Understanding Mental Illness

RELIGION AND PSYCHIATRY: THE FOURTH DIMENSION

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e-Book 2015 International Psychotherapy Institute

From *Understanding Mental Illness* by Nancy G Andreasen

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. . . men must learn by suffering Drop by drop in sleep upon the heart Falls the laborious memory of pain, Against one's will comes wisdom. The grace of the gods is forced on us Throned inviolably

AGAMEMNON. AESCHYLUS

Traditionally, psychiatry views man in terms of three dimensions —his relationship with himself; his relationship with other people; and his relationship with his surroundings and the physical world. These three dimensions of man have been the subject of previous chapters. Unfortunately, the fourth dimension, his relationship to the supranatural or spiritual, is often ignored or neglected by psychiatrists. This neglect is puzzling and paradoxical, for psychiatry is the most philosophical and humane of all the medical disciplines, and the illnesses it confronts are ones which often blight the human spirit in addition to the mind and emotions. One can only explain the neglect as a byproduct of the pervasive philosophical materialism of the twentieth century and note with hope that existential psychiatry, which does see man as more than a physical being, is receiving more and more attention in psychiatric circles. Man's fourth dimension, his relationship with the supranatural or spiritual, is the subject of this chapter.

The Problem of Moral Responsibility

One of the most difficult issues which both religion and psychiatry must face is the problem of moral responsibility. The Freudian approach in particular has stressed the impact of early childhood on adult behavior. The medical model suggests that many psychiatric illnesses are caused by derangements in body or brain chemistry. In either case, there is an implication that the person suffering from a psychiatric disorder "can't help it." But, on the other hand, such a point of view is prone to lead to an attitude of defeatism or apparently condone morally irresponsible behavior. The following examples illustrate the problem.

> As Mrs. Jones visits her psychiatrist, she gradually realizes that she relates to other people in shallow and immature ways. As she grew up, her feelings and behavior were shaped by cruel rejecting parents who rarely displayed love. Small successes received mocking comments about their lack of importance or the admonition that she really ought to have been able to achieve more. If she failed at something, this was taken as a personal reflection on her family and her parents, and she was sharply criticized. Little gestures of affection such as a good night kiss on being tucked into bed or an invitation to crawl up on her father's knee for a moment were never given. Consequently, she was taught to expect rejection continually and was never able to experience real feelings of trust for other people. Now she is unable to leave herself open or to give to others. She finds receiving is much easier, and she believes that one had better grab whatever love substitutes one can find, such as food or fine clothing, whenever one can. She lives in a comfortable middle-class home now, is married, and has several children. Continual

snacking gives her a weight problem, while fear of physical or emotional closeness gives her a sexual problem. She is jealous of her husband's secretaries and continually accuses him of infidelity. Inability to reach out to other adults gives her an interpersonal problem. She rarely invites people into her home and is unable to show spontaneous signs of friendship. Small wonder that she is lonely, depressed, and sometimes self-pitying.

Mrs. Jones is a tormented, unhappy, fearful and self-centered person. In part, she is living by reaction patterns which she learned as a means of survival during her childhood. Judged from the point of view of most religions, her behavior is not admirable, but it was in part determined by her upbringing. Can she be considered morally responsible?

Mr. Smith is a paranoid schizophrenic. His illness makes him terribly sensitive to rebuffs from other people, and at times when he feels they are "against" him he strikes out with hostility and anger. He is emotionally quite cold and is aloof, superior, and overly stilted and formal to his associates. Although he rarely mentions it, he believes that he is the victim of a conspiracy against his life and well-being which is masterminded by the FBI and CIA, who follow him, harass him, and sometimes secretly enter his home or office and examine his possessions and business records. If someone presses him too hard, or if he becomes too ill, there is always a chance that he may break down completely and commit an act of violence. His thoughts and behavior are in part determined by a complex interaction between his environment and his brain chemistry. Can he be considered morally responsible?

