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Religion and Psychiatry

Catholic Physicians' Guilds

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[Editor's note: We present companion articles entitled "Religion and Psychiatry" one of which is in the nature of a dialogue between the editor of *The Marquette University Magazine*, T. E. Blackburn, published in the Fall, 1964 issue, Vol. 6, No. 1, and Reverend R. G. Gassert, S.J., dean of the Marquette University College of Liberal Arts, and the other by Paul Lawler, M.D. of the Psychiatric Department of Marquette. The latter material covers the major portion of a lecture presented in October 1965 to all the Sisters stationed in the Milwaukee Archdiocese in conjunction with a series of psychiatric and psychological discussions.]

A Talk With
Fr. R. G. Gassert, S.J.

(At one time, it seemed that religion and psychiatry would never be able to come together. Practitioners in each field regarded the other field with suspicion, some psychiatrists suspecting religion of being mere superstition, and some religious suspecting psychiatry of being based on atheistic premises. In recent years, though, dialogue between religious and psychiatrists has opened a number of areas of common interest.

(Such dialogue has been fostered by the Menninger Foundation of Topeka, Kansas, which annually awards fellowships for priests and ministers to observe psychiatric treatment and exchange views with psychiatrists. The Rev. Robert G. Gassert, S.J., dean of the Marquette University College of Liberal Arts, spent the 1962-63 academic year at the Menninger Foundation. One result of the year was the book, Psychiatry and Religious Faith, *by Fr. Gassert and Dr. Bernard H. Hall, M.D., director of Adult Outpatient Services at the Foundation. In the following interview, Fr. Gassert discusses some of the points at which psychiatry and religion meet.)*

T.E.B./ To start, could you describe the ideal relationship between the priest and the psychiatrist? Under ideal circumstances, would there be a priest assigned to every psychiatric hospital — or isn't this necessary?

R.G.G./ I don't really know what the ideal would be in that regard. What we were trying to point out in our book is that there are many problems that a priest might run into in his pastoral work that need or might need psychiatric help. This doesn't mean that every time he comes across a problem he can't solve himself the priest should refer the person to a psychiatrist. I think it does mean that the priest can gain insights from psychiatry that may help him in his own pastoral work, and he may, through personal acquaintance with psychiatrists, be able to discuss a given problem and thereby help himself and the person he is counseling.

But it is a two-way street. The psychiatrist might very well come across a patient who has a definite psychiatric illness, but, tied in with it, there may be some religious problems which the psychiatrist is not able to handle by himself. Maybe, by his talking to a priest, the psychiatrist would be able to broaden his understanding of the religious dimension of the problem. So I think it's a question not of turning priests

into amateur psychiatrists or of turning psychiatrists into substitute ministers of religion, but rather of getting them to work together somewhat as a team. Not that they keep referring people back and forth, but, by discussion of problems with one another, they can increase the effectiveness of their own work in their own areas. That is what we were trying to get at.

T.E.B./ Why did you and Dr. Hall write the book?

R.G.G./ I suppose the "why," in a sense, was an accident. When I went to the Menninger Foundation for the year of postdoctoral study, I had no particular plan to write the book. The program was set up for people with their doctorates in theology to spend a year at the Foundation taking courses with the other professional students there and to try to familiarize them with psychiatric theory.

Shortly after I got there, I became acquainted with Dr. Bernard Hall, who is director of the Adult Outpatient Services. Now, Dr. Hall has spent quite a lot of time in the past ten years working with groups of priests, nuns, seminarians and the like, and he mentioned very casually one day that he would like to do some writing in the field. Probably we weren't too serious, at first, about actually doing a book, but as we spent more time together on weekends and evenings and talked over problems — both from the psychiatric aspect and from the religious aspect — we got the idea that there may be a real value in trying to write a simple introduction to the field, covering the nature of psychiatry and of psychiatric treatment and taking a few specific problems that, say, religious superiors, masters of novices or priests might be confronted with.

