent of the movement of philosophical practice, which seeks to apply the philosophical ideas to the psychotherapeutic process and to organizational and individual consulting. It is doubtful whether this perspective can be separated from psychotherapy, when it is seen, as it is by Kernberg, as a relationship whose aim is the improvement of one’s personality and, concomitantly, the achievement of changes in one’s personality.

Even the idea that psychotherapy deals with “mental illness” (though it obviously does not, as most clients in psychotherapy are reasonably healthy individuals who seek a resolution to their problems) does not necessarily distinguish between psychotherapy and philosophical practice, in the sense that there is nothing to prevent an otherwise “mentally ill” person from seeking philosophical counseling. I have personally refrained, for quite some years, from engaging in counseling with psychotic persons, for a variety of reasons, including, as I thought, the need for such persons to be focused on their medication and the psychiatric therapist, who is familiar with the history of that medication and has the institutional prerequisites to hospitalize the patient, if necessary. This changed on an occasion when I was approached by the mother of a schizophrenic man who desperately tried to get an appointment for him. I refused, for all the mentioned reasons, plus the fact that it was the mother, who appeared to be overwhelming, who sought the appointment, where the role of the mother would likely need to be explored prior to even starting work with her son. However, the next day I received a phone call from her son, who said to me: “I know that I am ill, and I know that this is the reason no psychotherapist would talk to me. You all assume that I am taken care of by my psychiatrist, but I am not. My

psychiatrist does not want to talk to me, either. She just gives me drugs. Although I am ill, I am still a human being, and I should have the opportunity for someone to talk to and discuss my difficulties". I realized, after this conversation, that the root of my refusal to work with psychotic patients was my fear, my own sense of insufficiency, and my misperception of what it is to be "psychotic". In most situations, psychotic patients are not psychotic all the time; most of the time they are what we would describe as normal, with occasional decompensations and psychotic episodes. One wonders whether such episodes are triggered by "cerebral illness" (a hotly debated topic in psychiatry and psychotherapy, for which there is nowhere near enough space to be discussed separately here) or by the impasses in everyday life that might, at least to an extent, be addressed by counseling, just like with any other client. I thus remain undecided on what position to take on the appropriateness of psychotherapy in general, and philosophical counseling in particular, for psychotic clients. Perhaps, the most reasonable approach is to judge this on a case-to-case basis, until more principled conclusions on the matter are reached in the ongoing debate amongst psychiatrists, psychotherapists, and neuroscientists (consider, for example, [Damasio 1994](#), or the work of critical psychiatrists such as Joanna Moncrieff—e.g., [Moncrieff 2018](#)).

The controversies over the actual role of psychotherapy and philosophical counseling highlight, by my lights at least, two conceptual conclusions. The first is that the difference between psychotherapy and philosophical counseling is an illusion. There is no such thing as philosophical counseling that would be distinct from psychotherapy. Both practices occur in the same format, with the same types of expectations and limitations, and are subject to the same type of controversies. For example, the controversy over whether psychotic subjects are proper interlocutors for psychotherapy/philosophical counseling stretches across the range of psychotherapy, where it is assumed that individuals who cannot express themselves coherently may not be subjects to psychotherapy. The same type of argument applies to philosophical counseling, with any other limitations being left to psychiatry and neuroscience to potentially decide. In fact, psychotherapy is as informed by philosophy and by value considerations as is philosophical counseling ([Fatic and Zagorac 2016](#)). Thus, the difference between psychotherapy and philosophical counseling collapses when both are considered in light of the behavioral issues that reflect the values, patterns of decision making, and affective reactivity that influence our micro-social environment, or what the Lacanians call our relevant "structure" ([Verhaeghe 2008](#); [Lacan 2007](#)). This blending together of psychotherapy and philosophical counseling based on the behavioral aspects of decision making and a subjective sense of being "stuck" as the prerequisite for attending psychotherapy/philosophical counseling brings us to the third concept, which I use here as the overarching one, namely, that of behavioral philosophy.

