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Recently a woman (I shall call her Kathy) to whom I had given some guidance called upon me with a problem of conscience emanating from her group sensitivity sessions, which are supervised by a psychiatrist. There were six or seven members in the group, almost equally divided between the sexes. In one of their discussions a single woman in her late forties told the members of the group her extreme trauma upon the breakup of an affair with a married man. Kathy responded to this revelation with the remark that the other woman should see her interior anguish as part of the punishment which God allows one to suffer for sin; and that this suffering could be salutary for the woman if she realized that such an affair could never bring real peace and happiness.

In the ensuing discussion the other members of the group took a very dim view of Kathy's observations. The woman protested that she felt she had done a great deal of good for the married man whose wife was an invalid. Another said that morality was not an issue in the woman's trauma and that at times psychological health was more important than moral considerations. The psychiatrist believed that the group should discuss only the psychological aspects of this woman's love affair. In short, Kathy was told and made to feel that she was lacking in compassion because of her stress upon the moral aspects of the affair. On other occasions, when members of the group discussed premarital or extramarital affairs, in which almost all the other members had been involved, Kathy felt like the proverbial sore thumb, because she introduced ethical points into the discussion. Her question to me was whether she should remain with the group.

Temporarily, I said that she should remain and continue to express her views as forthrightly as she had done in the past. She had benefited from being in the group, but was afraid that she would be either ostracized by the other members or she would succumb to their manner of ethical thinking. I replied that she should play this contingency by ear while seeking further moral guidance. This incident has prompted me to reflect anew upon the perennial problems of moral values in psychiatric practice.

Once it was said that the psychiatrist should not try in any way to influence the moral values which his patient possessed. The whole process of therapy was purely psychological, concerned with the healing and redirection of the instincts and emotions, but avoiding questions of moral good or moral evil. What was said of the psychiatrist was likewise affirmed about the counselor whose task must be to help the person to self-identity and understanding with no discussion of moral goals and means. While many psychiatrists and counselors knew this was practically impossible, it was a kind of heresy express dissent from the prevailing doctrine of neutrality in moral questions.

Gradually, with the emphasis on the importance of the relationship of the therapist and patient, it was admitted that the value-personality of the former influenced the latter in both perceptible and imperceptible ways. But this was not a didactic process. The psychiatrist did not intend to teach. Later, however, some psychiatrists who were well grounded in philosophy and religion discovered with educated patients that the whole process of self-discovery could be accelerated by several sessions in which both the doctor and the patient shared ideas about goals and purposes and principles. A Catholic psychiatrist, for example, who was treating numbers of Catholic priests, seminarians, brothers and nuns told me that by the educative process mentioned above he was able to save time and to help individuals focus on the source of their disorders. Since these same persons had good backgrounds in philosophy and theology, they found it easier to engage in the process of introspection and, with the doctor's guidance, to begin acquiring insight into the source of their problems.

Again, in more recent years, the influence of logotherapy, as exemplified in the writings of Viktor Frankl (Man's Search For Meaning, The Doctor and the Soul) has added another dimension to psychiatry in the sense that the patient is asked to examine his basic goals more carefully to determine whether the lack of a goal or a false
goal is a contributing factor to a neurosis. Still more recently, books like FUTURE SHOCK raise the question of the relationships between "future talk" and present mental health. In such preoccupations moral values are bound to play a part.

I do not believe that any sophisticated psychiatrist would hold that his relationship to his patient did not involve some discussion of moral values and some positions taken on matters of war, peace, violence, honesty, care for the aged and for children, and of course the marital relationship or the vocational commitment of the religious and clergy. Every free decision is a moral question, whether it is recognized as such or not; and other actions, which lack some degree of freedom and responsibility retain a moral dimension. This is so obvious as to make one wonder why I treat the subject.

I raise the question because I believe that we have categorized the work of the psychiatrist and the work of the moralist in neat compartments, as if they could be separated, when in truth they cannot. Their competencies are distinct but not separable, because both the therapist and the moralist are concerned with the same human actions of the one person. It is true that a psychiatrist, as a psychiatrist, does not hear the patient's confession of sins; that the moralist or priest, as such, does not attempt to diagnose the psychological sources of the person's mental state; but each must know something about the other's area of competence if they are going to help the patient. A moralist who ignores the psychological background of the person will not understand or be able to help him any more than a psychiatrist who prefers to ignore the moral issues troubling his patient. In this respect many psychiatrists show real sensitivity, hesitating to give advice which the patient in conscience cannot accept, although the psychiatrist may differ strongly from the position of the Church on the question. Many psychiatrists do point out that the patient has a moral problem for which he should seek counsel from a competent person.