With that in mind, we outlined the topics that should go into such a book. This would not be a textbook. It would be something in plain, ordinary English that would be aimed at giving people the right attitudes toward the problems of mental illness and psychiatry.

T.E.B./ That program under which you studied has been going on for a number of years now, isn't that right?

R.G.G./ Yes, it has. It started out five years ago with support from the Danforth Foundation. Prior to that, the Menninger Foundation had another program which was not so much directed toward theoretical study, but was more practical in its orientation. It was a program in pastoral counseling. Clergymen working in parishes or in hospitals would do religious pastoral counseling under the supervision of the Foundation's staff who had been trained in this area. That program has been going on longer and still runs parallel with the more theoretically orientated program I was in.

The group I was with included three Protestant ministers and myself, each studying the aspects of psychiatry that interested him.

T.E.B./ Did you take part in any of the cases at the Foundation?

R.G.G./ We did not participate in the cases to the extent of working with patients. We did sit in as spectators, or listeners, in a number of case conferences in which the psychiatric professional staff would meet to discuss, say, a diagnostic evaluation of a new patient or the progress being made in a case after a period of several months.

But we were there pretty much just to listen and see what approaches the various members of the psychiatric team — the psychiatrist, the neurologist, the psychiatric nurse, social worker — would take. They meet periodically to pool their information.

T.E.B./ From the history of those two programs, is there any evidence that religious superiors and religious counselors understand psychiatry better now? How would you say the climate between psychiatry and religion is today?

R.G.G./ I think the climate has changed tremendously over the last ten or 15 years. When I did my theological studies at St. Mary's College in St. Mary's, Kansas, from 1951 to 1955, we knew that the Menninger Foundation was in Topeka. We knew that a few of the professors would occasionally go in for lectures, conferences and so on. But we ourselves had no contact with the place, and yet we were only 25 miles away from it. The last five or six years, the seminarians, in their last year of training at St. Mary's, spend a week each fall in a rather concentrated session of talks, discussions and seminars where they are given a sort of bird's-eye view of psychiatry. Now that, in itself, represents a tremendous change, so that the people coming out of their studies now have an introductory notion that we didn't get ten or twelve years ago.

And I think it is changing all over the country. There are many places that have summer institutes in psychiatry or pastoral counseling for priests. For example, in Collegeville, Minn., at St. John's College, they have been running seminars each summer in pastoral psychiatry. Loyola of Chicago has a program, and Fordham University has institutes in which they bring clergy from the area together to discuss psychiatric problems.

So the whole climate has changed quite a bit. It is certainly different from the days when Bishop Sheen was denouncing psychiatry and Freud and anything that smacked of the whole Freudian influence in the field. Today, that is looked upon pretty much as a thing of the past. It's not that important anymore.

T.E.B./ You made a point in the book about an "attitude of non-judgmental concern for human suffering," which psychiatrists must develop in order to work with patients. What does that mean?

R.G.G./ Well, I don't know if I can put it in a brief way. I think that it does not pose a problem for the psychiatrist as such, but it may pose a problem for a priest or one who is interested in the moral formation or moral training of an individual.

It has to be looked at from two different points of view. When a psychiatrist takes a non-judgmental attitude toward a given action of a patient, it does not mean that he is

trying to condone what the patient is doing. As we say in the book, the fact that a psychiatrist listens to a prostitute and doesn't "lecture" her does not mean that he condones prostitution. He feels, rather, that the patient herself knows whether something is right or wrong.

If he is going to work closely with a patient, it is not going to help the psychiatrist, from the standpoint of the treatment, if he tries to stand in judgment of the patient.

However, a different problem arises when, for example, I, as a priest, would confront the same person in a confessional setting. If a penitent says, "I have done such and such," I, as a priest, must, in a certain sense, make a judgment about the person's guilt. Otherwise, I cannot give sacramental absolution. If I think a penitent has really done nothing and is just subject to delusions or halluciations, I would have to conclude that there is no real matter for confessional absolution here. But in a counseling situation I could also take a non-judgmental attitude in my efforts to help the person. In one case I must, in a certain sense, make a judgment, but in the other case I can be more helpful by not assuming a stance in which I appear to be acting as a judge.

