PASTORAL PSYCHOPATHOLOGY

MINISTERING TO THE MENTALLY ILL

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The issue of mental illness among those committed to a religious cause has for long intrigued psychologists and psychiatrists, pastors and ministers, philosophers and theologians. Various theories have been proposed to explain mental disorders when manifested in "religious" symptoms. These theories give rise to correspondingly different attitudes adopted by those helping the mentally ill.

Questions often arise in pastoral situations where one has to deal with Christians having serious psychological problems. Such problems have an impact on their life as Christians and hence it is natural that they turn to the pastor for help. What is involved here is more than an academic question that can seemingly be answered by drawing a line of demarcation between what is purely psychological and what is strictly religious. The complexity of the problem both as subjectively experienced by the individual and as objectively assessed by any pastoral psychologist requires a serious and responsible response beyond naive pragmatism.

In this article, our attempt is to present ways of understanding and helping mentally disturbed Christians, both psychologically and pastorally. We shall offer suggestions for an integrated psycho-pastoral approach in dealing with these people. To do this, we need both a knowledge of mental disorders and also a theological understanding underlying the pastoral approach in dealing with these disorders. Just as effective therapy has to be based on an accurate diagnosis and a sound etiology, so pastoral aid has to be built on a clear understanding of the real problem and its manifold causes and manifestations. Accordingly, this article will investigate possible theological approaches to mental disorders and the consequent pastoral attitude towards the psychologically disturbed. Clarifications will be made about the meaning of mental disorders, as well as about the differentiation and integration of the psychological and the pastoral. The final section will suggest the type of psycho-pastoral aid to one specific example of a neurotic Christian: the obsessive-compulsive.

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Theological Approach to Mental Disorders

It is not our purpose here to develop a theology of psycho-pathology. Such an interesting, pioneering task would necessarily require a serious investigation of the Biblical, Traditional, moral, systematic and pastoral aspects involved. We are simply offering a few reflections to serve as background and to set the stage for the rest of the article.

In examining the relationship between religion and mental health, one may consider mental health as a religion, or religion as a means towards mental health, or perhaps as a danger to it, or religion as incompatible with psychopathology. In terms of religious experience, is mental health a necessary component of holiness, or is holiness to be found also among neurotics? These two questions have given rise to quite a few controversies among authors.

In his book, "Holiness is Wholeness,"[1] Goldbrunner (1964) cautions against identifying certain "illegitimate illnesses" of mind and body with the notion of holiness. Striving for holiness does not entail getting mentally or physically ill. "There are unhealthy features in the faces of the saints which are not the expression of true human suffering" (p. 3), as the author puts it. On the other hand, it is a fact that for some Christians a mental disorder served as an opportunity for religious experience and spiritual growth. It seems that a neurosis opens them more to God's love and grace, increases their hope for salvation, makes them more aware of their self-insufficiency and hence for the need of God. This is sometimes also experienced by the physically ill or handicapped.[2]

Anton Boisen (1936), the father of the clinical pastoral education movement, confesses that his own experience of mental disorder "of the most profound and unmistakable variety" (p. 297), was for him an opportunity for a religious experience of profound significance. Not only in his own experience, but also in studies on others he found that marked religious concern was characteristic of acute disturbance and involving a sense of union with a higher Being. He concludes (p. 298):

> There is thus a definite relationship between the mystical and the pathological which is to be explained by the fact that religious concern is invariably associated with the attempt to grapple with the viral issues of life. And wherever the conflict is keenest, there we are likely to find both religious and pathological manifestations.

Boisen's assertions may be considered as one particular viewpoint expressed fifty years ago and that since there have been many developments in this

1. It is interesting to note that the original German title was literally "Holiness *and* Health" and nowhere in the text does the author equate the two terms.
2. Some of the canonised saints have even been diagnosed as mentally ill: St. Theresa as hysterical, St. Paul as epileptic, St. Joan of Arc as paranoid, etc.

area. But those same developments took place partly because of the impetus given by his ideas. And besides, we know that both in medicine and in psychology, we have a better understanding of 'normal' phenomena through a knowledge of the pathological. We can understand a lot about the nature of religious experience when lived under the influence of mental illness.