1.3. Behavioral Philosophy

Behavioral philosophy is a concept that unifies the traditional applications of psychotherapy and the recently revived practice of philosophical counseling with the other behavioral interpretations of values, cognitions, and affective responses at levels ranging from individual to society-wide. It is based on the assumption that behavior is not merely a manifestation of our mental processes; the application of autonomous decision making, exemplified in discipline and deliberate self-improvement, exerts an influence on the mental processes. On a limited scale, this is the idea of Cognitive Behavioral Psychotherapy, which rests on the assumption that a change in behavior results in the breaking apart of old patterns with their corresponding neural pathways and the creation of new ones. The principle is sometimes associated with the plasticity of the brain thesis, where a part of brain plasticity is taken to consist in the brain's ability to adapt its structure, morphology, and especially the size and electrical activity of its particular regions to changes in the person's behavior and experience. A consequence of this idea is the controversy over many psychiatric diagnoses, including that of "major depression", which is taken to set in after 4 weeks of what would otherwise be considered a "reactive (healthy) depression", where

the 4-week cut-off is associated with the observed changes in the morphology of the brain, where certain regions swell and others shrink. This has so far been taken to call for the aggressive use of antidepressants, because of the idea that once the brain has changed, recovery is much more difficult. In fact, a lot of the research on depression suggests that unlike any other organ in the human body, the brain responds to experience, and if the experience changes sufficiently, then the changes observed in the brain will either revert to the previous condition or improve further (Radulescu et al. 2021).

If behavior has such a comprehensive effect on brain plasticity, this generates a number of major changes in the way neuroscience must think about the central nervous system (Damasio 1994), including consequences for the philosophical concept of free will. While there is much to discuss philosophically on the very meaning of the new neurological findings that Damasio, Moncrieff, and others detail in their work, I will be content here with a relatively safe and uncontroversial preliminary conclusion, namely, that the orientation to determining a person's or a community's values and general issues inculcates both the manifestations of their internal mental processes and assumptions in the person's or collective's behavior and the actual ability of the behavior to change the processes. What we deal with is behavior, and it is on the basis of behavior that in any kind of counselling, we are able to speculate about the person's values and affective structures behind their decisions. The psychotherapeutic theories that arise from such stipulations starting from behavior are sets of assumptions and arguments based on those assumptions, such as the assumption that a person's or group's behavior signals that certain decisions pay off for the person on some level, despite the pain and harm that they obviously cause (the psychological concept of secondary benefit, characteristic primarily of Transactional Analysis); that the neural processes are learning curves triggered by conscious decisions in practical life (Cognitive Behavioral Therapy); or that subconscious architectures of experience account for the suppressed dynamics of current behavior (psychoanalysis as broadly conceived). All of these theoretical constructs are aspects of behavioral philosophy. I thus use the concept of behavioral philosophy as that of value-informed interpretation of behavior with a variety of practical emphases, including that of psychotherapy and/or philosophical counselling as overlapping and possibly entirely coinciding forms of therapeutic practice. The use of behavioral philosophy as an inclusive concept here relieves us of the burden of needing to distinguish precisely between the more and the less philosophical forms of counselling under the names of philosophical practice or psychotherapy.

2. The Quest for "Normalcy" as a Social Normative Ideal

Normalcy as a therapeutic ideal is predicated upon a social structure of virtue that articulates particular aspects of what it means to be an ideal community member (Fatic 2016). In other words, we construct what it is to be "normal" based on a construct of social desirability. Not everything that is not ideal is necessarily seen as pathological, but if it is sufficiently unacceptable, disturbing, or unusual, it is highly likely that it will be labelled "abnormal". Thus, the construction of normalcy is an aesthetic and a medial and generally social normative category. For example, a person acting humorously while apparently neglecting the reality of the situation and relationships in a particular social setting will generally be accepted as amusing, perhaps odd, but most likely not "abnormal". Another person, with the same level of apparent departure from what would be a realistic appreciation of social facts and relationships, in the same situation, who acted in a dislikeable way (not necessarily threatening, but causing others to feel confused or their mood to decline) is more likely to be seen as mentally ill. Our perception of what it is to be "normal" and "abnormal" is shaped aesthetically as much as it is determined through "objective" medical criteria (cognitive grasp of reality, ability to control affect, presence of emotional dissociation, etc.) (Musalek et al. 2022).