This may not be too clear. Did you have a specific problem in mind?

T.E.B./ Well, my next question was going to be whether you think the fact that the psychiatrist does not denounce sin when he runs across it in a clinical setting may be the key to the hostility, or gulf, that existed in the past between religion and psychiatry.

R.G.G./ No, I don't think that was the central issue. I think the original hostility sprang more from the philosophical climate in which psychiatry began. Freud himself was against formal religion. For example, he tried to explain the origins of the Judaeo-Christian religion in terms of some kind of primitive father-complex 'way back in pre-historic times. When he wrote his book on *The Future of an Illusion*, he looked upon religion as a more or less neurotic manifestation of man.

Now, we have to separate Freud's religious thinking from the real contributions he made to the understanding of mental illness. Because of Freud's attitudes toward religion, many people got the idea that he was trying to do away with the fact of human freedom. He was trying to explain sin simply as a manifestation of mental illness. They thought he was attacking the whole notion of personal responsibility and hence undercutting the Christian view of man. Now, in this case you have to make the distinction between Freud's scientific contributions and his own philosophical view of man, or his theological views.

T.E.B./ You say in the book that sin and sickness are connected, but not an equation. They aren't the same thing, but what do you mean by "connection"?

R.G.G./ There, I am speaking as a theologian. The root of evil, both physical and moral evil, is intelligible in terms of the fall of man, the fall of the human race in Adam. And sin and death in New Testament theology are rooted in man's fall. Now, it is in this wide sense that there is a connection between sin and sickness.

It does *not* mean, though, that a person who is mentally ill is *ipso facto* morally culpable for the illness. It is not an individual thing here. It is simply the human condition of man as fallen and in need of God's grace for salvation and redemption.

So, what we were trying to say in that particular part of the book was this: That most people, I think, still make some kind of a moral judgment about a person who has a "nervous breakdown" or is committed to a psychiatric hospital. They make a judgment that this person has brought that on himself by moral negligence or sin. It is the validity of this judgment that we decry.

We are in no position to judge that kind of equation between sin and sickness. And, strangely enough, we do not do that in regard to physical illness, even though there may be cases where physical illness can be brought about by an individual's sinful deeds. If a person neglects his health, drinks too much, and brings on a physical disease, we can see some kind of connection. But in the case of mental illness, it is not that type of simplistic equation. I think that this is the attitude we were trying to correct, the prejudgment we were trying to get rid of.

T.E.B./ Does religious belief ever enter into mental illness as a cause?

R.G.G./ It depends on how you define religious belief . . .

T.E.B./ I'm thinking particularly of scruples.

R.G.G./ I think that, in some people, the way they practice their religion is a bit neurotic. Some people have superstitious ideas of religion. Some develop almost an obsession where they have to do certain religious rituals every day, rituals that are pretty much foreign to the rest of their lives. It is not a question, for them, of using these rituals to influence their lives or form their religious thinking or their conscience. It is just, well, a type of obsession. I think in many cases scruples are a neurotic manifestation, an anxiety and a fear that are built up but are not related to reality.

T.E.B./ So that religion can be a sort of a crutch for mental illness — or at least the semblance of religion can be?

R.G.G./ I think that can happen. I think also — and this is just a guess — that perhaps one of the reasons for Freud's view of religion as a type of neurosis was the fact that many of the patients he dealt with manifested this type of religion. That is the type of religion he experienced in his patients, and from that he made the mistake of generalizing about all religion being a form of neurosis.

But I don't think, on the other hand, that you can say that because a person is deeply religious and has a well-grounded and integrated faith, he is immune to mental ill-

ness, any more than he is immune to a heart attack or cancer or anything else.

This comes back to the sin-sickness relationship. You can't make a simple equation here.