Here there are two familiar abuses: the moralist who becomes an amateur psychiatrist; and the psychiatrist who assumes the role of father confessor in helping the patient solve a moral dilemma. It must be admitted that the temptation to cross over into another discipline is great. In superficial matters a certain amount of this double role playing goes on—with no substantially grave effects, in the absence of either the therapist or the moralist-priest. But serious disorders can flow from this practice, as witness a young woman of twenty-three who was told that her sexual inhibitions with her husband might be overcome by having an affair with another man; or a young nun with serious emotional difficulties on the eve of perpetual profession who was encouraged by a priest to take her vows, while "leaving everything in God's hands."

These abuses are avoided by adequate communication between priest and psychiatrist both helping the same individual. Even in the attempt at communication, however, misunderstandings between two professional people may arise if they do not check with one another concerning comments carried back and forth by the patient or counselor. It is a safe presumption that a person who is emotionally upset is not always an objective communicator of either the doctor or the priest. The person who tells the priest that the psychiatrist advised her to have an affair may have distorted the psychiatrist's reflections in which he had informed the patient that she already had this desire latent in her behavior. The only way the priest can know what the psychiatrist did say is to communicate with him. And vice versa. If communication is not possible immediately, then suspension of judgment and a presumption that the other professional person knows what he is doing is the just solution. In this way needless mistrust which always hurts the patient can be avoided. But there is a positive area in the relationship between doctor and priest which is seldom considered, namely, the development by the patient of truly human values and goals.

Perhaps more than any other contemporary psychiatrist, Viktor Frankl has underlined the need for personal goals as necessary for psychological balance and spiritual harmony. In lecturing he has said repeatedly that the paperback copy of his book, Man's Search For Meaning, has sold so well in America because many have discerned a spiritual vacuum in their lives and are seeking goals which will give meaning to their life in the future. It is man's reaching out for a transcendent that makes him to be bored, rowdy, belligerent, with philosophies and psychologies which never go beyond the proposition that man's mental peace in adjusting himself to his environment in such a way that he derives maximum self-satisfaction. Frankl sees the ministers of Western religion as far too timid in asserting the transcendence of moral values in the humanization of man. For this reason, he claims, psychiatrists, psychologists, and various other counselors often assume the role of the spiritual counselor. The situation will be improved if clergymen realize their potential in helping the neurotic person to discover spiritual values and goals. In a sense, clergymen can complete the work of therapists in presenting a plan of life to the patient or counselor. Nor must they wait until a person ceases psychiatric or psychological counseling before attempting to widen his spiritual horizons.

The difficulty today is not that either clergymen or psychiatrists are imposing their system of values on the patient, but that too little is said to him about the necessity of consciously developing a system of values and goals. Millions of Americans, for example, have adopted from their materialistically oriented environment a philosophy of hedonism which allows them to approve of licentious use of sexuality and to condone abortion on demand, and other denigrations of the value of life itself. These attitudes, per se, are not the objects of psychiatric treatment, as they most certainly are.
ing in therapy the doctor will concern with the happiness and moral aspects of their work. The actually, truth imposes itself and needs no intervention. (1)

In the empathetic relationship set up in therapy the doctor will very probably influence the patient in the choice of moral values. The question is the avoidance of undue influence by one who cannot really be morally neutral. It seems that he must promote at least the basic premise of morality, namely, to seek to do good and to avoid evil. Patient and doctor may differ concerning what is good and what evil, but both have the responsibility to seek good and to avoid evil.

Both the priest and the psychiatrist must be aware of the interdisciplinary aspects of their work. The science of moral theology and the practical art of therapy are both concerned with the happiness and mental health of the person. While the psychiatrist may study the personal past of the individual, his contemporaneous significant relationships, and his attitude toward the future, he knows that moral goals in the individual influence psychological health; on the other hand, the priest-moralist is aware that many human problems involve both sin and neurosis, and that he ought to know the sources of common neuroses as well as new thinking about the nature of sin.

It is interesting to note, for example, the way in which currents of thought about the human person, developed in different disciplines, are concerned with the same values. Over twenty years ago, when Karl Rogers' Client-centered Therapy first became known, it was feared that its practice would lead to unduly permissive counselors, who, by their silence, would condone immoral practices among the clients. Then came the movement of personalism in philosophy with its stress on the dignity, mystery, freedom and responsibility of the person, as developed in The Church in the Modern World and in the Decree on Religious Freedom. (See Walter Abbott, S.J., The Documents of Vatican II, Angelus Press, 1966.) Gradually there emerged a new view of Rogers.

