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("Knowledge begins with practice, and theoretical knowledge which is acquired through practice must then return to practice"--Mao Tse Tung.)

ABSTRACT, This paper takes seriously Mao's epigram to tackle two important and interrelated themes. First, it looks at the extent to which practice in one helping profession (social work) may be said to be informed by theory. Indeed, Mao's statement that 'knowledge begins with practice' turns out to be a useful way of grasping the relationship between ideas and action. Second, knowledge gained from practice is returned to practice. Habermas's process of reconstruction used in the analysis to tie theory to practice is employed in the development of a conception of 'public knowledge' to increase professional accountability.

Standard sociological accounts of the helping professions agree that the possession of a body of specialized theory is an important attribute of these occupations (Vollmer and Mills, 1966; Langford, 1978). Indeed, some writers would insist that it is a distinguishing feature of the professions that we may expect of the professional some justification for his conduct in terms of a theoretical rationale.[1] Very little attention has been paid, however, to the details of just how theory is translated into practice. When they have considered the question, neither sociologists nor the professionals themselves have been able to demonstrate the nature of a link--if indeed such a link exists at all--between ideas and action.

This is a significant omission. In this paper it is intended to tackle two important, interrelated aspects of the problem. First, it will be argued that in looking at professional activities we should ask whether (and if so, how) the practitioner's actions can be justified in terms of some codified theoretical rationale. Second, following Feyerabend (1975; 1980), it will be argued that we should ask to what extent the professional's action--and any theoretical justification underpinning his activities--is open to critical scrutiny by others (whether peers or the laity). This introduces the dimension of public knowledge into our conceptions of professional accountability.

Given the enormous latitude the professions have to define our problems and to propose solutions, issues of accountability assume prime significance in the sociology of the professions today (Friedson, 1977; Slayton and Trebilcock, 1978). Professional accountability, however, implies more than just making experts more responsive to the public (important though that is). Questions of theory choice are vital too, and we need to know more about the relationship between theory and practice if we are to be able to scrutinize professional activities effectively. We need to develop a conception of public knowledge in the helping professions. In saying that we are emphasizing that the ideas and actions of experts should be open to the possibility of criticism not only by immediate professional colleagues, but by a range of 'outsiders' including related professionals and, if possible, laymen (Feyerabend, 1975; Phillips, 1977).

Certainly some progress has been made analyzing the values and assumptions behind the various social science theories used by practitioners (Gouldner, 1971; Pearson, 1975). What is needed now, however, is a more detailed examination of these theories and just how they relate to day-to-day professional practice.

My plan will be as follows. First, to look at some unsuccessful attempts to relate theory to practice in social work, showing why they are defective; then, to examine an alternative view of the translation of theory into practice; and, finally, to discuss some of the implications for professional accountability of the arguments presented here. The focus will be on a specific but most important aspect of social work, social casework, though the general line of argument will be seen to apply to other helping professions like psychiatry and clinical psychology. Moreover, the analysis will be limited to one part of the broader issue of 'theory into practice', ignoring for the time being other factors (such as the study of moral-evaluative terms), which must be taken into account in a fuller treatment of the topic.

The philosophical techniques of conceptual analysis and an analysis of the logic of clinical reasoning will be used. Because the methodological approach employed may be unfamiliar, a brief word about it is in order. My concern here is to clear the ground, paving the way for future empirical research. In that case, as Habermas puts it, the emphasis is appropriately not on 'empirical-analytic' procedures but on 'formal analysis': 'the methodological attitude we adopt in the rational reconstruction of concepts, criteria, rules and schemata' (Habermas, 1979:8). It is in the reconstruction of practitioner's accounts of their work, then, that we seek an explication of the relationship between theory and everyday professional practice.[2]

Theory in Practice in Social Casework

How is theory translated into practice in a helping profession like social work? Most accounts never get past the bald assertion that theory is applied in practice. Two sociologists, 'Integrating Theory and Practice', provide a typical specimen:

> Diagnosis consists of applying a taxonomy and on the basis of the classification that is made of 'the problem', a prescription can be made. This prescription is based on some theory which specifies certain manipulations which are presumed to affect the diagnosed condition. On the basis of the prescription, the treatment is carried out (Leonard and Skipper, 1971:282).

