# UNDERSTANDING MENTAL ILLNESS

## A Layman's Guide

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## Nancy G Andreasen

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**To all my teachers**

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himself feels that he has learned to dislike alcohol or find other members of his sex physically unappealing.

Another form of behavior therapy is known as reciprocal inhibition. This is often used for phobias or anxiety. The patient is first taught relaxation therapy—how to systematically and consistently relax various muscle groups in his body until he feels a pleasant state of total relaxation. Once he has learned techniques for relaxation, he is then placed near the situation or stimulus which evokes his fear or anxiety. While in the situation he is then requested to assume the relaxed state of mind and body that he has learned to produce himself. Gradually he learns to gain control over the fear or anxiety through consciously relaxing himself in its presence.

## Treatment Facilities

Treatment facilities are basically of two types—outpatient and inpatient. Outpatient treatment facilities include individual physicians' offices, clinics, and a variety of community facilities. Inpatient treatment invariably occurs in hospitals, of which various types are available.

Evaluation on an outpatient basis is the logical place to begin for most people seeking psychiatric help. Some people are lucky enough to have a knowledgeable family physician, minister, or lawyer who can immediately sense the types of problems and recommend the appropriate source from

whom to seek help. Most people, however, are not this lucky, and the decision as to where to go can be quite difficult. Facilities vary from one community to another, depending on community size and level of medical sophistication. Thanks to a strong mental health movement established in many areas through the national leadership of a man named Clifford Beers, himself a manic-depressive who wrote an eloquent account describing his experiences with the illness *(A Mind That Found Itself),* some communities have excellent mental health centers. In others only private facilities will be available.

The typical community mental health center is staffed by a psychiatrist, a psychologist, and a social worker at the bare minimum. Larger community mental health centers will have several workers in each category on a full-time basis, while in smaller ones the psychiatrist may work in the community facility part-time while involved in teaching or private practice activities during the remainder of his time. Community mental health centers are funded by individual states or counties and tend to be community and service-oriented. Ordinarily, treatment at a mental health center is much less expensive than with a private psychiatrist. Community mental health centers can usually be identified simply through telephone book listings, and if you are unable to determine whether or not one is available in your area, you can probably obtain this information through a local social service agency. Because they are service-oriented and try to reach a large number of people, community mental health centers ordinarily do not provide extensive

psychotherapy. They are most useful for evaluation, crisis intervention, and brief or supportive psychotherapy, as well as the management of medication. Community mental health centers usually do not have inpatient facilities of their own, and patients requiring hospitalization are referred from them either to private hospitals or to state hospitals.

Some communities also have family service agencies instead of or in addition to community mental health centers. Family service agencies are typically staffed by psychologists and social workers. Like the mental health centers, they can usually be found by looking under the appropriate heading in a phone book. Some of these are church-oriented, and your minister may know about whether one is available in your area or not. Family service agencies tend to specialize in marital and divorce counseling, family therapy, and youth and drug problems. Like the mental health center, they are service-oriented and provide short-term counseling rather than extensive psychotherapy. They usually do not have a psychiatrist working within the agency, although one may be available to them on a consultant basis. Management of patients on psychoactive drugs is usually outside their scope.

Private treatment facilities tend to be available much more extensively. In a moderate-size mid-western town, an outpatient diagnostic evaluation ordinarily costs approximately fifty dollars and psychotherapy sessions cost approximately thirty-five dollars an hour. These tend to be higher in larger

cities and on either coast. More and more insurance companies, however, are extending their coverage to include outpatient treatment of all types, including psychiatric treatment. The primary advantage of private psychiatric treatment is continuity of care and personal involvement by the physician. Like all physicians, psychiatrists vary in skill and personality. Further, within a particular community psychiatrists also tend to vary in point of view. Some psychiatrists are much more medically oriented and tend to concentrate their practice on drug management and electrotherapy with a minimal emphasis on psychotherapy. Others tend to specialize particularly in psychotherapy and may not wish to take on patients requiring extensive hospitalization. Tactful enquiry of a potentially knowledgeable source, such as a family friend or minister, may be helpful in indicating which private psychiatrist might be most appropriate for a particular problem. If you are unable to obtain the information, it is not inappropriate to phone a psychiatrist's office and obtain from his secretary information concerning fees, types of treatment provided, and whether the psychiatrist has hospital facilities available to him.