As the Rogerian concept of empathy becomes properly understood, it is clear that it is based on a profound respect by the counselor for his client. Empathy is now seen as a process by which the counselor helps the counselee to see himself more truly and to be willing to accept himself. In other words, empathy has high regard for the uniqueness and freedom of the person. It recognizes that man must change himself from within. It is now clear that traditional forms of directive counseling, as used by some counselors, tended to infringe upon the freedom of choice of the counselee. Thus, approaches which on the surface seemed to be too permissive some years ago, are now regarded as more in consonance with our contemporary moral theological view of man.

Client-centered therapy implies that everyone must suffer in the process of solving his own problems; and that growth accompanies the pain of making decisions and accepting their consequences. The emphasis is where it ought to be, on the individual, whereas in some applications of directive therapy there was not as much growth because decisions were initiated by counselors, and not by the person himself. There was always the danger that the personal bias of the counselor unduly influenced the decision finally accepted by the counselee.

What is badly needed to facilitate the integration of moral and psychological values in the person of the client is better communication between the therapists and the clergy. With all good intentions—time is a real obstacle. Both the psychiatrist and the clergyman are so busy that they do not get together to compare notes on the individuals they both know and see. Seldom is there difficulty in getting the person's consent to communicate with the psychiatrist or with the clergyman, because the patient is usually pleased to be getting so much attention. I believe, however, that his failure to communicate with the other concerned professional person is not merely due to lack of time. I think it is more a question of both professional men remaining unconvinced of the practical importance of collaboration. Those of us who have served on a Child Care Team appreciate the importance of the regular staff meetings involving psychiatrists, psychologists, social case workers and the like to discuss the children so as to help them. Could not similar arrangements be made between the clergyman and the psychiatrist in those instances where the person desires it? Actually, where such collaboration exists, the patient benefits.

Aptly, Howard W. Clinebell, Jr., writes: "Candor requires one to recognize that our record of interprofessional relations in the past has been nothing to shout about, except perhaps in protest. With some notable exceptions, distance between clergy in and physicians has been painfully prevalent. The territorialism, mutual ignoring, stereotyping, and one-upmanship which have occurred among all the "helping" professions have recently vitiated fully effective helping of the burdened, troubled, or sick person. We've talked a lot about team work, but actually practiced it much too infrequently.... The need, opportunity, and resources for clergy-doctor collaboration are greater today than at any previous period of history. In a society that fragments persons..."
and relationships, it is imperative
that the healers get together." (2)

Hardly has it to be said that an
effort at communication between
the clergyman and the psychiatrist
will involve many difficulties. "The
two different perspectives involve
different language games, imply
different meanings in common
words, and value the various aspects
of communication differently. Risk-
ing overstatement, I am tempted to
say that, a psychiatry expertise in
listening is more highly prized than
skill in speaking; in theological
circles the opposite values prevail." (3)

Communication can take place on
many different levels, from the
highly theoretical to the clinically
practical. It demands that those
involved are able to speak one an-
other's language with reference to
a specified problem, preferably in
their mutual effort to help the same
person or group of persons.

But there is an area of theology
which the psychiatrist would desire
to know more about if the clergy-
man were willing to teach it to his
patients. I refer to the principles
of ascetical and mystical theology
found in the writings of St. Teresa
of Avila, St. Francis de Sales, and
many others. All these writings
Teach that man can transcend him-
self by the power of divine grace,
and that man is drawn to do so, as
Pius XII also affirmed.

"Scientific research is drawing
attention to a dynamism which,
rooted in the depths of the psychic
being, would push man toward the
infinite, which is beyond him, not
by making him know it, but through
an ascending gravitation issuing di-
rectly from the ontological substrat-
um. This dynamism is regarded as
an independent force, the most
fundamental and the most elemen-
tary of the soul, an affective
impulse carrying man immediately to
the Divine, just as a flower opens
up to light and sunshine without
knowing it, or as a child breathes
unconsciously as soon as it is born...
It pertains to the technique of
your science (psychiatry) to clarify
the questions of the existence, the
structure, and the mode of action of
this dynamism... To the
transcendental relations of the psy-
chic being there belongs also the
sense of guilt, the consciousness of
having violated a higher law, by
which nevertheless one recognizes
himself as being bound, a conscious-
ness which can find expression in
suffering and in psychic disorder.
Psychotherapy here approaches
a phenomenon which is not within
its own exclusive field of com-
potence, for this phenomenon is
also, if not principally, of a reli-
gious nature." (4)