But we are still left wondering about the precise details. Nor are recent discussions of 'practical reasoning in action' in therapeutic settings enlightening. Neither Schwartz's (1976) discussion of motives and mistakes in psychotherapy nor Anderson's (1978) account of the referral process in a psychiatric center offers an explicit analysis of the details of theory applied in practice.

Following a seminal paper by Lehrman (1962), a few notable exceptions do try to deal with how theory is used by the professional helper. These studies mainly have been concerned to explicate a 'logic of diagnosis'. Lehrman sought to reconstruct the steps in decision-making through which (it was presumed) the clinician had followed. For example,

> Mr. Jones is irresponsible
>
> Psychopaths are irresponsible
>
> ∴ There is a possibility that Mr. Jones is a psychopath.[3]

More recently Martin Bloom's landmark work "The Paradox of Helping' (1975) sought to reconstruct the logic of clinical reasoning in social casework. Bloom's efforts, in fact, extended an earlier analysis of clinical psychology by Sarbin, Taft, and Bailey (1960). All of these writers employ the categorical syllogism as a model of the reasoning process, although they allow for some modification of the basic logical form to fit the complexities of actual practice. For instance, only rarely in practice will the clinician be dealing with 'all' or 'none' modifiers to basic theoretical propositions. That is, practitioners are unlikely to be working with a major premise

such as--'all older persons are harmed by relocation from their own homes to an institution'.[4]

These writers rely ingeniously on probabilistic statements to get over this hurdle, thus fitting the complexities of actual practice into a syllogistic mode. An example will convey the fundamentals of these two closely similar approaches (Bloom and Sarbin).[5]

> All older persons are harmed by relocation to an institution (this proposition has a probability of being true 50% of the time as indicated by research)
>
> Mrs. Smith fits the social worker's definition of an older person in nine out of ten defining attributes of the given class: a probability level of 0.90
>
> ∴ There is a joint probability of 0.50 times 0.90 giving 0.45 that Mrs. Smith will be harmed by relocation to an institution.[6]

A number of important criticisms may be levelled at this account of clinical reasoning.

First of all, and this point applies to Lehrman's syllogism too, the conclusion (above) is not expressed in the form of what Anscombe has called an 'action imperative'. That is, the conclusion does not yield 'a description of some future action . . . cast in the form whose point in the language is to make the person do what is described' (Anscombe, 1963:3). To put it bluntly, the conclusion does not express an intention to act. As an example of a practical syllogism, then, it falls short of the mark (see Norris, 1975).

Second, there is no good prima facie reason to suppose that the order of our thinking processes in clinical activity follows a syllogistic line from major to minor premise then to a conclusion (see Bloom, 1975:121; Norris, 1975:77-84). Rigid adherence to this assumption has apparently been a serious stumbling block to attempts to reconstruct the logic of clinical reasoning. This point leads straight to the next one.

Third and finally, running through all of these accounts which seek to follow the logic of clinical thinking there has been an assumption that the professional has to do some explicit theorizing, involving the consideration of maxims or propositions about what to do, for an action to be counted as theory-guided. It has been taken for granted that some deliberate cognitive work must be done, however speedily, before action is taken, if the claim is to be sustained

that the help offered was informed by some theory held by the professional. Let us call this the Pre-Action Cognition Model of how theory is translated into practice in the helping professions.[7] Undoubtedly this view has been attractive because it embodies the apparently essential virtue of 'The Professional'--rational man thinking through each step before acting.[8] It is now time to develop a critique of this approach and here I shall rely on the ideas of a philosopher, Gilbert Ryle.

The 'Pre-Action Cognition Model' Criticized

Ryle's interest was not in the study of clinical activities. His concern was to attack a philosophical position he called 'The Intellectualist Legend' which, he asserted, is based on the absurd assumption that any sort of performance 'inherits all its title to intelligence from some anterior internal operation of planning what to do'. For example, on this muddled view,

> The chef must recite his recipes to himself before he can cook according to them; the hero must lend his inner ear to some appropriate moral imperative before swimming out to save the drowning man (Ryle, 1949:28-29).

There is a parallel between in philosophy what Ryle called 'The Intellectualist Legend' and what I have just called as the Pre-Action Cognition Model in accounts of the helping professions. It has been assumed that for a clinical action to have been informed by the professional's knowledge, a piece of theorizing must, always and immediately, go before a piece of doing.