2.1. *The Aesthetic Character of “Normalcy”*

The aesthetic dimension of normalcy presupposes that the ability to be “normal” requires a degree of common aesthetic sensibility between the individual and the society—a sensibility that is typically developed through socialization. If a person is caught in a structure of cognitive, affective, and behavioral patterns that others find aesthetically unacceptable, the person is likely to be treated as deviant or as mentally disturbed. While not all types of mental disorders are perceived as primarily aesthetic displeasure by the majority, generally, the greater the divergence between an individual’s sensibility and values and that of the society is, the more likely it is that the person will be perceived as “abnormal”. This point is debated at length in the current debates on mental illness in terms of “neurodivergence” as opposed to any type of clear-cut pathology (Legault et al. 2021).

One of the tasks of psychotherapy is to reconcile this need to bring the individual’s sensibility and behavior more or less within the aesthetical and broader socially normative realm of general acceptability (in order to be considered “normal”) and, at the same time, the need to perceive the individual, the client, in light of one’s entitlement to a substantial degree of “neurodiversity”. To do so, typically, the psychotherapist must align with the client within a discursive process that places them in a position of common quest for change. The therapist does not demand change from the client; they ally themselves with the client in a common expectation of change that they hope will arise from their therapeutic relationship. This relationship of the two co-wanderers and co-sufferers seems remarkably like the work of faith—the belief in a light from above, in the possibility of a miracle of change occurring in the midst of a common quest; in such case, the therapeutic profession would indeed remain an ultimately “impossible profession” (Freud 1964). To use the metaphor by Maria Zambrano, the therapist and the client wander around a wilderness of the client’s divergent and socially dysfunctional mindspace, seeking a “clearing” as an inroad into change. Whether, how, and when a clearing in the wilderness will emerge is unknown to both the client and the therapist (Johnson 2005).

The motif of a clearing, of expecting an opening or an opportunity for constructive change whilst cultivating a community of therapy, is what characterizes almost every successful therapeutic process. The closeness that develops between the therapist and the client grows into a therapeutic community, where the therapist is simultaneously an ally, an example, and a powerful life resource for the client. By “having” therapy and the therapist, the client already changes important aspects of their life. However, the meaning and mission of this community go beyond the mere healing relationship; it also includes an expectation of the opportunity to do something together that would result in a lasting positive change for the client. There is a sense of common expectation based on the virtue of togetherness and mutual dedication within the therapeutic relationship that resembles common prayer. In modal logic terms, the therapist and the client expect a change in the modal worlds of the client’s (and, sometimes, also the therapist’s) life experience that might occur simply by virtue of a different modal world being “called into reality” by the dedicated therapeutic relationships and process (Fatic 2023a). The exact way in which this change in modal worlds happens is usually unclear to both the client and the therapist. In strictly logical terms, the change that neither participant in the therapeutic relationship can exactly explain, understand, or predict may be described as an experiential “miracle” (Leal et al. 2002). Perhaps the best documented types of specific, concrete “miracles” in psychotherapy of this type are synchronicities, which are now generally accepted as a phenomenon for which we remain without a strictly rational explanation, yet one that regularly occur in psychotherapy (Cambray 2009).

2.2. *Sharing Beliefs as a Spiritual Element of Therapy*

The way in which modal worlds are called into actuality is by generating different psychological conditions. Typically, this requires the creation of a community that is powered by particular values or intentional psychological content (Searle 1983). The latter might include various psychological dispositions, such as desires, fears, anticipations,

anxieties, or intentions. A community that shares the same or similar intentional content is characterized by a particular “mentality”, and within a different communal mentality, different kinds of social realities are possible. Such a changed community mentality is a different modal world that facilitates possibilities that were previously unforeseeable (Keany 2018).

Sharing the same type of beliefs decreases the likelihood that some within the community will perceive themselves as superimposed on others and that they will engage in what the Lacanians call “master discourse”, or hierarchical communication, which is usually ineffective in psychotherapy (Verhaeghe 1995). Being a part of the community of like-minded peers increases the likelihood of equality, solidarity, and collaboration as opposed to the strategies of verticality, domination, and control. The former are all attributes of the therapeutic community, while the latter are literally anti-therapeutic. Thus, the change in modal worlds that makes large leaps in personal change possible within psychotherapy may arise from as little as the cultivation of a therapeutic relationship itself, as the nuclear community of belief and mentality, consisting of just the client and the therapist.