On a somewhat similar vein, Maurice Nesbitt (1966) analyses his own experience of nervous breakdown in the light of Biblical themes. He tries to share with others how the process of psychological freedom can be experienced by neurotics through a re-reading and imaginative adaptation of Biblical idioms.

James Lapsley (1972) explains how salvation and health (including mental health) are interlocking processes, that is, distinct but interdependent and inseparable. Thus, "not even the most severely crippled person is completely without ability to participate in the salvatory process" (p. 92). In this sense, the mentally ill are called to salvation and to holiness as much as others are. Indeed, some would say even more. According to R.D. Laing, the famous promoter of the 'anti-psychiatry' movement, those suffering from schizophrenia may be in truer touch with reality than others. This may lead some to affirm that schizophrenics would therefore be closer to spiritual reality and mystical experience than others.

This I think is an extreme position. My personal opinion about these authors' viewpoints is that the conclusion to be drawn from their statements points to a relationship between mental illness and religious experience. But what kind of relationship? We know that even statistically, from a high positive correlation between two variables one cannot deduce a direct cause-effect relationship (unless changes in the dependent variable are shown to be due to changes in the independent variable). If the mentally ill happen to be also religiously oriented persons, that does not imply that mental illness brings about intense religious experience nor that intense religious experience leads to mental illness. Besides, among both 'normal' and 'abnormal' people we find a whole range of persons from very holy to totally irreligious.

It is true, however, that there is a close relationship between religious conversion and acute mental illness, especially when we look at each as a process more than an event. In studying the conversion of great religious figures,[3] we often come across typical psychopathological symptoms, at least for a period of time. As a result of these, some emerge as better integrated psychologically while others as crippled. These alternatives are true both for any mental illness and for any religious conversion. The question therefore is: does one attain holiness because, or in spite, of mental illness? I would say that the mental illness is not the cause but rather an occasion for conversion. This is true also for physical illness or for any

3. For a study of St. Ignatius' conversion in this regard, see Woollcott (1969).

material evil that can befall a person. It is *through* these events and the way we react to them that conversion occurs. Theologically, God invites us and offers His grace to us through these experiences.

In this context, one must recall that genuine holiness or mature religion comprises integration as an essential quality. Pruyser (1968) referring to Boisen's book, comments:

> Boisen put a new stamp on psychopathology and religion by placing both in a framework of the life crisis. Mystical experience can best be understood if it is seen in the same order of intensity and depth that attaches to severe mental illness. Both are processes of disorganization and re-organization of personality, of transformation, of dealing with man's potentialities and ultimate loyalties.

In relating holiness to mental illness, there is the tendency of placing the mentally ill in a privileged religious position. They are presented as being more disposed to respond to God's call, more inclined to religious contemplation, less concerned about worldly things, more intense in their religious attitudes, etc. These same exterior manifestations, however, may also be interpreted as a result of pathological motivations, defence mechanisms, escape from reality, and so forth. The slogan "being fools for Christ's sake" is not a pretext for rationalising our idiosyncrasis or odd behaviours, and then displacing them all on to Christ.

Psycho-Pastoral Aid

The preceding reflections should serve as a theoretical background for a practical pastoral approach with the mentally ill. What we intend to explore in this section is the specific nature, type and form of pastoral help that may be offered to the mentally ill in general.

Pastoral aid is not limited to sessions in pastoral counselling. The healing process that may take place extends beyond the one-to-one relationship of the patient with the pastoral psychotherapist. It includes the whole community that offers human support to the individual, the experience of membership in a loving fellowship, the celebration of forgiveness and healing. It embraces a whole Christian tradition that respects the worth of every person, that believes in a compassionate God, that trusts in the ultimate victory over suffering and evil, that promotes genuine growth and that offers a fulfilling way of life.

Experience has shown that Christian faith and practice do in fact support strongly one's mental health. Conversely, as Jesuit psychiatrist James Gill (1969, p. 13) confirms, experience with the mentally ill

> has provided striking evidence of the lack of such supporting elements in their lives. These are excessively anxious, pessimistic,

> withdrawn, or hostile adults who had either failed to develop the religious aspect of their psychic life or had for some reason abondoned it along the way.