T.E.B./ Then a truly holy person could have a mental illness.

R.G.G./ Just because a person is holy doesn't mean that he is going to be immune from emotional conflicts and the possibility of mental illness, even severe mental illness. There is an example in the early life of St. Ignatius, shortly after his conversion, when he was spending a year or so at Manresa, living pretty much as a hermit. In his diary, he describes how he was so depressed by scruples that he felt like throwing himself out the window. Well, I think that any psychiatrist would say that that was not a healthy manifestation. Again, that is something St. Ignatius overcame, but he mentions it as a really severe temptation to commit suicide, and I think any kind of self-destructive tendency is a manifestation of illness.

T.E.B./ People like saints — and I'm thinking, too, of some artists — set themselves goals that are different from those of "normal" or more worldly people. Take St. John the Baptist, out there in the desert preaching when he could have enjoyed the comparative comfort of town. If he were living today, wouldn't a psychiatrist be inclined to think there was something wrong with him? I mean, doesn't just being a saint involve deviating from the norm, from normal behavior?

R.G.G./ What do you mean by "norm" there? If you take the norm as a statistical average, then surely the saints are different. But they are not doing something that is inhuman. They may be doing something that transcends the human.

The use of the word "normal" is the thing that throws people, I think. What is the norm of Christian conduct? Well, we're not going to find that by counting heads and saying that just because 55 per cent of a given population does not go to Mass on Sunday that is normal for a Catholic not to go to Mass. No, the observance of Sunday is the norm, even if only ten per cent of a given group attends. So, if you speak of a saint "deviating from the normal," I think that simply means that he is differently trying to live his religious vocation the fullest.

T.E.B./ Well, he was trying to hurt himself and his actions are consistent with what he was trying to do, but how would a psychiatrist who himself had no religious faith cope with him? Would the psychiatrist say the saint had a compulsive delusion about God that was disordering his life?

R.G.G./ Well, he might. But I think even if a given psychiatrist had no religious values himself, if he were a competent psychiatrist he could attempt to respect the values of another. If he saw that this given person — the saint — were integrating his life around central values, he would have to respect the type of life-direction this person had taken.

If the psychiatrist went out of his field and judged that this person

was basing his life on something the psychiatrist considered unreal, well, he would simply be wrong. He would be making a wrong judgment.

There are some really knotty difficulties there. One of the things a psychiatrist speaks about is the "reality principle." How does this person judge reality? What is his view of reality? Now, hidden in that principle is a philosophical and a theological view. If a given psychiatrist equates reality with what you can see, touch and feel, and then proceeds to say that because a person is God-directed or is orientating his life toward a supernatural goal — if he goes on from there to say that a person is out of touch with reality, then he is imposing his own philosophy or letting his own philosophy interfere with his judgment of the person. I think there is a real difficulty here.

T.E.B./ In the book, you mention that psychiatrists regard murderers, robbers, rapists and the like as mentally ill. What does this mean in regard to guilt as far as the priest hearing Confession is concerned?

R.G.G./ I don't think it destroys the problem of guilt. A person can be mentally ill and also guilty. It may mean that, in some cases, besides the individual's need for repentance and forgiveness he needs psychiatric help.

Psychiatrists aren't in favor of turning prisons into mental hospitals. (I shouldn't speak for all psychiatrists, but at least the ones I have talked with are not in favor of that.) But, at the same time, what they want to have recognized is the fact that in many criminal cases there may be a dimension of illness. As a result, a murderer is not going to be helped simply by being incarcerated for 20 or 30 years. That isn't going to do the job of rehabilitating him.

Along that line, I might mention that — I think due to the influence of the Menninger Foundation — in Kansas they have just, in the last two years, instituted what they call a diagnositic and reception center for prisoners. In the state of Kansas, when a person is convicted of a felony, prior to sentencing by the court, he is sent to this center. On the basis of recommendations by a team of doctors, psychiatrists and social workers, the judge then tries to tailor the sentence of the prisoner to the findings of the team of specialists.