A good example of therapeutic communities outside a therapy setting per se are the close religious communities, where many of the members are there because otherwise, they would be lonely and isolated. The relationships that they establish within the church community are with the like-minded individuals. When such relationships are intimate (such as marriages), they have much higher chances of long-term success, because there is a value resonance between the spouses which they have adopted from the value structure and sensibility of the community that they are a part of. The modal world of marriages in such communities is different from the modal world within which most other couples get together in the society at large; consequently, their prospects and quality of life tend to be more stable and better than in the society at large. Some of the modern physicians and physicists have grounded the scientific explanation for this type of resonance in modern energy-based physics. While I am not able to comment on physics authoritatively, there appears to exist a striking similarity between the social intuition of “resonance” within harmonious communities and the quantum physics theories of vibration and frequency, which suggests the potential ways in which individuals establish rapport that is neither verbal nor behaviorally explicit, nor is it limited to the physical proximity of the individuals (Chopra 1993). The concept of normalcy within a religious community is somewhat different from that in the society at large: many behaviors that are widespread in society are considered “abnormal” in more organic communities. The structure of virtue and value more generally define normalcy more strictly and thus narrow the room for individuals to be “struck” in their ways without a value perspective to guide them to what their community would consider and encourage as “normal”. It is this “stuckness” that typically brings people to psychotherapy (Peck 1997).

3. Prayer and Psychotherapy

The crucial experiential aspect in prayer is the attitude one takes; it is contrary to the attitude of “dignity” and “pride”, which is usually associated with rational debate, where we fight for our opinions and views and desire to prove them correct as opposed to others’. In prayer, being “right” does not matter at all; what matters is attracting the mercy of God, namely, admitting one’s own faults and fallacies and showing as broad as possible an openness to God’s intervention, whatever that intervention might be, including our own death. Only such an attitude in prayer leaves the person sufficiently susceptible to change to experience a miracle.

3.1. *The Attitude in Prayer and in Therapy*

One of the paradigmatic examples of the attitude in prayer is that of King David in the *Old Testament*. Having suffered the problems of arrogance and overextended ego that are characteristic of almost unlimited political power (van Ginneken 2014, pp. 1–13) and having betrayed his closest friend, whom he has sent to die in a hopeless battle in

order to have his wife, the beautiful Batsheba, David finds himself surrounded by enemies from the outside and from the inside of his court and weeps to God. David's *Psalms* of the *Old Testament* are used as everyday prayers by Jews and Christians for their tone of submission and repentance. In them, David relates every trouble and illness he faces to his transgressions of the law of God (and of moral law). In the *Psalms*, the most powerful man in Israel sounds like the humblest servant of God (*Psalms*, 38: 3; 38: 18; 51: 3–5; *Leviticus*, 26: 39–40—[The Holy Bible 1988](#)). They are the classic example of the attitude in prayer that Jews and Christians believe is a prerequisite for the prayer being answered by God. Even if the prayers are said and the rites performed perfectly, an attitude or thoughts of self-importance or any kind of arrogance will annul them in the eyes of God. It is this attitude of submission that arises from an awareness of one's own fundamental inadequacy that calls into reality new modal worlds, new sets of circumstances, in the vision of a mercy of God. It is the expectation of change, forgiveness, or a blessing that increases the quality of life of those suffering, and at the same time, the same dispositions create the conditions of the emergence of the "clearing" mentioned earlier on.

There is obviously an ethical element in the attitude of submission in prayer, where the idea of one's own limitations and impotence to address life's challenges necessitates respect and reverence for God as the source of both redemption and specific salvation from daily calamities. This type of ethics is also highly practical in psychotherapy, because it enlightens the therapeutic process with an awareness, both by the client and by the therapist, that there are limits that they can achieve as individuals. The client has typically already tried everything in their power to solve the problem prior to arriving to therapy. The therapist, on the other hand, is aware that the array of interpretations and interventions that he or she possesses are of limited value if the process remains in the hands of the therapist alone. What they both ought to expect is the creation of a new psychological reality within the therapeutic process, like the attitude of expectation and submission that characterizes prayer, which would then allow for the emergence of a change. Neither the client nor the therapist knows exactly how that change will occur and what its exact nature will be. Their work is largely in the dark, and they rely on a common attitude of looking for a conceptual and psychological clearing whilst cultivating their relationship in good faith. There is a remarkable similarity between the attitude that characterizes the therapeutic expectation and that of prayerful waiting for God.