This is understandable especially if we regard the neurotic as living a self-centred life, as Allport (1950) points out, and that most neuroses are "from the point of view of religion, mixed with the sin of pride" (p. 95). He goes on to suggest that

> a more becoming basic humility, held in the religious perspective, could not help but improve the state of the sufferer's conscience, and thus indirectly affect favourably his mental health. Even when his compulsions get the better of him he need no longer regard them as of central importance in his life. As the focus of striving shifts from the conflict to selfless goals, the life as a whole becomes sounder even though the neurosis may never completely disappear.

This is the wider context of pastoral aid available to the 'neurotic' Christian. But in a more specific manner, this is focused and made explicit in the pastoral counselling situation. Not that the healing or cure is expected to be automatically delivered by the person of the pastoral counsellor. It is rather the process which transcends both the counsellor and the counsellee. As Gerald Jenkins (1981, p. 45) wisely expresses it:

> Now some might prefer to say that nature heals and I would not object. Others might prefer to say that healing comes from within oneself as the restrictions and impediments to healing are removed and I would not disagree. In whatever way we say this we point to a process beyond the therapist, one that he may evoke, or stir or contribute to, but not cause.

Nonetheless, the minister, priest or pastoral counsellor has an important role to play in contributing to the healing process. If we adopt Seward Hiltner's (1958) framework for understanding the ministry namely under the threefold perspective of shepherding, communicating and organizing, the pastoral care of the individual through counselling occupies a dominant place in the shepherding perspective. In this regard, the minister or pastor has an advantage over the 'secular' counsellor or psychotherapist in that he can take the initiative and intervene without waiting for the individual to make the first step.[4]

The pastor finds himself in a special position compared to the health professional in other ways too. His role and status may serve as extra help to the patient. He enjoys a certain authority in the eyes of the counsellee and this can be used to the benefit of the latter, at least in certain cases. Because

4. This pastoral prerogative of initiative and access is explored in greater depth by Paul Pruyser (1972).

of his role, the pastor may help the individual to be integrated into the social structure, for instance by helping him or her join an organization, find a proper job, relate with other people, etc. The pastor also adheres to explicit value systems. These are transmitted to the individual not only verbally but also as embodied in the person of the pastor. In this sense, through his personal beliefs, principles, life-style and behaviour, he is setting a concrete model for the counsellee.

The pastor seems to have another advantage over the secular therapist not only in the treatment (therapeutic) but also in the prevention (prophylactic) of mental illness. For besides acting as counsellor, he also has opportunities for preaching, educating, family visiting, and group meetings. Dr. Menninger (1978, p. 201) himself admits:

> No psychiatrists or psychotherapists, even those with many patients, have the quantitative opportunity to cure souls and mend minds which the preacher enjoys. And the preacher also has a superb opportunity to do what few psychiatrists can, to prevent the development of chronic anxiety, depression, and other mental ills.

It is also true that at times the role of the pastor may consist in helping the mental patient decide to seek help from a psychologist or psychiatrist. Quite often, some patients find it hard to accept they need professional help and so the pastor can use his power of persuasion and credibility to encourage the person to accept referral. He will also continue to give him or her support during treatment and work in close collaboration with the mental health professional.

Role of the Pastoral Counsellor

All this leads us back to the basic question: What exactly is the specific role and unique function of the pastoral counsellor that set him or her apart from other counsellors and mental health professionals? In spite of the many descriptions given by various authors, there is as yet no unified, integrated picture of the pastoral counsellor's distinct task.

Clinebell (1966) lists as distinguishing features the explicit goal of spiritual growth, social and symbolic role, tools, setting and training (pp. 49 – 52). Hiltner (1961) proposes the 'context' of pastoral counselling as its distinctive characteristic, that is, the setting, aims, expectations and limitations inherent to the pastoral situation (pp. 29 – 31). For Tillich (1956), the discriminating factor lies in focusing on the ontological rather than pathological anxieties of life (pp. 72 – 77). David Switzer (1974) emphasizes the symbolic power of the pastor, initiative, prior relationships with persons and the availability of a faith-communinity (pp. 20 – 28). In more general terms, Cavanaugh (1963) mentions the presence of a third person, God, in the counselling relationship as a specific difference (p. 8).

