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John F. Harvey

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Integration of Spiritual and Psychological Values in Therapy

John F. Harvey, O.S.F.S.

Father Harvey is president of De Sales Hall School of Theology, Hyattsville, Maryland. He has published many articles in theological journals as well as having his work appear in The Bulletin of the National Guild of Catholic Psychiatrists and Linacre Quarterly. He is a member of the Catholic Theological Society of America and American Society of Christian Ethics.

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 to 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 values and 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 [illegible] 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 person 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 counselee. 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 lives in the future. It is man's reaching out for a transcendent that causes him to be bored, downright bored, with philosophies and psychologies which never go beyond the proposition that man find mental peace in adjusting himself to his environment in such a way that he derives maximum self-fulfillment. 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 counselee. 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

of spiritual guidance.

But somewhere in the process of treatment value questions will come up for discussion, and the therapist will respond to them, either verbally or nonverbally. He will help the patient if he makes it clear to him that such matters are the patient's responsibility. Whether one chooses to be responsible to society, to one's own conscience, or to God, is up to the patient, but establishing the goal for which one is to be responsible is crucial. As Viktor Frankl says:

The logotherapist's role consists in widening and broadening the visual field of the patient so that the whole spectrum of meaning and values becomes conscious and visible to him. Logotherapy does not need to impose any judgments on the patient, for, 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 contemporary 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 clergymen 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 who have served on a Child Clinic 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, distancing between clergymen and physicians has been painfully prevalent. The territorialism, mutual ignoring, stereotyping, and one-upmanship which have occurred among all the "helping" professions have frequently 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 two different language games, imply different meanings in common words, value the various aspects of communication differently. Risking overstatement, I am tempted to say that, in 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 another'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 clergyman 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 himself* 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 directly from the ontological substratum. This dynamism is regarded as an independent force, the most fundamental and the most elementary 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 transcendent relations of the psychic 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 consciousness which can find expression in suffering and in psychic disorder. Psychotherapy here approaches a phenomenon which is not within its own exclusive field of competence, for this phenomenon is also, if not principally, of a religious 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 angels in his powers of transcendence. This tendency is basically non-intellectual, 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 clergyman and the doctor. Both false and true guilt can lead to psychic disorders.

Considering the trend in moral theology today, however, to regard the complete satisfaction of the sexual 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 motivation* 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-Christians 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 therapeutic process is going to produce a thoroughly free human being. Something else is necessary to restore 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 psychiatrists for years continue to flounder until they *also* find some understanding and guidance concerning 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 something 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 *Introduction to the Devout Life* find contemporary application. Alcoholism is mentioned only once in the twelve steps and that is in the context of humility: the admission that one was alcoholic and that he was powerless concerning it and had to rely on a power greater than himself.

For years I have taken students in pastoral theology to A.A. meetings, 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 previously compulsive drinking. Noteworthy also is the fact that this ascetical way of living does not mean that the person rids himself of his neurosis concerning 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 alcoholic does not rid him of the neurosis of alcoholism, but it does enable 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 homosexual to lead a more free and human life? Where is the greater

freedom? In acting out? In cho ing one partner only, in what s badly na ed a "marriage"? O n a life o nterior chastity and x-terior c ty? Could he lead the latter ki of life if he were prop-erly m ated by a clergyman working vith the psychiatrist? basicall community support moveme could not homosexuals who bel that any passionate ex-pression their tendency is both immoral a stunting of true hu-man growth, band together for mutual support in the practice of virtue? Is Homosexuals Anony-mous possible?

I believe that it is questions like these which should be discussed everywhere by clergymen and thera-pists. Space does not allow devel-opment of the mystical dimensions of man, but they are not to be written off as impractical. The more the healers of the *psyche* know about the mystery of divine love at work in the human heart, (and that is mystical theology), the better they will understand the pos-sibilities for healing the whole man. The search for mystical experiences by so many is only one indication that contemporary man is reaching out toward the transcendent, and not merely running away from the harsh world via the drug route. The renewed interest in religions of the East and the Pentecostal Movement among Christians are other indica-tions that contemporary man will not be satisfied with a bare moral-ism; he wants to fill a void within himself with the bread of trans-cendent truth and love which he is not getting in traditional church attendance. In any program of co-operation between clergyman and psychiatrist these dimensions of man must be recognized and de-veloped. (6)

Although the ascetical and mys-tical dimensions of man are just as real as the instinctual, intellec-tual, and emotional, insufficient is said about them in the literature dealing with religion-psychiatry re-lationships. I do not fault the psy-chiatrists for this, but the clergy-men. It is time that we helped those sent to us by psychiatrists by revealing another dimension of man. We could recommend to these people (and to therapists as well) the following passage which shows what mystical prayer is all about and how it is related to our natural powers:

"God alone by his infinite knowledge sees, searches and penetrates all the twists and turns of our minds. He understands our 'thoughts from afar.' He discovers our paths, doubling back, and evasive turns. . . . Indeed, if our minds wish to turn back on themselves by reflecting on their own acts and reconsidering them they will enter into labyrinths from which they in-evitably lose the outlet. It requires impos-sible powers of attention to think what our thoughts are, to consider our consid-erations, to view all our spiritual views, to discern what we discern, and to re-member what we remember. Such acts would be mazes from which we could never free ourselves. . . . (This is not prayer.)

"If prayer is a colloquy, a discussion, or a conversation of the soul with God, then by prayer we speak to God and God in turn speaks to us. We aspire to Him and breathe in Him: He reciprocally inspires us and breathes upon us. . . . Prayer and mystical theology are the same thing. . . . Prayer is called mystical because its conversation is altogether secret. In it nothing is spoken between God and the soul except from heart to heart by a com-munication incommunicable to any others but those who make it. The language of lovers is so special in character that no one understands it but themselves."

". . . Prayer and mystical theology are simply a conversation in which the soul lovingly speaks with God. . . ." (7)

To sum up my argument: Both the clergyman and the psychiatrist (or psychologist or counselor) should make their common client aware of *all* his human dimensions and potentialities as he seeks to be a whole man. The contribution of each professional is important to the patient's self understanding. Despite the difficulties of com-munication between the professions, persistent cooperative efforts should continue for the sake of the patient.

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