I don't know if Kansas is the only state that has that set-up, but I think it is a step in the right direction.

It is not a question of finding the prisoner not guilty; the prisoner is convicted of a felony. But rather than giving him a simple prison sentence, the judge attempts to get the person the kind of help he needs within the confines of a prison.

One of the difficulties, of course, is the fact that most prisons do not at present have the kind of staff or facilities to give the treatment that is recommended by the medical people.

T.E.B./ There is a shortage of psychiatrists and facilities anyway . . .

R.G.G./ That is one of the big difficulties.

The better psychiatric hospitals are usually the private hospitals and those are mighty expensive. The cost of treatment is prohibitive for most people.

Again, there is an interesting aspect of the philosophy of the Menninger Foundation, at least in the training they give doctors in residency there. They try to point them toward working in public institutions — to try to upgrade the staffing and the kind of treatment given in state and local hospitals and clinics. Of the 35 or so doctors who finished their residency the year I was there, only one was going into private practice. The others were going into some kind of clinical team practice, some perhaps in private hospitals, but many in state systems or veterans' hospitals.

T.E.B./ You make a wonderful statement — or really two related points — early in the book, which I would like to touch on before we finish. You say, first, that there is too much concern about people losing their faith and not enough about people finding faith. And, a little later, you talk about psychiatry as a way of releasing a person to live faith to the fullest.

R.G.G./ Again, I think what the psychiatrist is trying to do in treating a person is to enable him to make his own choices from motives that come from within and not be pushed and shoved by blind drives and external circumstances of life. And I think that insofar as they are trying to bring a perso to assume a greater responsibility or his own life, in that sense the are trying to help a person regai his mental health so that he will in a better position to meet his eligious responsibilities and to e his life a deeper religious dim ion. That's what we had in mind

The Lecture of Dr yler

Our current scie approach to mental disorder at the great majority of ment nesses represent general diffic in adaptation and adjustment t This is also explained in wha believe is the best definition chiatry, i.e.; psychiatry is tha nch of medicine which deal h the origin, manifestation an tment of any disordered or un able personality functioning w interferes with the subjective li the individual or his relationsh with others or his capacity to ad to life in society. In understa g these definitions we immed ly realize that there are two env ments to which an individual mu adapt. One is the external world about the person, and the others is his own internal world including drives, feelings, impulses, etc. This viewpoint, then, must immediately deal with religion as part of adjustment. If there is a God and a meaning to life, this obviously represents a part, the most important part, of adjusting and adapting to life. Now, of course, Freud did not believe God existed. Unfortunately, even today there are some psychiatrists (as there are people in other walks of life) who are atheistic. This then, naturally modifies to some degree their approach to patients in their practice of psychotherapy.

While it is true that most psychiatrists do not directly tell their patients their own beliefs and attitudes, I think there is some influence that occurs in the close relationship between doctor and patient. In intensive and long term psychotherapy, I believe part of the change that occurs in a patient is due to the patient identifying with the personality of the psychiatrist. In many subtle ways, such as type of questioning, inflection of voice, facial manifestation of approval or disapproval, etc., the patient does develop some ideas about the psychiatrist's approach to such things as morals, value systems and other important attitudes about life. These may well have considerable effect on the patient. In extreme cases, I believe atheistic psychiatrists have even more directly depreciated religion and have encouraged behavior or attitudes opposed to Christian principles.

This is not, of course, much of a problem for a psychiatrist who treats cases of mental illness with only physical methods of treatment, such as electroshock therapy or drugs. A more complex problem, and a more commonplace one, arises for those psychiatrists who believe that psychiatry and religion are two distinct and separated disciplines. I wholeheartedly disagree with this. As psychiatrists, scientists who are students of human behavior and functioning, we are and should be concerned with individual attitudes toward life, value systems, feelings about other people and ourselves. We are very much aware of the importance of a person's inner reactions to his behavior, his self concepts and his ideas about interpersonal relationships. We deal with loves and hates; guilts and ideals. Certainly religion is also very concerned about these very things. It is true that we often do approach these areas from a different plane or viewpoint. Psychiatry is basically a natural science, and looks at the individual from a natural viewpoint, whereas religion is concerned primarily with the spiritual dimension of man. Even here I do not believe there can be a sharp and distinct division any more than we can separate completely the body and the mind. We deal with the whole man, and man is composed of both body and soul.