Does the caseworker--or any other helping professional--have to do some deliberate theorizing, involving the consideration of propositions about what is to be done, for the action to be theory-guided? The point turns on a distinction Ryle makes between knowing 'how' and knowing 'that'.[9]

> Although a given cook may learn to cook from a cookbook, the principles of cookery are logically a distillation from the practices of those who know how to cook, just as the principles of valid argument are a distillation from the practice of those who know how to argue. Thus knowing how to do things, being able to perform intelligently, is logically independent of any anterior theorizing (Urmson, 1967:270).

Or, as Ryle himself put it, 'efficient, practice precedes the theory

of it'.

The argument still needs to go a step further. Ryle insists that to hold that a practice can only be intelligent when it is preceded by intelligent thinking would lead to an infinite regress. As John Passmore put it (and the American reader should substitute baseball for cricket):

> . . . if there were any good reason for supposing that intelligent cricket-playing must be preceded by intelligent theorizing about cricket, there would be exactly as much reason for supposing that intelligent theorizing must in its turn be preceded by intelligent theorizing about theorizing and so on ad infinitum (Passmore, 1970:446-447).

Now this does not mean that practitioners never think before they do something; for instance, when they help someone in trouble. In the very first place, in learning a therapeutic (or other) skill it is highly likely that deliberate, self-conscious theorizing--in the form of consideration of maxims about what to do--actually preceded the actions in question. Standard sociological accounts of the process of professional socialization certainly support this view (e.g., Pavalko, 1971:80-110). But, and this point is crucial, the broad assertion 'that all intelligent performance requires to be prefaced by the consideration of appropriate propositions' (Ryle, 1949:30) is plainly false.

Professional Practice As Knowing 'How'

Thanks to Ryle we should have demolished one myth about the helping professions--the view that to be theory-guided, therapeutic actions must immediately be preceded by some prior intellectual operation. Perhaps we would do better to view social casework and the other helping professions as a skill to replace the Pre-Action Cognition Model. What I am arguing is that a limited parallel may be drawn between many of the routine helping actions of an experienced caseworker and, say, the actions of an experienced motorist driving a car. While what is done today may (or may not) at one time or another have been learned, according to explicit maxims, none are involved necessarily in the performance of the action now. The social worker need no more go through some deliberate process of theorizing to connect theory to practice than the motorist, to drive properly, has to recite to himself: 'red light, I'd better stop' or 'look in the rear view mirror before changing lanes'.

Is there any evidence to support this way of looking at

professional practice? Some recent sociological research in a closely related field appears to provide a good deal of corroboration. Michael Bloor's empirical studies of decision-making in medical consultation certainly lends weight to the Rylean approach (Bloor, 1978:39-47).

Decision-making in novel situations, Bloor found, will involve the doctor in considerable interpretive work. He will have to make sense of what is going on, including the identification and classification of various properties of the case. However, in the more frequently encountered decision process in routine contexts:

> There is no conscious deliberation of the costs/benefits of projected alternative courses of action in such situations, rather decisions emerge automatically as a consequence of unthinkingly adopting a set of routines. To be sure, these decisions may once have been painstakingly formulated, but to say that the costs/benefits model may be an accurate description of decision-making in the historical past is not to excuse its inadequacy for describing the decision-making process in the present (Bloor, 1978:40).

In other words, Bloor suggests, most of the time, unless something goes awry, the professional's actions will be routine, unthinking--yet to say that does not mean that what was done to help is without theoretical justification.

Let us look more closely at this Rylean conception of practice as skill. On this view professional practice should be seen as a skilled performance, i.e., as knowing 'how' rather than knowing 'that'. In the first place, a crucial element of a skilled performance is that prior learning has taken place. As far as casework is concerned (and probably other helping professions, too) this has been an explicit process of professional training or 'cognitive socialization' in the form of:

1. Repeated trials and exposure to both standard and new cases. The neophyte will encounter a range of fairly typical instances as well as a variety of cases which fall outside the usual range in different ways. Basic proficiency has usually to be demonstrated on the standard cases before moving to the graded, harder examples.

2. The newcomer has been 'shown how' by examples from textbooks and cases presented in the classroom, probably with special attention to 'classic' illustrations of particular problems (e.g., an alcoholic) in practical work and agency visits.

3. The student will be stimulated by critical comments from peers and professionals, and encouraged to engage in critical self-reflection. These activities will take place both in the classroom and out in the field during practical training.

4. There will usually be some basic or minimal level of proficiency to be attained before one can be said to possess the skill.