More recently, Homer Ashby (1981) posited the construct of values and moral context as the identifying characteristic (pp. 176 – 184).

My own personal position on what makes pastoral counselling specifically patoral is that its difference from psychological counselling is to be found not only in the extrinsic or exterior circumstances surrounding the counsellor-counsellee situation, but within the counselling setting itself. Suppose we take the three structural aspects of counselling to be the content, the technique and the counsellor-counsellee relationship, and apply them to the pastoral counsellor.

As to the content, the pastoral or spiritual content of a counselling session gives it a specific orientation at various levels. Adopting Egan's (1975) stages, at the initial level of self-exploration, through awareness of God's presence in one's life; at the next stage of cognitive re-organization, through self-understanding in the light of Revelation; and the final phase of decision-action, through behaviour change motivated by faith, hope and love. As to the relational aspect, this attributes a special role to the counsellor and creates the proper context conductive to a faith consciousness, a Christian perspective of reality and a behaviour change modelled on gospel values. But as to the technique, I do not believe there is or should be a specifically unique pastoral one. A technique is a tool or an instrument to be used as a means towards an end. And there exist not a few psychotherapeutic techniques that can be adapted and employed for pastoral ends. Besides, while every technique is adaptable to the various contexts it is also continuously influenced and coloured by the content and by the consellor-counsellee relationship.

But the issue concerning the specificity of pastoral counselling is linked to the larger issue of the relationship of the psychological and the religious. Without entering into this far-reaching problematic, let me briefly clarify a few points and present my option.

Psycho-spiritual integration

The spiritual and the psychological dimensions in man, though distinguishable, are inseparable and closely interrelated. We should not confuse psychological problems with religious difficulties, mental illness with spiritual sinfulness, psychotherapy with confession. Hence we have to distinguish between psychological treatment and pastoral care or spiritual healing. For otherwise we would be putting spiritual band-aids on psychological wounds. Eventually, there has to be an integration of the psychological and the spiritual, but for this to be healthy it must be preceded, I believe, by differentiation.

Some advocate religion for psychic and somatic cure. It is true God heals us, our whole person, through His grace. But He normally cures us of particular bodily or mental ills through the instrumentality of medical or psychological facilities available.Miracles do occur but exceptions should

not be stated as rules. And not to tempt the Lord our God, we are expected to take the ordinary measures if we want to be healed.

In discussing spiritual means to psychological goals, Meehl (1959) concludes that faith may assist in the mastery of neurosis, but it does not enable the person to overcome his neurosis. And in dealing with psychological means to spiritual goals, Pattison (1969, p. 84) summarizes thus:

> A competent 'secular' therapist may contribute more than a 'spiritual' therapist who neither provides the necessary emotional relationship nor has the technical and personal skill to help clarify the patient's religious distortion.[5]

So even for healthy religious experiences, psychotherapy may help an individual remove blocks that are a hindrance to experiencing God. Smet (1954) notes that one must experience the basic elements of love, faith, trust, and hope at the human level before one can experience them with God. The "corrective emotional experience" may then be a necessary prelude to healthy spiritual experience with God.

At times it may even be detrimental to patients to offer them a spiritual solution to their psychological problems. Not only would they experience frustration in never seeing the light at the end of the tunnel, but their faith in God might be shaken and an immature type of religiosity may develop based on an image of God as "Deus ex machina." While some privileged authors may rightly claim that their own psychic healing was the result of some religious form of therapy, there is a large number of cases – some of which in my own clinical experience – where the result turned out to be negative.

If scientific rigour demands that psychology and theology be properly differentiated, the unity of the person to whom they are addressed requires some form of integration. Such integration should manifest itself especially in the application of psychology to counselling or psychotherapy and of theology to pastoral care. This would lead to an integrated approach in caring for the mentally ill. It should respect the autonomy of the psychological and the pastoral but also affirm their interdependence and close relationship, especially when dealing with Christians or religious persons.