Another conflict can occur when an individual has symptoms and the question arises as to which discipline is primarily responsible for the treatment of these symptoms. Some psychiatrists attempt to handle problems of a religious or spiritual nature, and some religious counselors at times attempt to treat problems which are primarily psychiatric in nature. It is not easy to always avoid this or to always make the proper judgment. There is no question as to who treats a broken leg or appendicitis, as there is no question as to who gives religious instructions! And when there is obvious insanity or psychosis the problem does not exist because everyone immediately recognizes it as a medical mental problem.

But the majority of psychiatric treatment now consists of handling cases of neurosis and personality disorders. Here, we psychiatrists deal with anxieties, fears, depressions and other manifestations of unhealthy personality functionings. Immaturity and emotional conflicts in an individual, which are essentially psychiatric problems, do manifest themselves in multiple ways, and at times some symptoms may involve themselves to some degree with religion. In extreme cases it is easy to see that the primary problem is mental. As an example of this, we frequently see psychotic symptoms such as delusions and hallucinations with religious content. A patient may believe he is God or speak directly and verbally with God or see visions of the Blessed Mother, etc. In other cases, where the degree of mental illness is not so obvious, we sometimes see religious counselors attempting to treat cases which are truly psychiatric in nature. This can lead to dangerous errors in treatment and can at times be harmful to the patient. This is why there is an increasing recognition of the need for training of religious to recognize which cases need religious counseling and which cases need psychiatric treatment.

Now let us discuss the more positive aspects of this subject. We know that psychiatry, by increasing understanding of human nature, can help humans in some areas of the application of religious knowledge. As reasonable people, we know we have to use the truth of Religion in our approach to treating people with problems. We should try to clarify some of these principles terms of the nature of goals of hese disciplines. Psychiatry is asically a medical discipline which eats mentally sick people. It is o more a substitute for religion n religion is a substitute for ps hiatry. In psychotherapy we try t elp people to understand themse s and their relationships with ot s. We use the approach of ca and effect in producing their iculties and leading to symptom nation. We recognize the import e of subconscious or unconsciou elings which influence overt be or and attitudes. We stress influence of early child-parent tionship and early childhood ex nces as influencing personality lopment. We use the concepts ts of the personality, the Id, nd the Super Ego, as being in lict with each other and produc ternal tension and anxiety. W into account social and cult influences in determining rea . This is all on the natural . We try to remove restricti itudes and influences which fere with the person achievin success in life of which he is c le. The goal of psychiatric trea t is to produce a mature, healt ersonality. The goal of religio s primarily to glorify God and have man attain eternal salvatio While the immediate goals of e discipline are different, I be each discipline can be of help the other.

First let us look at how religious principles can help in achieving and maintaining mental health. Religion alone can give the firm anchor, the fixed purpose and meaning to life.

Religion gives man a true understanding of the essence of life and unchangeable goal of life. Christianity provides perfect rules and guiding principles of living. We are taught by natural and revealed law the direction we need in life. Many psychiatrists feel that Christ Himself centuries ago laid down the principles of mental health. Religion teaches and stresses the importance of love, the most powerful emotion of life. It is because of the fact that God created each individual that we see the personal worth and dignity of others as well as ourselves. I need not go into all the details of the importance of the capacity to love as related to mental health because this is quite well known as a necessary ingredient of a healthy personality. Religion teaches a person to accept frustration and suffering and therefore helps an individual to cope with those realities of life in a healthier way. The individual, aware of life's basic meaning, more readily endures sorrow, grief, the monotonies of daily living and emotional crises that might otherwise result in depression, tension or other symptoms. All humans struggle to some degree with hostility as part of their human nature. Religion helps resolve this by its positive attempt to stress the opposite virtue, love.