Furthermore, Ryle and others (e.g., Scheffler, 1965) make a distinction between, on the one hand, intellectual capacities (e.g., map reading) or critical skills (e.g., playing chess) and, on the other hand, habits (presenting arms) and facilities (simple arithmetic computation). Intellectual capacities/critical skills, they argue, are learned by training whereas habits/facilities are inculcated by drill and repetition. It is presumably just this distinction which highlights the crucial role of strategic judgments in critical skills or intellectual capacities; i.e., the whole notion of skill, then, implies the meld of theory and practice in an act of judgment by an experienced practitioner.

Finally, as stated earlier, it is highly likely that deliberate, self-conscious theorizing--the explicit consideration of maxims about what to do (e.g., 'always do a home visit')--actually precedes actions during the process of learning skills such as those involved in a helping profession. This point is entirely consistent with sociological accounts of 'cognitive socialization' in professional schools (Pavalko, 1971; Anderson and Western, 1976).

Relating Theory to Practice

So far, however, I still have not said just how theory is related to practice. It is one thing to point to the shortcomings of the Pre-Action Cognition Model. What is required now is to show that skilled professional practice may involve the translation of theory into practice.

We turn now to an ingenious solution to the problem provided by the philosopher B. A. Farrell.[10] The beauty of Farrell's approach is that he takes a typical diagnosis (p) and a typical plan of action or treatment statement (q) and shows how the two logically are related --a necessary move if we are to be able to claim that an action was guided by some theoretical position held by the professional. Farrell's analysis is particularly helpful because it enables us to work with actual examples of diagnoses, etc., taken from clinical practice.

Consider the following diagnostic statement, p, made about a client:

> 'Mrs. Smith is suffering from a delayed bereavement reaction,'

and the treatment statement (q):

> 'The first thing we should do is to see Mrs. Smith on a home visit.'

Farrell says that we should ask: do we have a situation of the kind

> if p ∴ q?

That is, if p is true, then q follows. Really there are three main possibilities if we wish to tie the helping action q to some theoretical position held by the practitioner:

(a) perhaps p ∴ q follows, because the terms are embedded in some particular theory held by the clinician;

(b) perhaps it is an analytic truth: we are led to q as a logical consequence of holding p by itself, and;

(c) the most likely contender, to treat 'if p ∴ q' as elliptical.[11]

Farrell argues that the key to our problem is to treat our statement 'if p ∴ q' as an enthymeme, a syllogism with a suppressed premise, which may be reconstructed as follows. With a major premise inserted--for the purpose of our example some hypothetical, theoretical statement--our 'if p then q' becomes:

> All persons suffering from a delayed bereavement reaction get better in the first instance by a home visit from a social worker

p Mrs. Smith is suffering from a delayed bereavement reaction

∴ q The first thing to do is to see Mrs. Smith on a home visit.

There we have a valid form of the syllogism. We can now see that the translation of theory into practice in a helping profession like social work need not necessarily include, and it certainly does not entail, the prior consideration of maxims about what to do (e.g., the major premise). It is in the kind of reconstruction that Habermas advocates that past actions may be related logically to theoretical propositions. This point is absolutely crucial. We must be able to show this logical

relationship if we are to be able to claim, rather than merely to assert, that the helping action was informed by some theory held by the practitioner.

A Proposed Modification to the Practical Syllogism

In this obviously preliminary analysis of clinical action sentences I am not concerned to explore a greater range of examples. What has been important, via Farrell's solution, is the demonstration of a theory-practice link without resorting to the Pre-Action Cognition Model with all of its attendant difficulties. However, several objections, two in particular, may be raised against the solution above, though no criticism can be levelled at Farrell, who was working with clinical information borrowed from another research project.[12]

1. In its present form the practical syllogism really doesn't give any indication of the basic professional commitment to help persons in distress. That is, the value base which provides the rationale for professional intervention is missing. One way to meet this difficulty would be to add the presumably suppressed premise which lies behind or, rather, 'frames' all social work activity:

> I shall do whatever I can to help my clients get better.

2. In its present form the conclusion does not look entirely adequate. 'The first thing to do is to see Mrs. Smith on a home visit' is not cast in the form of an 'action imperative' because it does not seem strong enough to make the person do what is described. 'I shall see Mrs. Smith on a home visit' does meet this objection squarely, because it commits the clinician to that line of action. Because I have been working with an actual example of a treatment statement what I propose to do is simply to modify the words to include 'I shall' in the practical syllogism. The final form of the modified practical syllogism is as follows:

> All persons suffering from a delayed bereavement reaction get better in the first instance by a home visit from a social worker
>
> I shall do whatever I can to help my clients get better
>
> Mrs. Smith is suffering from a delayed bereavement reaction
>
> The first thing I shall do is to see Mrs. Smith on a home visit.