Whatever type of outpatient treatment you seek, any good facility will make every effort possible to respect your privacy and to keep your records confidential. All psychiatrists are ethically required to treat anything they are told as privileged communication except under the special circumstance that their records are subpoenaed on court order. In practice, this means that a psychiatrist will not reveal what a patient has told him without obtaining

specific permission from the patient himself. If you ask a psychiatrist about a friend’s or relative's condition, he may be rather vague and evasive because of this rule of confidentiality. If the patient has agreed that he can talk freely with a relative or friend, then ordinarily the psychiatrist will do so. In some cases, such as marital discord or adolescent problems, confidentiality is usually an absolute necessity if the psychiatrist is to make any headway at all with the patient. Many private offices are carefully set up to protect the patient’s privacy. A series of waiting rooms may be available so that patients do not see one another come and go. If you have a particular concern about privacy, you should communicate this to the psychiatrist you are seeing and usually he will try his best to respect your wishes.

INPATIENT FACILITIES. People who are unfamiliar with psychiatric wards usually accept a stereotyped view. A person may imagine psychiatric wards as snake pits—dark, crowded, dismal places where unkempt people pound the walls or sit in a stupor all day long. At the other extreme, some people envision psychiatric hospitals as full of golden sunlight and cheerful sweet-faced nurses who move through bright modern surroundings tending the needs of patients who are inspired to get well simply by the beauty of the atmosphere. In fact, psychiatric hospitals or wards are rarely like either of those extremes, but rather tend to fall somewhere between them.

Basically there are three types of hospitals which specialize in the care

of psychiatric patients. These are private hospitals, university hospitals, and state hospitals. State hospitals have improved remarkably over the years, and few, if any, meet the “snake pit” stereotype. Some are housed in quite old facilities, however, and making them beautiful and modern would be quite difficult. Further, state hospitals tend to house at least some patients requiring chronic hospitalization who have not responded to any form of treatment and may remain in the hospital the remainder of their lives. Such patients are almost never found in university or private hospitals. Current thinking in most state hospitals now is that even these patients benefit, however, from mingling with patients who have a better prognosis. They are no longer hidden on “back wards,” and therefore they are definitely visible to anyone who visits a friend or relative in a state hospital. State hospitals, as the name implies, are financed by state government, and therefore treatment there is usually less expensive.

University hospitals are teaching hospitals. Facilities vary from old fashioned to very modern depending on the wealth and age of the particular university. Such hospitals are ordinarily staffed by permanent faculty members who may work in the hospital on either a full or part-time basis and by a group of resident physicians in training who care for patients under the supervision of the faculty. Most university hospitals handle both state and private patients. In some cases university facilities exist as completely separate hospitals, and in others they represent a wing or a substantial area

of a general hospital. Private hospitals devoted exclusively to psychiatric care are not numerous, but a few very fine ones exist. They tend to be relatively expensive, but insurance coverage increases the availability of such facilities to larger numbers of people. In most cases, however, a psychiatrist seen on a private basis will have hospital privileges on a psychiatric ward within a general hospital.

Routines on psychiatric wards vary from hospital to hospital. In general, physicians, nurses, and aides make a strong effort to keep patients active and busy. Patients usually wear street clothes in most psychiatric facilities, and in many, nurses and attendants also wear street clothing rather than white uniforms. Psychiatric nurses often assume a significant role in counseling patients and providing supportive therapy during their hospital stay. Most hospitals provide some form of recreational activity on a daily basis, such as attending movies, having parties or song fests, or working together on an artistic project. In many hospitals patients often have private rooms, and they gather for meals or recreational activities in a common living room or dining area. Some hospitals continue to have “locked wards,'' while others do not. In general, these wards occur in those hospitals which care for severely disturbed patients, since they could become a danger to themselves and others if permitted to leave freely without supervision. Even on such “locked wards,” however, the majority of patients are permitted to come and go at will simply by asking someone to unlock the door. Facilities which handle

acutely disturbed patients often have an area where patients are kept alone in order to quiet them down when they are behaving violently.