These are difficult questions, both morally and legally. The law is clearer on the matter than ethics, however. The law would consider the neurotic Mrs. Jones completely responsible for her behavior, while the psychotic Mr. Smith would probably be considered "not guilty by

reason of insanity." In terms of religious ethics, it is in one sense very cruel to consider either fully responsible, since the behavior of both has been shaped in part by factors which they are unable to control. On the other hand, Mrs. Jones certainly still has free will at any particular moment, and she can make a conscious choice to surmount her neurotic childhood. To a large extent, in fact, she can only benefit from psychotherapy if she is considered fully responsible for her behavior. And therefore the pragmatic and sensible course is to treat her as if she is responsible, although in a compassionate and non-judgmental way.

To some extent this point of view also applies to Mr. Smith. It is therapeutically more effective to consider him responsible for his day to day activities, but aberrant behavior must be regarded much more tenderly in his case. For, to the extent that his illness blinds his insight and reason, he does not truly have free will. And ultimately only God can determine the extent to which either Mrs. Jones or Mr. Smith is to be held accountable. We human beings usually behave more effectively in moral matters if we leave judgment to God and use his mercy and grace as our guidelines when attempting to improve interactions with society.

The Problem of Evil

Even if we leave judgment to God, the presence of psychiatric illness (like the presence of all illness in the world) raises another issue, at least if we follow the medical model and consider the more serious psychiatric disorders as ultimately subtle forms of physical affliction which manifest themselves in the emotional or behavioral spheres. That is the problem of evil: How can a just and loving God permit the torments of illness, particularly those which affect the mind, to afflict mankind when as an omnipotent being he has the power to destroy illness. Or, as the victim of mental illness and his loved ones might phrase the question: Why have we been given this burden to bear? Why must we suffer in this way? What is its meaning for us?

The problem of evil is a subtle theological problem which has been examined by thoughtful men and women for centuries. One could not hope to add much to their theological explanations—that suffering was introduced into the world by man, not God, at the time of the Fall; that suffering tests man's mettle and his love for God; that suffering purifies and leads to wisdom: that suffering leads to compassion for others who suffer; that suffering is the just reward for all men, for all are sinful. Some of these explanations are more convincing or comforting than others, and for the person suffering from psychiatric illness it is perhaps most valuable to focus upon those which stress the

positive qualities which grow from suffering.

In the first place, people for many years have suspected that psychosis can for some people be a regenerative or insight-provoking experience. Shakespeare portrays in *King Lear* the way in which Lear grows in maturity and understanding through the course of his madness and emerges again to sanity somehow purified and redeemed. Anton Boisen, a catatonic schizophrenic who has written several books about his experience with psychosis, has said:

> ... an acute schizophrenic episode assumes the character of a religious experience. It becomes an attempt at thoroughgoing reorganization, beginning at the very center of one's being, an attempt which tends either to make or break the personality. ... It was necessary for me to pass through the purgatorial fires of a horrifying psychosis before I could set foot in my promised land of creative activity.
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> Out of the Depths,
>
> (New York: Harpers, 1960, pp. 205, 208)

Others have described psychotic illness as potentially a positive disintegration which must precede a creative reintegration in which new insights are both achieved and fully understood. Seen in this way, a psychotic experience may somehow be akin to a mystical experience. Speaking as a psychiatrist who has dealt with many psychotic individuals, I feel that there are less perilous and painful ways to

achieve new insights, but nevertheless one cannot ignore those who testify to the value of psychotic experience. And one cannot help but be grateful and hopeful that the potentiality for growth through illness may exist.

Such severe psychotic breaks are fortunately not common. The vast majority of people who experience psychiatric disorders suffer from milder or less crippling forms—the depressions, neuroses, and adjustment problems previously described. These people in particular have a significant potentiality for learning and growing through their experience with suffering. The depressive and the neurotic suffer great emotional pain. Yet, many respond to it by having greater compassion for others who suffer rather than by feeling bitterness or anger. Often working with their illness prompts them to reorganize their lives so that they can use their understanding of suffering to reach out and help others—through volunteer work, through their professional lives, or through their personal lives. Thus many are able to turn their weaknesses into strengths and use their own experience of pain to alleviate the pain of others. In this way, the problem of evil is at least partially resolved. Some good does come out of evil.