Religion alone can give man the personal assistance of divine grace, which lights and illuminates his reason and strengthens his will. This is God's help in time of need. The idea that "God will help me" can contribute greatly in producing a sense of trust, security and strength to handle problems in life. These are only a few of the multiple ways that I see religion as directly influencing good mental health.

Psychiatry, as any science, can be of help to religion when correctly used. Undoubtedly God has given us intellect and the ability to achieve scientific knowledge in order that we might utilize it to gain our ultimate goal in life. Just as the science of communication has helped spread the Word of God, the science of psychiatry, understanding human personality, can be utilized also in the service of religion.

In general, the knowledge of modern psychology and psychiatry has influenced our society and culture. People are more aware of the psychological needs and drives of mankind. Everyone is more interested in the areas of mental health and mental illness. More attention is paid to child-rearing practices, educational efforts and other means of achieving emotional satisfactions and harmonies among people. Deeper awareness of interpersonal relationships and feeling of individuals has lead to social and cultural advancement. These factors have helped achieve in many cases a more Christian atmosphere among people.

More specifically, psychiatric knowledge has brought about greater understanding concerning such important matters as guilt, hostility, responsibility for behavior and freedom of will.

Personality comes into existence as a result of a number of factors: native endowment, environment and will. Native endowment is the individual's organic, somatic or

biological constitution. The basic equipment is influenced by the environment — the social surroundings and the cultural group of which he is a member. Everyone is strongly influenced by parents and family background and also by other people and circumstances as personality growth occurs. We now know that personality is not just the sum of a man's endowment plus environment, but rather the product of the interplay between the two. The demands of the environment interact with native equipment and modify it within limits.

Also, personality traits are not simply the result of environmental influences passively received by the psycho-physical organism, but as he matures a man can actively shape his life, destiny and personality by means of his will power. He can use his will to exploit his mental abilities to the utmost, and he can use his life's experiences to serve the purposes he outlines for himself. Although he necessarily undergoes the influences of the socio-cultural standards of his environment, he need not be a slave to those standards. An example of this would be Nazi Germany where some individuals refused to submit to the impact of this culture and did not believe in killing minority groups. Man may formulate for himself ideals and principles of conduct; by abiding by these he can gradually develop personal attitudes. Many of these will have moral connotations.

Psychology, psychiatry, sociology or other sciences are not in a position by themselves to establish the ultimate and stable principles of morality. Ethics and moral theology have the task and exclusive right to lay down the norms and the rules of the moral order and to teach what is morally good and what is morally evil. The moral system presupposes as a basic condition the existence of a personal God who created the world and rules it with infinite intelligence. God is the supreme law giver. This means God has laid down a set of rules that form the standard by which a person's actions must be judged either morally right or morally wrong. These rules are irrevocable and eternal. No system of moral rules will be satisfactory unless based on objective and absolute principles. God's Natural and Revealed Law gives us these rules. One of the major aims in psychiatric treatment is to help an individual become a responsible individual. A responsible and mature individual is able to face reality and meet his responsibilities and duties. Thus we can see in successful psychotherapy that a person does become a more morally responsible individual. In cases of erroneous conscience, it is the task of the moralist to rectify this error so that the person can use his maturity and responsibility and freedom of will to act morally correct.

One of the early errors of psychiatry and Freud's unacceptable theories is the theory of psychic determination. This would indicate that man does not have free-will. As Catholics, of course, we reject this determination which says that the will is so influenced by one's motives that it cannot choose another. We know that man makes decisions to perform unpleasant duties rather than doing only what is pleasurable. However, Catholic moralists agree that there are factors that may cause certain motives to influence a person so strongly that his freedom of will is impaired. Psychiatrists recognize that unconscious factors (factors outside the level of awareness) can influence human thinking, feeling and behavior to variable degrees. Thus we see, both from religious knowledge and psychiatric observations, that man's will is not under all circumstances completely and objectively free. We recognized that strong emotional conditions may create obstacles to free choice — such as fear, anxiety, rage or depression. Other conditions that may influence an individual's freedom of action may be attitudes and outlooks on life gained during the formative years. Suggestions or threats can also influence an individual.