Although most people imagine psychiatric hospitals as gloomy or violent, these hospitals in fact tend to be relatively cheerful and pleasant places, even when the buildings themselves are not ultramodern. Both patients and their relatives are often pleasantly surprised when they find out what psychiatric facilities are really like. Patients, in fact, usually show a great sense of relief on being hospitalized, since they know they will be protected from their frightening or harmful impulses. Some patients even grow so fond of the hospital that they must be protected against the condition known as "hospital dependency," which refers to the feeling that they could not maintain a satisfactory life outside the hospital. Psychiatric patients are sometimes popularly imagined as pitiful people locked away in institutions for life, but in fact the thrust of modern psychiatry is to prevent hospitalizations whenever possible, to make it as brief as possible when it does occur, and to prevent as many patients as possible from remaining chronically hospitalized.

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# How Friends and Relatives Can Help

*So faith, hope, love abide, these three; but the greatest of these is love.*

1 CORINTHIANS 13:13

Good psychiatric help and effective drugs and other forms of treatment are crucial to recovery or remission of symptoms in psychiatric disorders. But the help that friends and relatives can provide is perhaps even more crucial. Philosophers of the past have commented that man is “a thinking animal” or “a political animal.” One might also add that man is a spiritual animal. As all these statements indicate, human beings are characterized by their need for one another and their need for a feeling of purpose or meaning in their lives. They need faith, hope, and love, but most of all love. Psychiatrists and medications can help patients alleviate their symptoms. But friends and relatives can help them find faith, hope, and love.

## Recognizing Symptoms

The first reaction of a friend or relative to the development of symptoms in a loved one is often a refusal to recognize symptoms. To psychiatrists, this is the familiar “mental mechanism” of “denial.” Denial is both a great source of

comfort and a great deceiver. Essentially, it is a refusal to recognize warning signals because they are too frightening or too painful. It is denial, for example, which prevents the heavy smoker with a chronic cough and difficulty breathing from giving up smoking before he develops emphysema or cancer. Or it is denial which prevents women from going in for annual pap smears or recognizing the danger signals of carcinoma of the cervix such as unusual bleeding. None of us wishes to recognize something as painful as the potentiality or reality of illness and death. When denial prevents people from recognizing symptoms, it is a great danger and a great deceiver. Nevertheless, it can also be a great source of comfort at times, particularly in the case of a person who has a terminal illness but wishes to go on living as happy and normal a life as possible prior to his death.

Just as people avoid recognizing the symptoms of physical illness in themselves or others as long as possible, so too they often avoid recognizing symptoms of psychiatric illness. Bill, for example, who was slowly developing symptoms of schizophrenia began to believe he was possessed by witches and began to hear their voices talking to him and to see them appearing before him. Terribly frightened by this experience, he told his parents about it, and they replied that it was his imagination or a bad dream. He again told them about it two or three times more, but when he received the same reply, he finally decided to keep the experience to himself. It was finally called to everyone's attention when he broke into a church and defaced the altar when

the commands from the witches became irresistible. Perhaps if Bill had received treatment when the first warning symptoms were communicated to his parents, he and society might have been spared at least some of the consequences of his illness. It is, of course, only natural to hope that, if one closes his eyes and ignores the symptoms, they will go away. Occasionally this happens, but not often.

You may be asking yourselves: how do I know there really is a problem? Some warning signals are so flagrant that they should never be denied. Bill's hallucinations of witches, described to his parents with great fear and emotion, represent an example of a very obvious warning signal. So, too, is the expression of a desire to commit suicide in a person who has also been clearly despondent. In general, it is easier to determine that a person definitely needs help if the problem is either quite serious or quite acute. More specifically, it is easier to make decisions in illnesses such as depression, schizophrenia, or mania.