The Problem of Guilt: Can One Be Too Religious?

St. Paul has phrased the fundamental human dilemma with painful clarity in Romans 7:18-19: “I can will what is right, but I cannot do it. For I do not do the good I want, but the evil I do not want is what I do.” Human sinfulness and weakness are facts of human nature. Recognition that, as long as he depends upon himself alone, man will remain frail and fallen is the beginning of wisdom from the point of view of Judeo-Christian tradition, for that recognition will turn the individual toward dependence upon his Creator. Psychiatrists also deal with the fact of human weakness on a daily basis. Some patients are all too painfully aware of their sinfulness, and their preoccupation with their sense of evil paralyzes their capacity to improve. Others seem to need to become more aware of the ways in which their selfish or cruel behavior creates misery for those around them. In attempting to help people suffering from such problems, psychiatrists are only assuming in the secular sphere a role which clergymen have carried for centuries. What is the relationship between psychiatric illness and feelings of guilt? Is a sense of sin always valuable, or can guilt feelings sometimes be excessive?

Through an accident of history, psychiatry has seemed to emphasize that a preoccupation with guilt is dangerous. Psychiatry as a medical science was born during the Victorian era, an age notable for its puritanism, hypocrisy, and emphasis on works and the work ethic.

Reacting against this, many psychiatrists began to stress the oppressive and dangerous effects of over harsh and punitive childrearing, puritanical attitudes toward sexuality, and a morbid preoccupation with matters of conscience. At that time, such an emphasis was a wholesome corrective. Many patients did seek psychiatric treatment because of their disproportionate sense of sin—because of "overdeveloped superegos" in psychiatric parlance. But now, one hundred years later, we seem to have learned only too well the lessons which early psychiatrists tried to teach, and the pendulum may have swung too far in the other direction.

During the past thirty or forty years many parents have feared that they will constrict their children's emotional and intellectual development and inhibit their freedom and creativity if they discipline them too much. And now many patients seek treatment because their underdeveloped conscience and sense of guilt has gotten them into trouble. Although they usually do not recognize the deficiency and present it as their primary problem, "too little superego" has led them to undisciplined or self-centered behavior, and they usually seek treatment in the groping awareness that the consequences of such behavior are social rejection and a sense of personal emptiness and restlessness. Confronted with such patients, psychiatrists are just beginning to recognize and emphasize that we must reassess our

priorities, that a sense of sin may at times be quite a good thing.

Several case histories may further illustrate the nature of the problem which psychiatry and religion confront.

> Mr. Miller was admitted to a psychiatric unit because of overwhelming feelings of despondency. At sixty-four and in ill health, he felt he was going to die soon and that damnation was certain. He sat for hours musing over sins that he had committed over the years—ranging from occasionally failing to attend church because he wanted to go fishing to a premarital sexual experience which he had in his early twenties. His despair was so great that he was seriously contemplating suicide, certain that damnation was inevitable anyway. He refused to eat, lost twenty pounds, and slept only two or three hours a night, typically awakening after only a few hours of fitful sleep to ruminate about his fallen nature and his multiple (but actually not very serious) sins.
>
> Mr. Wilson came in initially with his wife for what was identified as a "marital problem." Both were in their early twenties and had been married for about a year, although they lived together for a year prior to their marriage. Mrs. Wilson was in her fifth month of pregnancy, and her husband felt the main problem was the stress which the pregnancy placed on them. She was often tired, was working fulltime to supplement the rather limited income he made as a trumpet player, and was no longer as quick to perform household chores or to respond sexually. She also described some mild depressive symptoms. In the course of therapy, it emerged that he was having an extramarital affair and that he tended to have a lifestyle characterized by taking advantage of others, emphasis on self-gratification, and a limited sense of responsibility toward his wife and child. The "marital problem" in this case was primarily due to his self-centered behavior, and eventually he (rather than his wife or the marriage) was

identified as the primary focus for psychiatric treatment.