Note the following points. First of all, the modification is in the form of a valid argument. The professional does have a theoretical justification for the action taken. We are entitled to conclude that there is (in this instance) a relationship between theory and practice because the plan of action follows logically, if not elegantly, from the premises. The modified practical syllogism yields a resolution to do something as a conclusion, in a way that commits the professional to carry out the treatment plan. Moreover, the distinctively social work component, which gives the general rationale for the professional's helping actions, is now clearly in the picture.

Second, and this point is very important, the process favored by Habermas refers to a post hoc reconstruction of clinical activity of a special kind--an analysis of the logic of action sentences to demonstrate whether or not a relationship exists between what was done to help and some theory held by the practitioner. Certainly it is not being suggested here that practice is always informed by theory in helping encounters. What I have tried to show is just how the theory-practice link may be made.

Third and finally, this analysis of action sentences will need to be extended to include the study of moral-evaluative words. The working language of caseworkers and other helping professionals is replete with 'oughts' and 'shoulds'. A full treatment of the translation of theory into practice must sooner rather than later tackle the prescriptive side of professional helping.

Summary and Conclusions

Despite those who would urge us to 'de-professionalize' and to 'de-school', it looks like the professions--as a manifestation of credentialism and our reliance on expert knowledge--will be with us for the foreseeable future. As Anderson and Western (1976:54) rightly remind us, there are few laymen 'who could successfully build bridges, remove inflamed appendices, set compound fractures, remove impacted wisdom teeth, and keep operational the technological devices on which our developed society depends'. It is a sobering thought. The curious thing, however, is that there is now some firm evidence that many of the helping professions (particularly social work, clinical psychology, and psychiatry) have often yielded paltry results when dealing with the major human problems of our time--crime, mental illness, drug abuse, and poverty (see, for example, Schur, 1973; Mullen and Dumpson, 1976). Yet there is no sign of these occupations withering away.

In that case we need to know as much as possible about the helping professions. I have been concerned to tidy up one small but

nonetheless vital aspect, the question of whether and, if so, just how theory is translated into practice in everyday helping encounters. There is certainly no attempt here to 'reform' practice in the sense of legislating about how practitioners should do their job. But one interesting practical implication of the strategy advocated for reconstructing clinical activity is that it holds significant promise for the development of a conception of 'public knowledge' in the helping professions.

The claim that practice is informed by theory now appears capable of a more precise rendition. We now have at our disposal the tools for a closer analysis of what was done to help and why it was done. In that sense professional behavior seems to be more open to scrutiny than ever before. Through the study of accounts--and, in particular, the justification of conduct--the concept of 'professional accountability' may come to have some real force. This needs to be spelled out in a little detail.

First of all, scrutiny of the experts should begin with the fundamental question: what is the relationship between ideas and actions? Can a particular action by a practitioner be justified by some theory which they hold? If not, what if any justification may be offered--appeals to past success, previous 'experience', or what?

Second, we need to look closely at the theories which are produced to justify professional behavior. In particular we need to ask whether the focus is--both at the level of the imputation of causal efficacy and moral responsibility--primarily upon individuals or social structures. If the professional wishes to justify his behavior in terms of a theory which stresses individual frailty and personal responsibility, then this needs to be identified. Furthermore, the particular theory-choice may need to be defended against competing accounts of the problem. For instance, domain assumptions about individual pathology may need to be justified in terms of whether they provide both a better explanation of the problem and a more satisfying grounding for action than, say, an account which stresses structured social inequality. And vice versa.

Feyerabend (1975; 1980) says he wants to 'democratize' science by making expert judgment more open to criticism by lay people. My own opinion is that he is far too optimistic. Both the logical reconstruction adapted here from Habermas and the process of analysis of theory-choice which I have advocated seem to be the province of experts --albeit other than the helping professionals themselves. Certainly there seems to be little room for lay people in the fairly technical activities required to analyze effectively what the professional has done and why. Professional accountability, at least in the sense of

the post mortems on professional conduct described here, seems to be mainly an exercise for the experts. Indeed, Feyerabend (1975) himself has shown how experts in one domain (e.g., lawyers) may effectively scrutinize the activities of experts in another sphere (medicine).