I have quoted this statement to
illustrate several points: Man may
be a naked ape, a sexual being, a
social being, a political animal, but
he is also a little less than the an-
gels in his powers of transcendence.
This tendency is basically non-in-
tellectual, open to study by both
the theologian and the psychologist
or psychiatrist. Guilt is primarily
a religious question, but also a
problem involving both the clergy-
man and the doctor. Both false and
true guilt can lead to psychic dis-
orders.

Considering the trend in moral
theology today, however, to regard
the complete satisfaction of the sex-
ual instinct as close to an absolute,
as almost necessary for mental
health, it is necessary to underscore
man's ability to transcend himself
by the process of conscious motiva-
tion known as the ascetical life. It
does not matter whether you call
this sublimation or not, provided
you admit that it is free and grace
inspired, and practiced by many
Christians and also by non-Christi-
ans like Mahatma Gandhi. Where
there is a lack of motivation and
an absence of virtue in the life of
a patient, it is not likely that
engagement in the strictly thera-
peutic process is going to produce
a thoroughly free human being.
Something else is necessary to re-
store this man to his full humanity,
and that has to be the practice of
virtue. But he shall never know this
unless someone teaches him. It is
my opinion that many people who
have received expert care from psy-
chiatrists for years continue to
flounder until they also find some
understanding and guidance concern-
ing the higher dimensions of their
humanity. Actually, in his heavily
goal-orientated psychiatry Viktor
Frankl moves in this direction. (5)

The experience of Alcoholics
Anonymous, moreover, has some-
thing to say to both the clergyman
and the psychiatrist. While the
causes of alcoholism are multiple,
ranging from the organic through
the psychological to the moral
and spiritual, the mastery of the
compulsion is fundamentally an
ascetical process, in which the
Exercises of St. Ignatius of Loyola
and the practices recommended by
St. Francis de Sales in his Devout
Life find contemporary application.
Alcoholism is mentioned only
once in the twelve steps, and that is
in the context of honesty: the
admission that one was alcoholic
and that he was powerless concern-
ing it and had to rely on a power
greater than himself.

For years I have told students
in pastoral theology to A.A. me-
nings, and we come away with the
feeling that these men and women
have grasped the importance of
virtue and their need for mutual
support in practicing such. It would
take another article to analyze the
social dimensions of A.A. Suffice
it to say at this point that living an
ascetical life (the practice of the
Twelve Steps) has helped thousands
to lead a meaningful life in place
of their previous compulsive
drinking. Noteworthy also is the
fact that this ascetical way of liv-
ing does not mean that the person
rids himself of his neurosis con-
cerning drinking, or any other
neurosis he may suffer from, but
only that he can move more freely
toward human goals.

Opening up the possibilities of
an ascetical way of life for the alco-
holic does not rid him of the neu-orisis of alcoholism, but it does en-
able him to transcend it. Why not
apply the same kind of thinking
to certain forms of sexual disorders,
like homosexual practices? Could
not the practice of an ascetical life
enable the formerly overt homo-
sexual to lead a more free and
human life? Where is the greater
... Prayer is called mystical because it is laden with such terms as 'intimate,' 'inner,' 'sacred,' and 'secret.' In it, one is united with the soul of another person, with the soul of the entire universe, and with the soul of God. It is a time when one is brought into a face-to-face relationship with God, when the soul is brought into a face-to-face relationship with the soul of another person, and when the soul is brought into a face-to-face relationship with the soul of the universe. It is a time when one is brought into a face-to-face relationship with God, when the soul is brought into a face-to-face relationship with the soul of another person, and when the soul is brought into a face-to-face relationship with the soul of the universe. It is a time when one is brought into a face-to-face relationship with God, when the soul is brought into a face-to-face relationship with the soul of another person, and when the soul is brought into a face-to-face relationship with the soul of the universe. It is a time when one is brought into a face-to-face relationship with God, when the soul is brought into a face-to-face relationship with the soul of another person, and when the soul is brought into a face-to-face relationship with the soul of the universe.

SELECTED READINGS


ROGERS, Carl — On Becoming a Person, Boston, Houghton Mifflin, 1951.


ST. TERESA OF AVILA — Autobiography, (Allison Peers Translation)