Obviously, Mr. Miller and Mr. Wilson have different kinds of problems. Mr. Miller suffered from a severe depressive illness, of which his preoccupation with sin and guilt was a symptom. His sense of guilt was developed to such an extent that it was disproportionate to his actual behavior, and therefore it was actually harming and handicapping him. One should emphasize that religion itself was not to blame for his illness, and ultimately the positive aspects of religion were used to help him as he recovered.

On the other hand, Mr. Wilson lacked an adequately developed conscience. His marriage was indeed failing, and in this case most of the responsibility for the failure fell on him, although he did not realize it initially. Therapy in his case involved helping him come to a realization of the destructive effects of his self-centered behavior and actually to experience a sense of guilt about his rather cavalier neglect of his wife's feelings and the pain he had caused her. He was then able to try to "make it right" to her and eventually achieved feelings of self-worth based on self-improvement that he had never experienced before. At one point in treatment he commented with surprise, "But I thought it was wrong to feel guilty." He gradually learned the distinction between pathological guilt, which he never experienced,

and wholesome guilt, which he needed to experience more often. That is the major distinction upon which the problem of guilt in psychiatry depends.

Religion and Health: How Religion Enriches

Thus, a religious point of view, even one which places emphasis on sin and guilt, is not harmful for psychiatric patients. Some may overemphasize sin and develop pathological guilt, but that is due to illness rather than religion. Depressive symptoms tend to manifest themselves as pronounced guilt feelings in people with a religious background, while someone with a more secular point of view will simply develop other depressive symptoms. Most clergymen would agree that the severe pathological guilt of the depressive is a derangement of a potentially sound or healthy religious tenet, and both clergyman and psychiatrist would try to direct such patients toward the more comforting aspects of religion. Not only is a religious point of view not harmful: it may actually be extremely helpful.

For a psychiatric patient experiencing severe despair, suicide is always a significant risk. Although hard facts are not available, suicide seems to be increasing in incidence during the twentieth century, and this is probably related to the advancing tide of secularism. In earlier

centuries suicide was always seen as an irrevocable sin leading to damnation, since it involved voluntary destruction of a life given by God and could not be propitiated or rectified since it led to death. For a religious person in the twentieth century, such reasoning can still serve as a deterrent. Even such a patient as Mr. Miller will usually respond to a line of reasoning which stresses the irrevocable quality of suicide—that he can commit suicide at any time if he really wishes to do so, but that his suffering may diminish in a few days or weeks and that deferring suicide until then is probably worthwhile since he has little to lose by waiting to see what the future holds but a great deal to lose if he commits suicide at once. Further, such patients can be reminded that God is merciful and loving, that no sin is too great to be forgiven, and great saints have experienced spiritual aridity similar to that from which they suffer.

Religion may also be helpful to other types of patients. For a patient such as Mr. Wilson, religion may help define a moral structure which will help him in building a superego or conscience. It is the superego which gives us a perspective by which to determine right from wrong, appropriateness from inappropriateness, value from valuelessness. My own experience leads me to prefer the teachings of Christianity. However, as a student of human behavior, I also know that each person resolves religious questions out of his own personal

ethnic setting, language pattern, and social structure. And as a psychiatrist, I see how often we, as human beings, tend to turn our own descriptive confessions into prescriptive teachings which we then may use to denigrate the beliefs of others in order to enhance our own self-esteem. While I can speak confidently of my own experience with Christianity as valid and meaningful, if truth is one, then we must be open to the possibility that other experiences too may be valid and meaningful sources of truth. Some patients may find Judeo-Christian tradition emotionally or intellectually unacceptable, for the time being at least, because they are in rebellion against many of the conventional values of Western society. Their right to inquire and reevaluate should be respected. Whatever intellectual position is most acceptable to them in building a moral framework and helping them to think in terms of a spiritual reality greater than themselves is of significant value in their process of personal growth.