Mental Disorders

A mental disorder is defined by the "Diagnostic and Statistical Manual of Mental Disorders" – Third Edition (1980) widely known as DSM-III (p. 6) as

5. Helping a Christian who is psychologically disturbed requires the close collaboration of pastor and psychotherapist. Ideally, I think it could be a psychotherapist or psychiatrist familiar with religion, or else a pastoral counsellor trained in clinical psychology.

> a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability).

In classifying mental disorders, DSM-III omits, for the sake of coherent classificatory purposes, the classical standard class of neurosis and instead of grouping them together are included under other disorders (Affective, Anxiety, Somatoform, Dissociative, Psycho-Sexual). Similarly, psychotic disorders are not grouped together under one category. In this article we are dealing mostly with those types that fall under "neurotic disorders". The term "neurotic disorder" refers to that disorder where the relatively enduring predominant disturbance is a symptom "distressing to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact; behaviour does not actively violate gross social norms" (p. 10).

In order that psycho-pastoral aid to neurotic Christians be effective, it is paramount that one understands the neurotic person, how he or she lives and experiences the neurosis, what lies underneath the disorder, how responsible the person is, what resources they have to cope with it, overcome it or at least be able to live with it.

We adopt Angyal's (1965) position about neurosis being a way of life and not simply a partial disturbance in one area of personality. This way of life appropriates the person's whole physical, cognitive and emotional functioning and transforms them according to its own system principle. It is itself an *organization*, as Angyal (p. 71) puts it,

> with its own goals, attitudes, and motivations, its own pains and pleasures: anticipated dangers that are feared with unusual intensity, animosities that are pursued relentlessly, promises of pleasure that are most tempting and compelling.

Viewing neurosis as a way of life does not eliminate the possibility of differential diagnosis and nosological description. Angyal's conception of dualistic organization ("universal ambiguity") – the bi-polar orientations of health and neurosis – allows for sub-systems within the two major organizations. These are understood as different dynamic patterns in a person's behaviour that once identified prove helpful for therapy.[6] Angyal's holistic approach has thus important implications for therapy. The therapist does not focus on single disturbances nor does he or she deal with symptoms piecemeal, but with a system of generalized attitudes. A holistic interpretation would lead from specific items to syndromic units and

6. I wouldn't agree with Angyal, however, in reducing these specific dynamic patterns in neurosis to a two-dimensional representation: the obsessive-compulsive and the hysterical. The verification of his hypothesis on this point would need, I think, extensive empirical research using factor analysis techniques.

through them to wider personal attitudes.[7] If this approach is correct, then neurosis is both an emotional and a cognitive disorder, and hence therapy would aim at an acquisition of a new orientation and attitude toward life.

An approach to neurosis which I find closely related to Angyal's is that expounded by David Shapiro (1965). With dynamic psychiatry and ego psychology as a background, Shapiro describes neurosis as a life style. It is the product of the individual's style of functioning which once understood, we can also grasp the meaning of the person's thoughts, fantasies, symptoms and behaviour. "His conscious attitudes and the way he sees things are essential parts of the neurosis" claims Shapiro (p. 18). And moreover, the person's psychological make-up moves him or her to think, feel, do things that continue the neurotic experience and are indispensable to it. According to Shapiro, then, the neurotic does not simply suffer or bear the neurosis, but actively participates in it, sustains it and functions according to it.

These conceptions of neurosis should certainly alert the pastor or pastoral counsellor in trying to help the neurotic Christian. To what extent is the patient responsible for his or her illness? Is their behaviour an attempt at evading, consciously or unconsciously, certain responsibilities? What about the notion of "secondary gains" from illness? As often happens in psychotherapy, patients might sincerely want to have all the inconveniences of neurosis removed without relinquishing the neurosis themselves. The ego may try to gain advantages by provoking pity, attention and love. As the inmate of an asylum remarked when special privileges were denied him: "Then what am I nuts for?"

The pastoral counsellor ought also to be aware of the defensive devices the patient employs in coping with the illness. In Karl Menninger's (1963) coping theory, illness is the result of a discrepancy between the patient's mode of coping and the actual situation. Originally, the patient devised modes of defences against threat or challenge in a particular situation and now continues to employ the same coping device for every situation. The pastoral psychotherapist would help such person become conscious of his or her mechanism, realize it is no longer effective nor necessary, suggest other alternatives of coping, provide support and reinforcement for new behaviour, encourage self-confidence and offer a faith perspective on the whole problem.