3.2. *The Sense of Insufficiency*

A related and perhaps more fundamental aspect that connects prayer and psychotherapy is that of insufficiency. On the one hand, it is the sense of insufficiency and inadequacy that brings individuals to therapy. Their inability to resolve existential difficulties with the use of their own personal resources faces them head-on with the deep-seated insufficiency of personality, or what Jacques Lacan called "lack" ([Verhaeghe 1995](#)). It is the sense of lack that moves us during life in an attempt to secure the "missing object", or the object of satisfaction, where the very nature of the game is pursuit itself. Paul Verhaeghe describes this game as a puzzle where the very ability of the pieces of the puzzle to move is predicated upon the absence of one piece of the puzzle. It is impossible to completely fill the puzzle, and if it were possible, then the puzzle would become useless as a game, because no piece would be able to move any more. However, the perception of lack, or insufficiency, especially of the inadequacy of personal resources to deal with pain and frustration is one of suffering; it is the complaint most often heard in psychotherapy rooms. The nature of psychotherapy is not to remedy the lack, or to fill the puzzle, thus making life itself devoid of dynamism and movement, but to make the client and the therapist alike aware of the mutual insufficiency. Thus, where insufficiency brings the client to therapy on the one hand, on the other, the recognition of the mutual insufficiencies of the client and therapist generates a situation of prayerful expectation of an opportunity to make an inroad into an otherwise insoluble situation. The client and the therapist recognize each other's insufficiencies ([Vallas and Cummins 2014](#)). The cultivation of a therapeutic relationship, based on

such a recognition of insufficiency, but marked by a mutual dedication and preparedness for sacrifice (of time, attention, and energy, at least), is then what heals in psychotherapy, rather than any specific technique of “intervention” (Eigen 2014).

One way in which we tend to compensate for our insufficiencies is by identifying with larger identities that make us feel less inadequate and incomplete. This process of identification of groups, ideologies, and even with objects, which thus become seemingly inseparable parts of our lives, is what Jung made famous as “participation mystique” (Jung 1966, 2009). The subjective sense of lack is compensated for by participation in larger relationships. This is why individuals tend to find spouses who compensate for their own inadequacies or exhibit qualities that they themselves feel they lack, and at the same time, it is why the passion with which we tend to adopt ideologies, join various schools of thought, or embrace particular moral values or aesthetic taste tend to correspond with the intensity of the felt internal insufficiency. The applications of Jung’s theory of participation mystique are potentially vast and can especially usefully address issues of human conflict ranging from interpersonal psychological conflict to warfare (Fatic 2023b).

The prayerful nature of psychotherapy is closely connected to the concepts of lack and insufficiency, in at least two ways. First, it is the sense of a missing object or satisfaction or the broader sense of insufficiency that is required for personal change, including that through the psychotherapeutic process. Without a sense of inadequacy, no amount of psychotherapy or counseling can lead to meaningful personal development. Secondly, and more importantly for my present context, the sense of insufficiency points to a structure of power that is displaced from the very therapeutic process and made vertical, like in prayer. In a joint quest for an opportunity for change and for therapeutic success, the therapist and the client relinquish the idea that they have the power to effect such change. The psychotherapist does not believe that he or she has the capacity to change the client, nor that the client can change themselves. Rather, both direct their expectation of change to the outside of their relationship, in the belief that the relationship itself will create the psychological conditions for a modal logic switch of modal worlds, for the onset of internal and external circumstances that, for the client, will make possible what at present seems impossible. It is this expectation that is constructive, active, and filled with a joint investment of belief, energy, and time in the creation of an organic therapeutic community that typically invites major specific inroads into situations that the client and the therapist, sometimes, do not even talk about explicitly. The very structure of psychotherapeutic training that is based on modal logic reflects this emphasis on bringing about real change in circumstances and life flow rather than being limited to a mere reinterpretation of events and modification of one’s subjective reactions to what is a given “external world” (Institute for Practical Humanities 2023). The novelty of the perception of psychotherapy as based on the dynamics of modal logic as opposed to that which traditionally rests on propositional logic is in part this bringing together of psychotherapy and a prayer-like attitude of an active therapeutic alliance in the expectation of modal change that is brought about by the organic community between the therapist and the client.