Sometimes a person coming down with a psychiatric illness directly expresses his symptoms and asks for help. If this occurs, the problem is relatively simple. More often, a friend or relative must himself assume responsibility for recognizing the meaning of changes in behavior. He may simply notice that Mike has become secretive and uncommunicative. When people talk to him his answers are brief and evasive. He may withdraw to his

bedroom and be very seclusive, or he may simply sit apathetically in a chair and stare into space. Molly may show little interest in food and begin to lose weight. She may toss and turn in bed at night or complain that she can no longer sleep. She may begin to run herself down, alluding to her worthlessness or sinfulness. Such people may be in very great pain and wish treatment, but they may be afraid to ask for it because they fear criticism, rejection, or mockery. It is indeed a sad situation if the denial system of a sick person and that of a loved one interact with one another so that both avoid getting help for the suffering person. If you notice symptoms like these, *ask* in a kindly way about the person's behavior. Indicate that you feel they may need help and that you will give them support in seeking it.

You should be aware that if a person is very ill, he may not realize his need for help. For example, a person who is very depressed may feel so worthless and guilt-ridden that he actually wishes to die and considers it his due. He may feel that total abandonment and neglect is all that he deserves. Therefore, if asked whether he wishes help, he will probably refuse it. In such a case, if you recognize that symptoms of depression are present as they have been previously described, then you have a moral obligation to help him against his wishes. Similar lack of insight about need for treatment occurs in people suffering from schizophrenia or mania, and in the latter illness in particular it may be difficult to persuade the person of his need for treatment.

In the case of illnesses which develop more slowly, such as neurosis or alcoholism, the sudden and dramatic development of symptoms which require treatment is more unlikely. In these cases, therefore, it is more difficult to evaluate when there really is a problem. If in doubt, you should encourage your relative or friend to obtain a psychiatric evaluation and leave the decision about further treatment to him and the psychiatrist involved.

## Seeking Treatment

Your role in helping your loved one obtain treatment will vary depending on the nature of the problem. If he is very ill, you may have to take the initiative. If the problem is milder, he will of course be able to make the appointment himself, although your encouragement and support can be of considerable consolation to him. The extent to which you will be involved in the initial appointment will also depend on the nature of the problem and the preferences of the doctor or facility. Some facilities use a team approach. The doctor will see the patient, while a social worker will obtain a supplementary history from an accompanying relative. In other facilities the doctor may wish to see the patient alone.

Once the initial evaluation has been completed, the physician consulted should be permitted to determine what your role in treatment will be. If your relative is significantly depressed, for example, but the physician elects to

handle the problem initially on an outpatient basis, he may wish to have you quite actively involved. He may ask you to make sure the patient takes his medication, to watch him closely for the risk of suicide, to help him become more active and interested in things, or to report improvement or worsening of symptoms. On the other hand, he may have some important reason for requesting that you remain minimally involved. If this occurs, you should not take it personally or think that the doctor does not value your opinion. Ordinarily, this simply means that the doctor needs to establish a close relationship with the patient and that communicating with relatives might handicap this relationship. In some cases the doctor may ask that you have a continuing relationship with a social worker or psychologist while he continues to see the patient. In other cases, the doctor may ask to see both you and your relative together or the entire family together for family therapy.

Relatives are placed in a difficult position if they themselves feel that a loved one needs treatment and he in turn refuses. If this situation occurs, you have several options available. You may make the first appointment for yourself and describe your relative's symptoms to the doctor and let him advise you further as to whether or not you should insist that your relative come in. You may enlist the help of a valued friend, minister, or lawyer and have another person join with you in persuading your loved one to seek treatment. If the problems seem severe enough, you have a moral obligation

to insist on treatment for him, since the consequences of untreated psychiatric illness can obviously be serious.