The Obsessive-Compulsive Disorder

We have so far presented a few considerations on what psycho-pastoral aid involves when dealing with psychologically disturbed Christians. We have set out some basic theological and pastoral principles that are

7. In this respect, Angyal comes close to the psychoanalytic concept of "overdetermination" of a symptom or act (i.e. the presence of multiple meanings and motives for the same symptom).

applicable in this area, and clarified some notions pertaining to mental disorders in general. We shall now focus on one specific type of mental disorder and describe its specific nature, principal symptoms, possible causes and eventual therapy. These descriptions will have a religious bent in the sense that they will be viewed mostly in terms of their religious manifestations or pastoral impact. In this manner, the psycho-pastoral aid suggested will be more readily understood.

In discussing psycho-pastoral aid to Christians with mental disorder one would normally explain how to deal with various categories of such disorders and even present concrete cases for study. From the pastoral point of view, it would be helpful, for example, to study such types as the depressive, hysterical, personality disorders, etc. However, the limits of the scope of this article require that we focus on one type - the obsessive-compulsive. In a traditionally Catholic country like Malta, the obsessive-compulsives are still the ones I come across most in my psycho-pastoral experience.

Its Nature and Symptoms

The obsessive-compulsive types are easily detected during confessions. They want to confess very often, tell their sins with exaggerated meticulosity, sometimes writing them down on a piece of paper, argue with the priest that their confession has not been complete, express doubts about the validity of past confessions, insist on making a 'general confession' of their whole life, and eventually repeat the same process with another priest. Scrupulosity is considered to be one of the religious manifestations of their obsession. The guilt-complex is translated into a religious symptom and identified with sin.

What constitutes an obsessive-compulsive disorder? What are its main symptoms? How does it originate? And what are the chances for cure? Although it may range from mere tendencies to neurotic obsessive contact with reality, possibly developing into the schizophrenic's lack of contact with reality (psychotic in scope), it is usually classified under neurotic disorders. Its essential features are obsessions or compulsions. Obsessions are "recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic" while compulsions are "repetitive and seemingly purposeful behaviours that are performed according to certain rules or in a stereotyped fashion" (DSM-III, p. 234). The most common obsessions are repetitive thoughts of violence, contamination, and doubt ("la folie de doute" as sometimes referred to in French popular language). The most common compulsions involve hand-washing, counting, checking, and touching.

In terms of way of life, Angyal (1965) calls this "the pattern of non-commitment" (p. 157). And as a neurotic style, Shapiro (1965) characterizes it by "rigidity" (p. 23). Wilhelm Reich (1949) described these compulsive characters as "living machines" (p. 199). The rigidity is manifested in their body posture, stilted social manner, general behaviour,

but above all in their thinking. This intellectual rigidity is evident for instance in their focused attention and concentration especially on details. The Rorschach test brings out this quite clearly in their large number of small "d" responses, their precise delineation, and their mode of apprehending the ink-blots.

Work is the obsessive-compulsives' preferred area of existence. Their life pivots around activity to the point of becoming "workaholics", enslaved by their work pressure without ever enjoying it. Nor do they enjoy themselves at play because they experience it as something scheduled, that has to be done as planned. And so they never really relax, but always tense in their deliberateness and effort to get things done. Hence they develop "will power", issuing wilful commands and directives to themselves, setting deadlines to fulfil responsibilities and accomplish tasks. They imagine their whole life like a train that has to run efficiently, stopping at predetermined stations and scheduled times. And even when they have finished their list of things to be done, they remain anxious about the next compelling duty. They live in the future through anxieties or in the past through guilt feelings but never enjoy the present.

The obsessive-compulsive is assailed by guilt feelings. More than ordinary, normal guilt feelings these become a complex due to their disproportionate nature. Strong guilt is experienced for instance in "entertaining impure thoughts" while little concern is shown when the next door neighbour has a serious accident. There is a self-centred attitude, a regression to an infantile stage.