4. Conclusions

While the concept of normalcy is the construct of our community, our values, and above all, the projections of virtue that our community adopts as its social ideal (the closer one is to that social ideal, the more “normal” or healthy one is considered), it at once shines a light on how psychotherapy resembles prayer and spiritual practices more generally in seeking to help individuals attain thus defined normalcy and mental health. The general attitude in psychoanalytic and later most other psychotherapeutic schools and circles that the less of a “master discourse”, or dominating, “doctorly” approach there is in psychotherapy, the more effective the therapeutic relationship tends to be in bringing about the normalcy that is sought after through the process is at least suggestive of deep methodological and phenomenological similarities between psychotherapy and spiritual practice, primarily prayer. Perhaps the most important such conclusion is that the therapeutic alliance in

successful psychotherapy acknowledges the fundamental insufficiency of both participants in the therapeutic relationship—the client and the therapist—and positions them side by side on the task of establishing a sincere, devoted community whilst expecting an opening, a “clearing”, whereby an opportunity will shine from above and allow them to create an inroad into the problem. Thus, the therapeutic relationship pictures two persons, both proverbially “full of holes”, aware of their insufficiencies as human beings, soldiering in solidarity whilst awaiting a break, or a blessing, from above. Once the light comes, it transforms both the client and the therapist. They are often lost for words and rational arguments as to what just happened, and this is often reflected in debriefing after successful therapy (Yalom and Leszcz 2005, pp. 285–95).

While the concept of normalcy may be described in more or less static and simple terms, as an offshoot of the society’s projection of virtue and ideal community membership, the psychotherapeutic process, which is supposedly predicated upon the need to attain or regain normalcy where it is clouded or obstructed, either subjectively, for the client of psychotherapy, or intersubjectively, as the society’s perception of the individual, is more complicated. It is the quest for normalcy through psychotherapy that elucidates the pitfalls of the assumption that one person is sufficient to change another person through a type of “professional” intervention that resembles a medical cure. The very structure and dynamics of successful psychotherapy reveal a layered process whereby the inadequacies and incompleteness of both the client and the therapist are recognized and built into a humane and empathetic relationship that strives upwards. There is an element of expectation of a modality, or possible world, that makes possible what is currently impossible for the client, that is called into reality by a spiritual-like practice performed jointly by the client and the therapist. This practice is organic community building in the therapeutic process as the cultivation of the psychological conditions for a modal logical change or for a religious-style “break-through” that the therapist envisions and helps the client to expect; however, neither the therapist, nor the client, can determine, precisely describe, or control that the creation of such psychological conditions, much less the onset of a breakthrough. This prayer-like position of the client and the therapist is one where, side by side, they look above the current modal worlds, or sets of circumstances that determine the client’s experience and the limitations of the psychotherapist, believing in the psychotherapeutic process as a fundamentally transcendent one, where the boundaries of the current modal world that therapy starts from will, at some stage, shift and transform, in ways largely unfathomable to either of them, but in a manner that is brought about by their commonality and solidarity in the effort to meet and welcome the new reality.

The psychotherapeutic context that is most consistent with the prayerful approach is the one where the entire range of psychotherapeutic approaches and interventions are seen as philosophically informed and methodologically open structures focused on building the organic therapeutic community as a form of preparation of the psychological conditions for significant personal change. Such change is typically impossible at the outset of the therapeutic process, and it is this impossibility, of which Freud spoke so fervently, that accounts for the very need for psychotherapy and any kind of therapeutic help, from the Epicurean therapeutic origins of practical philosophy (Hadot 1995) to present Modal Integrative Psychotherapy.

Traditionally, psychotherapy has been based on the goal of changing the subjective experience of circumstances that, outside the individual, were largely regarded as irrelevant for the psychotherapeutic process itself. It has been assumed that one’s experience of reality is one’s representation and that changing representations is sufficient for increasing one’s quality of life. However, the modal way of thinking about psychotherapy goes beyond that and integrates the modal logical categories of possible worlds, possible structures of circumstances, which undoubtedly influence both subjective representations and the objective prospects of gaining satisfying future experience in life. This approach to calling into reality a different modal world, both subjective and “objective”, consisting of circumstances that live outside the client is marked by a prayer-like attitude and a deep analysis of what makes

us connect organically, not through the provision of “professional” services, but through the creation of an organic, committed community where the skills and interventions used through the therapeutic process represent an active expectation of change. Such a view of psychotherapy is both methodologically and substantively novel in the history of the discipline and brings psychotherapy into a perspective where it is both integral with a practical philosophical approach to “addressing suffering” and with the religious practice of prayerful expectation of a blessing.

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