No matter how strongly our own ideology requires lay control of the professions, this simply may not be feasible to any great extent. In that case the important thing is to recognize it, and to develop the more realistic controls--such as scrutiny by colleagues and the other professions--that we have at our disposal. One inescapable conclusion, however, is that if the process I have outlined is to become a reality, then the helping professions will need to develop in a more pluralistic fashion than they have done so far. To ensure a variety of critical standpoints on theory and practice, the personnel in these key occupations will need to be drawn from a greater range of social backgrounds (racial, class, sexual) than has been the case in these traditionally 'wasp' strongholds. Along with a broader perspective, the helping professions need to develop a strong commitment to the critical scrutiny of ideas and actions. This paper is intended as a small contribution to that direction.

NOTES

1 In saying that it is recognized that as well as theoretical justifications, professionals may also offer justifications for what they do in terms of past experience, previous success, prevailing 'local conditions', etc.

2 Lyman and Scott provide a useful discussion of accounts and the notion of justification of conduct (1970:3).

3 In this example and the ones which follow (Bloom and Sarbin, Taft, and Bailey), I have slightly modified the precise wording without seriously altering the main thrust of their analyses--the deductive nature of clinical reasoning based on a syllogistic process.

4 Of course what is more commonly encountered in practice is that there may be evidence that some old persons are harmed in some ways. But to use such evidence (based on 'some') as a major premise would lead to an invalid conclusion.

5 Perhaps the main difference between these scholars is that Bloom modifies his practical syllogism as follows: (a) a general statement with empirical support as averaged percentage of validated outcome (major premise); (b) individual

statement with preintervention measurement of problem events (minor premise); and (c) a plan of action with level of risk indicated (conclusion). The crucial point is the similarity between these approaches--both stress that clinical reasoning takes the form of a deductive, syllogistic process. I call this the Pre-Action Cognition Model and criticize it at some length in the text of the paper.

6 Although I have modified the precise wording the main thrust of their analysis is preserved. For reasons of limitations of space I shall not deal with Bloom's comments on inductive reasoning.

7 I deal with the Pre-Action Cognition Model at greater length in my paper 'Efficient Practice Precedes The Theory Of It' (Australian Social Work, 34(3), 1981, 21-26).

8 Indeed, as Aristotle reminds us, the very paradigm of choice between alternatives involves 'a voluntary act preceded by deliberation' (quoted in Connolly, 1974:158). The argument of this paper is that current thinking about professional practice has been strongly shaped by this powerful imagery about cognitive processes.

9 Habermas (1979:12-13) makes good use of Ryle's distinction between types of knowing in his recent analysis of communication in society.

10 Farrell's ideas have been developed in a paper 'The Logic of Existential Psychoanalysis' (1965:9-11) and his recent book (1981). Much of what follows is based on handwritten notes of a conversation with Farrell (3 February 1976) at the Department of Experimental Psychology, Oxford University. Farrell is not to be held responsible for any shortcomings in the analysis here because he was working with examples of actual social work diagnosis and treatment plans taken from my research on practitioners in England. See also the papers by Scriven, Suppes, and Pellegrino in Englehardt, Spicker, and Towers (1977).

11 Briefly, Farrell's reasoning goes like this: We can't derive q from p as implicated in or following from some theoretical position (e.g., crisis theory, grief theory) because most theories are too vague and the terms 'open-textured'. That is, we might hold any one of a number of theories and still want to assert our particular 'if p then q'. Or it might be that our theory leads us to p, then q does not

follow from the theory. Moreover, to deal with the second possibility, there is nothing about 'if p then q' that leads us to q as a logical consequence of holding that p, by itself. That is to say, it is not an analytic truth of the kind: 'every brother is a male sibling'.

12 One important question may be raised--to be dealt with separately, at length, in another paper--about the 'theoretical' status of the major premise used here. On a rather loose definition of theory the major premise probably would qualify as a theoretical statement. For the sake of a convenient example I have used it. However, following Lewis (1976:71-89), one is inclined to say that the major premise looks more like a 'rule of thumb' linking grief theory to practice rules than a theoretical statement itself. This point will be pursued at length in a subsequent paper exploring the relationship between broader, theoretical justifications for helping actions and immediate (e.g., agency-based) rationales.

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