Your doctor may recommend hospitalization if the illness is severe. He will usually indicate to you how actively he wishes you to be involved in visiting the patient. Most hospitals have some regulations about visiting hours and who may see the patient. These are usually rather liberal, but if the patient is somewhat disturbed, visiting may be restricted until he improves. Patients are often quite fearful of hospitalizations. This is only a natural reaction. People fear entering a hospital for treatment of a physical illness such as an ulcer, and psychiatric hospitalization also has an element of irrational fear associated with it because of the unenlightened attitude some people have about psychiatric illness. Therefore, you should support and encourage your loved one as much as possible. Usually you will help him by accompanying him to the hospital. Most hospitals have guidelines about what type of clothing and toilet articles he should bring with him, and you will want to help him get the appropriate necessities together.

Sometimes patients refuse hospitalization. This places a painful responsibility upon his relatives. Of course, no physician can force a patient to enter a hospital against his will. He can only recommend that the patient needs hospitalization. If the patient refuses and the risk to his life or the lives of others is significant, then his closest relative is usually asked to sign him

into the hospital against his wishes. This is legally known as a commitment. Relatives are often hesitant about committing a patient. They fear he may feel that they have rejected him or mistreated him. Usually after the patient recovers, however, he is grateful to his loved ones for making the decision to help him.

## Handling Your Own Feelings

Recognizing the symptoms of psychiatric disorder developing in a loved one is a terrifying experience. For example, your husband or wife's personality may change before your very eyes. A familiar lifetime companion may seem a different person. Depression may cause a vigorous active person to waste away as if consumed by a fatal illness. A teenager stricken with schizophrenia may change from a happy, intelligent, and well-adjusted youngster into a troubled, confused, and tormented person who seems to hold only a poignant shadow of dwindling promise. One may suddenly realize that the evening drink or the cocktail party circuit has turned into a destructive dependency which is crippling a spouse physically and mentally. Or a loved one may suddenly become paranoid, expressing frightening and irrational delusions about how others are trying to attack or poison him. Sometimes the loved one will include members of his family in his delusional system and accuse them of turning against him as well. Disappointment, heartbreak, bitterness, and fear may begin to haunt the relatives of people

with psychiatric illness.

You take the first step in handling these feelings when you recognize the symptoms and encourage your loved one to obtain treatment. His doctor may be willing to discuss these reactions with you. Most of the time, however, the “normal” relative is expected by the doctor to carry his responsibilities bravely and without a good deal of advice or support. Many times relatives are able to do this. Family members unite together to console and advise one another, or close friends may offer much-needed encouragement. With the partial disintegration of family life in our era, which means that various family members may be scattered all over the United States and people are frequently on the move, sometimes people do find themselves forced to handle the development of illness in a loved one without comfort or support from friends or relatives. If this should happen, and if you feel the stress becoming intolerable, you should not hesitate to seek someone out to talk with. This may be someone outside the medical field, such as a minister, or you may wish your relative’s physician to see you formally or to refer you to another physician or social worker with whom you can talk. In spite of their professional expertise, psychiatrists sometimes forget how difficult it may be for relatives to handle their feelings about illness in a loved one. It does not hurt to remind them.

Whether you talk to someone about them or not, you will notice

yourself developing feelings about your relative's illness which you may find troubling. For example, you may become very impatient with a relative who is severely depressed. Quite often, a husband or wife may feel that if only their spouse would get up and do something, the spouse would feel better. They may feel a very understandable but misguided desire to scold or berate their spouse. This will, of course, only worsen the person's feeling of guilt and worthlessness, and so such scolding should be avoided. Or you may become very angry and frustrated with a relative suffering from symptoms of psychiatric illness.

Schizophrenics, in particular, often have an apparent "method in their madness,"—a playful or teasing behavior which seems designed to irritate. For example, they may answer questions obliquely and insultingly, or they may become dirtier and more dilapidated if encouraged repeatedly to wash themselves. Psychiatrists call this trait "negativism," and it, like the apathy of depression, is part of the illness. Neither the apathetic depressive nor the negativistic schizophrenic really wants to be irritating. He simply cannot help it. You, as a loving relative, also cannot help feeling irritated. You will inevitably have feelings toward your relative which you find unpleasant. I can only stress that it is normal to feel this way. No one is saintly enough to deal with really sick people without having such reactions, and you should not feel guilty about them. On the other hand, of course, you should not let such feelings get in the way of an important relationship. Recognizing that such

feelings are natural and normal is helpful in learning to handle them and in keeping them from interfering with the relationship.