Religion is potentially enriching or helpful in another sense as well. Not only does it provide a value system by which a person may live, but it also provides meaning and purpose for an individual's life. Life without a spiritual center runs a significant risk of being either shallow or empty. Perhaps a person who lives according to the pleasure principle, seeking gratification for himself alone as his primary goal in life, is as happy when all is going well for him as a

person who lives according to spiritual principles. Perhaps not. Human beings being what they are—prone to rationalize and justify the pattern of behavior which they themselves pursue—-a person who lives hedonistically is likely to affirm that he is living the good life, while a person who lives by spiritual values is likely to feel that his life is more fulfilling. But when things go badly, there is not much doubt who is happier, by either's testimony. The individual who values only material things or power can find no meaning for his life if he somehow loses them. The person who can confront loss or suffering with the help of religious values finds pain infinitely more bearable.

Existential Psychiatry and the Future

Providing new hope for an emphasis on the fourth dimension is a relatively new movement known as existential psychiatry. Leading figures in this movement have included Rollo May, Viktor Frankl, Karl Jaspers, and Medard Boss. Although this school does not deny the contribution of the Freudian, behavioral, or medical points of view, it stresses the importance and value of spiritual and philosophical factors in human life.

A primary tenet of the existential school is an emphasis on choice and ethics. Looking back to the secular existentialist Jean Paul Sartre,

an atheist but also a profound moralist, they assert with him that "existence precedes essence." Fundamentally, that statement means that our behavior determines what we are and what we become. The choices that we make in the process of existing determine the essence that we have. In Sartre's words, "we are our choices." The practical result of this point of view is that great responsibility is placed on the individual for the direction and shape which his life will take. Although he may come from a neurogenic background, he *is* able to overcome it slowly through the manner of his existence. Each time he acts his personality takes on the moral quality of his act. Each time he performs a kindness, he becomes a kinder person. Each time he gives another person his faith and trust, he becomes a more trusting person. And, contrariwise, if he chooses to move in the direction of evil, he becomes the evil that he performs. Behavior, personality, and moral character are all interwoven.

A second tenet of the existential school is the emphasis on individuality. This is a corollary of the emphasis on individual moral responsibility. This tenet stresses that the clinician and scientist should focus their attention on the distinctive qualities of each individual's conscious experience rather than to try to fit him to the procrustean bed of a psychological framework such as Freudianism or behaviorism. This tenet is based on the teachings of a philosophical

school known as phenomenonology, particularly well expressed by the psychiatrist and existential philosopher Karl Jaspers, which stresses that mental phenomena are best understood by attempting to understand the descriptions given of them by human beings. Therefore it is sometimes called the phenomenological approach. Practically speaking, this point of view leads to psychotherapy which focuses on the personal experience of each individual patient. *His* perception of his pains and concerns is the main focus of attention, and in therapy both therapist and patient attempt to understand his experience, its meaning, and ways to surmount his personal pain.

A final tenet of the existential school is the emphasis on man's search for meaning in his life. Viktor Frankl in particular has argued that Freud is wrong in defining the fundamental human drives as sex and aggression. He believes that the most fundamental drive is toward finding meaning and purpose. Man shares sex and aggression with the rest of the animal world, but man is distinguished from the animal world through his search for a spiritual center which has greater value and magnitude than his individual existence. Practically speaking, this means that many patients who seek treatment are in fact seeking help in finding a purpose to their lives. From Frankl's point of view, psychotherapy with this type of patient should be a logo therapy, a therapy which assists the patient in finding a logos or spiritual center.

Rather than dwelling morbidly on his pain and personal suffering, the patient seeks to find a meaning for that suffering which will give his life a purpose or goal.

Although it cannot begin to resolve all the problems about how the mind works or how people can best be helped, the existential school has provided a wholesome corrective to the Freudian emphasis on man as a helpless victim of neurotic drives and the behavioral emphasis on man as a soulless being who can be mechanically manipulated by a system of rewards and punishments. Existential psychiatry is a relatively young and amorphous school in the process of evolving its points of view. As it continues to work toward defining its essences, we can all learn a great deal from it.

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