Freud, in fact, explains compulsion neurosis as a regression to the anal-sadistic stage. Thus, the compulsive's main traits of orderliness, frugality, and obstinacy, reveal an anal-oriented instinctual life. Sometimes this anal-sadistic orientation reveals itself in the form of reaction formation, a defence mechanism usually employed as a defence against guilt feelings. Besides regression and reaction formation, certain symptoms may appear in the form of other defence mechanisms like sublimation, isolation and undoing.

Helping Obsessive-Compulsives

Helping the obsessive-compulsive Christians does not necessarily mean curing them of their disorder. Even in the world of psychotherapy there are no agreed norms to determine what curing really means. Ideally, it should help the person not only to recover by getting well but to maintain his health by staying well and avoid relapses. The psycho-pastoral aid given may at times mean providing enough support and courage for the person to live with an illness which may be chronic and incurable. At other times it may consist simply for the pastor or pastoral counsellor to offer spiritual strength during psychiatric treatment. Or to encourage the patient in the first place to seek medical treatment. But always to integrate the patient's

illness within his or her faith experience. Healing thus becomes, as Jung would say, a religious problem.

Needless to say, prevention is better than cure and so healthy training and education would provide the best guarantee against mental illness. But unfortunately most people come to us only when their neurosis has taken deep roots. But they do come. In fact, unlike paranoiacs, the obsessive-compulsives take the initiative and seek treatment themselves, often by trying different professionals. Psychologically, total permanent cure is rare, but improvement is registered and most of them manage to adjust in life.

As to what form of psychotherapy they need, psychoanalysis claims that compulsion neurosis is the second great field in which it is indicated since it is regarded as the second type of "transference neurosis" (cf. Fenichel, 1945, p. 308). However, compulsion neurotics have difficulty in "associating freely" due to their isolation propensities. This defence mechanism keeps them in their categorical thinking and holds them from letting go of their spontaneous feelings and perceptions. Hence one should be cautious in promising cure through psychoanalysis especially in severe cases of long duration.

Sometimes, obsessive-compulsives, like phobics, respond to behaviour modification methods. They may be helped by relieving their symptoms through the process of systematic desensitization. The therapist or pastor has to set limits for them within their compulsive structure (e.g. to check gas only once) without ridiculing their structure. The pastor may even make use of his authority to order them what to do and to reassure them. A form of Rational-Emotive or Reality therapy in confronting their unfounded guilt feelings – for instance with objective truth, Biblical doctrine, canon law prescriptions, etc. – may at times serve to pacify them.

But one must be careful in employing insight-oriented therapy with obsessive-compulsives. As already noted, these people already tend to place high premium on intellectual content and use it as defence mechanism against emotional involvement. Hence insight and cognitive processes would be therapeutically effective only if accompanied or followed by techniques emphasizing the personal and the emotional. In this respect I have found it helpful from experience to allow these people to come in touch with their feelings, create an atmosphere where they can express themselves without inhibition or censorship within them or outside them, let go of themselves in relationships and accept their limitations and vulnerabilities. These can be effectively accomplished in individual counselling, group therapy or in their natural environment.

Strong guilt feelings have been listed as characteristic symptoms of the obsessive-compulsive. It is important to make some clarifications on this point. The role of the therapist or pastor is not to remove guilt feelings. These have to be brought to the surface in order to disentangle their various meanings and origins and then for the therapist to locate the real guilt which must be faced and not minimized. To feel guilty about betraying one's

values or causing harm to a loved person is a normal reaction. But often the neurotic displaces the guilt from its true source to some insignificant offence about which exaggerated guilt is felt. This can be a subtle form of defence or denial of guilt. It can even make the person pretend to be moral, conscientious and "spiritually" proud. Deep down, the person is not really sorry at all but is using the remorse as a convenient way to evade confronting what actually prompted them to "sin".

For the Christian it is important at this stage to understand the difference between psychological, moral, and religious guilt; not to confuse conscience with the super-ego, and not to identify Christian holiness with moral perfection. Certain attitudes based exclusively on one's own deliberateness and resoluteness to overcome defects and become perfect betray more spiritual pride and neurotic perfectionism than a genuine Christian disposition of trusting in God's love and grace.