From a psychiatric viewpoint, the healthier a person is, the more he is consciously aware of his motives and drives and thus can use intellect, reasoning and will effectively in choosing behavior. The greater the degree of mental illness, the greater his behavior may be motivated and influenced by unconscious factors which reduce his freedom of choice. In cases of mental illness people are not considered responsible for their behavior when the behavior is connected with the areas of illness in their personality. In mental patients we see combined relative responsibility in some areas of functioning and relative lack of responsibility for actions involving their pathology. It is obvious, too, that mental patients may be more responsible during periods when they are temporarily free from the acute attacks of illness. If degrees of responsibility of the mentally disordered were to be represented by means of a curve, one end would represent those who are completely or almost completely responsible; the other end would represent those individuals whose responsibility is entirely destroyed; and in between the two extremes we would find the great majority of persons with reduced responsibility. There is no complete demarcation or line between full freedom and complete determinism. It is like normal and abnormal, a gradual and imperceptible transition.

One of the common and important problems in religion is that of the feeling of guilt. Psychiatry often deals with this problem. We have to make the distinction between real (or normal guilt) and neurotic guilt. Normal guilt is moral law. In such a case the individual is in a state of guilt by reason of the direct violation of his conscience; he has knowingly committed a sin and he should feel guilty. No psychiatrist, therefore, is justified in attempting to relieve a patient of moral guilt; this is a matter for confessional absolution. There is, however, another guilt: neurotic guilt, a feeling of guilt in the absence of wrong-doing or a degree of guilt out of proportion to the transgression. In these cases, it is necessary to explore the psychological functioning of the personality and find the cause of the guilt through psychiatric understanding and methods of treatment.

In understanding our psychiatric approach to neurotic guilt and other neurotic symptoms, we must keep the following factors in mind. Our modern teachings in psychiatry indicate that certain conflict-full impulses, feelings, memories and attitudes, often originating in childhood, can be repressed, forgotten or excluded from the field of conscious awareness. They, however, can retain their emotional energy and forces, and at times can manifest their influences in the form of neurotic symptoms without the individual realizing their relationship to the uncomfortable symptoms. Since the forces and conflicts are unconscious, or at a low level of awareness, they can not be brought to light by superficial discussion and direct questioning. An approach which is not oriented in depth psychology can not reveal these forces or symptom producing factors. Therapy is complex and symptoms can only be removed by intensive psychiatric treatment aimed at bringing this material into conscious awareness, where the individual can then resolve these conflicts by using reasoning power and freedom of choice. These are natural phenomena and need to be removed by natural psychological means. In the future we must keep several things in mind. If continuing research and theory in psychiatry is to be correct it must be in accord with th truth of Catholicism. True, verif l, scientific knowledge can not in error nor can true Catholic ogma be erroneous. As both ar valid, we must continually strive t itilize the services of each to help e individual and mankind. We ust recognize that psychiatry is mposed of both facts and theori We must exercise some tolera as to the interpretation of the c vable facts of personality funct g because imperfect human be create theories to explain the cts. If the theory is correct, er research and knowledge v alidate the theory to make it a d conclusion and fact. If not c the theory is to be discarded urther effort made to determin h. We must also keep in mi at imperfect human beings te the facts of religion and in s cases we see difference of op in certain areas among theo ns. We must remember that th hs of religion may not always b een expressed clearly and co ly by mere humans. This i reality of life as it is.

I am certain religion and psychiatry will co ue to find common ground for m al understanding and cooperat in the work of alleviating huma uffering and in the salvation of s s.