## Being Supportive

Once you have learned to recognize your impatient or angry feelings as normal, you will be better able to support or assist your loved one in his recovery. Most relatives want to be as helpful as possible, but they are never quite sure what they should do. Perhaps the most basic thing the relative of a psychiatric patient can do for his loved one is to reaffirm his love and loyalty. He should indicate from time to time that he is ready to help whenever needed and that the illness will not interfere with their relationship.

Sometimes relatives are not sure about how much advice they should give to the patient. It is a good idea to talk this over with the patient's physician at some point. Ordinarily, a simple guideline is: Don't be afraid to listen to the patient and respond to his thoughts, feelings, or behavior, but also don't try to play psychotherapist yourself. Usually relatives are too close to the patient to make objective interpretations. Sometimes common sense will serve as a guideline. For example, if a patient persists in talking in detail about his sinfulness and guiltiness, when it is perfectly obvious to the observer that he is not a great sinner, this usually means that he wants to be consoled or reassured and thereby in a sense "absolved." It certainly does no

harm to positively reassure patients that they are good people, good husbands, good wives, good fathers, or good mothers.

Don't be discouraged if your relative does not respond to a substantial amount of encouragement, however. Patients do need love and loyalty in an abundance, but ordinarily this alone will not "cure" them. If it would, there would be no need for medications or psychotherapy. It is difficult for relatives to continue being encouraging and supportive when they get little positive feedback from the patient about their therapeutic effectiveness. But even if the relative does not respond immediately or even for several months, he usually responds eventually. At some point, as he improves, he will recognize and appreciate your loyalty. In addition to indicating your continued love, you can be supportive to your relative in other ways as well. If he finds the side effects of prescribed medications troubling, you can remind him that these, to some extent, are indications that the medication is working.

If an elderly person with an organic brain syndrome or a younger person who has had electrotherapy has trouble with his memory, you can assist by filling in gaps for him and reorienting him when he is confused. Handling paranoid delusions can be particularly difficult. One does not wish to encourage the delusion, but on the other hand, one does not wish to anger the patient by arguing about them. Ordinarily, a patient cannot be "talked out" of his delusions. It is usually best to avoid replying when the patient discusses

them or to indicate frankly that you can see how the patient might feel that way but that you disagree and then drop the matter.

## Recognizing Relapses

A final way that the relatives of people who suffer from the vast gamut of psychiatric illnesses can help is by remaining alert for the symptoms of relapse. Although discouraging for patient and loved one alike, relapses are in some respects easier than initial episodes of illness. At least the second or third time around, both patient and relatives have a better understanding of what is happening and have learned some resources for handling the situation. In the case of an initial episode, relatives are usually frightened and use denial. If they recognize the possibility that a relapse may occur, they are usually very careful about evaluating symptoms and seeking treatment immediately if symptoms do recur. In general, the sooner psychiatric illnesses are treated, the better the prognosis. Particularly in the case of illnesses such as depression, but also in the case of schizophrenia, early recognition of symptoms and increasing or reinstituting medication may avert a hospitalization.

Certain psychiatric illnesses are characterized by having a relapsing and remitting course. If relatives know that their loved one has such an illness, they should be particularly alert for the possibility of relapse. Those illnesses

which are particularly characterized by relapses and remissions include mania, depression, acute schizophrenia, alcoholism, and drug abuse. To say that these illnesses tend to be relapsing and remitting does not mean that relapses are inevitable, however. Each individual has his own characteristic course and pattern. Many people who experience a single episode of each of these illnesses or problems recover completely with treatment and never relapse. Others may have a single relapse, whereas a few have frequent relapses. No one can say what the future holds for a particular patient. Even in the patients who relapse, however, the future is certainly brighter if they have a supportive and enlightened relative standing by to recognize their symptoms and to offer them help in obtaining treatment.

# 6

# Religion and Psychiatry: The Fourth Dimension

*. . . 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.

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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