This kind of attitude is often detected in the scrupulous person who is tormented by every single fault committed, who feels a compulsive need to confess and expects a categorical reassurance from the priest about his or her state of conscience. In suggesting a pastoral care for scruples, Goldbrunner (1964) summarizes the medicine to be prescribed in the form of the following five 'tablets': no confession; recognition of sickness; obedience; no examination of conscience; no mortal sin (p. 93).

Pastoral aid

From the pastoral point of view, I think there is a lot one can offer by way of help to the obsessive-compulsive. I personally believe that the sacrament of reconciliation (confession), if properly administered and adequately revitalised, remains a major pastoral resource for Christians in general and for certain neurotics in particular. Paul Johnson (1953) himself advocates the practice of confession as an "honest relief in catharsis, and healing in a creative relationship of respectful appreciation, emotional understanding, and forgiving love" (p. 114). And Otto Fenichel (1945), exponent of Freudian psychoanalysis, admits that "confession certainly may cure or improve the neurosis of a faithful Catholic" (p. 550).

It is true that a false attitude towards confession may reinforce an immature Christian way of life. I know that for some, particularly adolescents, it is simply used for the relief of guilt feelings, to appease the super-ego, or as an excuse to self-indulgence. But confession can truly become a sacrament of reconciliation with God and neighbour and as a healing experience when it is lived as an encounter with God through the priest, of God whose love is greater than one's guilt and who accepts, forgives and offers spiritual strength to the sincere penitent. The experience of God's forgiveness makes believers less perfectionistic in their behaviour and more forgiving of their own flaws. The conviction that God can still love them despite their imperfect performance serves as a defence against relentless superego demands. And the expectation that special assistance

from above will be available in times of unusual distress or need provides yet another defence against excessive anxiety about the future.

In dealing with the scrupulous person, the priest or pastor should be aware of the basic psychological phenomena – often of an obsessive-compulsive nature – underlying the scrupulous behaviour. He should know that there may be deeply repressed unconscious sexual and aggressive wishes which are distortedly expressed through the symptom of scrupulosity. There are cases when a supportive type of counselling by the pastor himself may be sufficient to achieve improvement. At other times it might require a good number of psychotherapy sessions. In very serious cases, psychiatric referral may be indicated. In my own private experience of helping these people, I have found it necessary first to deal with the problem psychologically, spending a good number of sessions in depth therapy, and eventually integrate the spiritual dimensions in terms of their relationship with, and image and experience of, God. At times, certain directive orientations were needed. On the whole, a definite improvement could be noticed, but recurring tendencies could not be so easily eliminated.

Finally, I think the virtue that obsessive-compulsive Christians should be encouraged to cultivate is that of trust in God. God's love, care, providence and protection for them is always present. Since they are always anxious about the future and never enjoying the present, let them learn to leave tomorrow for God to take care of, trusting that He will. And since they are so guilt-ridden about their past and never experiencing the present, let them trust in God's mercy and compassion, and live today's life. Such surrender of their life into God's hands requires a deep spirituality that can only be fostered through prayer, meditation, the sacraments, and fellowship in the community.

Summary and Conclusions

The best way to conclude this article is to present its main points in order to bring out more explicitly its overall purpose and focus. And a clear, concise way of doing this is by formulating a set of propositions that summarize my basic ideas in this study.

1. A theology of psychopathology should be developed which would extend psychology of religion to psychopathology of religion and pastoral psychology to pastoral psychopathology.

2. The pastor or pastoral counsellor has a specific contribution to make in helping Christians with mental disorders both in the structuring of the counselling process and in the social setting surrounding the patient.

3. Such a psycho-pastoral aid should reflect an approach that integrates the psychotherapeutic with the religious while respecting the differentiation, and should express their inter-dependent relationship while respecting their autonomy.

4. Mental disorders are to be viewed not merely as a set of symptoms to

be removed but as an organized pattern, a way of life, a style of this individual person who needs to be helped in his or her whole being.

5. The scrupulous Christian is psychologically the obsessive-compulsive type who can be helped through individual or group psychotherapy experienced in the wider context of a loving, trusting relationship with God.

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