THE RELIGIOUS AND THE PSYCHIATRIST

By BERNARD GILSENAN

BEFORE WE consider in detail the question of emotional disturbance amongst priests and religious, it may be useful to begin with a general statistical survey.

The incidence of emotionally determined illness in the general population of Britain

Estimates of emotionally determined illness vary enormously, but data exist which make it possible to assess with some factual accuracy the likelihood of meeting people who are mentally ill. Current figures suggest that some seven and a half per cent of men, and a little over eleven per cent of women in England and Wales are likely to be admitted to a mental hospital once in their lifetime.[1] Moreover, the incidence of mental disorder, if hospitalization is reckoned as a valid indicator, increased by fifty per cent in the years 1951 to 1960.[2]

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[1] The probabilities of a first and subsequent admissions are:

	Men	*Women*
First admission	1 : 14	1 : 9
Second admission	1 : 28	1 : 20
Third admission	1 : 56	1 : 40

Official sources indicate that on 31st December 1960, for every 100,000 people in England and Wales, 262 men and 330 women were in mental hospitals. Total admissions for the whole of that year were 45,900 and 68,652 respectively. Cf Little, A.: 'Expectancy estimates of hospitalization for mental illness in England and Wales', in *British Journal of Sociology*, 16 (1965).

[2] *First admission rate per 100,000 population:*

	1951	*1955*	*1960*
Men	79	91	109
Women	99	108	149

A careful study, based on several practices in the London area, arrived at the conclusion that the incidence of emotional illness in a population of nearly 15,000 at risk amounted to 140 per 1,000, or 14 per cent. The majority of consultations were for psycho-neuroses (88.5 per 1,000), and 'psychiatric associated conditons' (48.6 per 1,000), a category used to include psycho-somatic conditions (29.9 per 1,000), organic illness with psychiatric overlay (15.0 per 1,000) and psycho-social problems (7.5 per 1,000). Cf Shepherd, M., Cooper, B., Brown, A. C. and Kalton, G. W.: *Psychiatric illnesses in General Practice* (London, 1966).

Studies of industry in Britain have shown that some 25 million working days annually are lost through mental illness.[3] It was suggested more than twenty years ago that in engineering plants emotional disorder was responsible for one quarter of all absence from work due to ill health.[4]

The frequency of emotional illness among university students has also been recorded, the figure of four per cent being given for severe psychiatric illness among Cambridge students, with an additional ten to fifteen per cent for less severe emotional disorders.[5] A study of students at Edinburgh and Belfast found that 9 per cent of male and 14 per cent of female students suffered from emotional illness.[6] The medical profession itself shows a high incidence of emotional illness, in that at least one male doctor in fifty kills himself before the age of fifty.[7]

The incidence of emotionally determined illness in clergy and religious[8]

The incidence here is significant, in spite of the relative incompleteness of relevant factual information. Dom T. V. Moore found

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[3] Hansard (Official report of proceedings in the British Parliament) for 1959.

[4] Fraser, R.: *The Incidence of Neurosis among Factory-workers:* Industrial Fatigue Research Board, No. 90 (His Majesty's Stationery Office, London, 1947).

[5] Davy, B. W.: *The Sources and prevention of mental ill-health in University students:* Proceedings of the Royal Society of Medicine (London, 1966) 53,764.

[6] Kidd, C. B. and Coldbeck-Meenan, J.: 'A comparative study of psychiatric morbidity among students at two different universities', in the *British Journal of Psychiatry.*

[7] Cf a'Brook, M. F., Hailstone, J. D., and McLauchlan, E. J.: 'Psychiatric illness in the medical profession', in the *British Journal of Psychiatry,* vol 113 (1967), pp 1013–23.

[8] The following comparative data concerning priestly, ministerial, psychological and medical personnel in Britain in the present century may be of interest:

Royal Medico-psychological Association

members:	*1901*	*1950*	*1960*
	722	1221	1920

(Population 32+m 43+m)

Medical and paramedical personnel		*Population per individual*	
1901	*1951*	*1901*	*1951*
95,777	278,236	340	157

Clerical personnel (all denominations)

1901	*1951*	*1901*	*1951*
56,210	51,198	579	843

Included in the latter totals were

Catholic priests and religious (including women).

1901	*1951*	*1901*	*1951*
9,307	17,154	3,495	2,580

It is frequently suggested that psychological ministry is replacing the priestly in this century. The above figures would seem to be some of the best available data relevant to a factual comment on this suggestion. Cf Halmos, P.: *The Faith of the Counsellors* (London, 1965).

that there was a higher incidence of mental illness in the general population of the United States than among religious, apart from the incidence of schizophrenia among religious women.[9] On this last point it has been urged that Moore's interpretation of the statistics he was handling may have been inadvertently alarmist.[10]

McAllister and Vandervelt, in considering factors in mental illness amongst hospitalized clergy, found that ninety-one per cent of these patients came from homes with dominant mothers.[11]

The case-studies of fifty-one clergyman psychiatric patients over a period of ten years revealed the following interesting comparison with similar studies of patients from the medical profession:

1. The clerical patients had a higher average age of breakdown, and presented themselves on average nearly seven years later than the doctor-patients.
2. There was a significantly higher incidence of both organic psychoses and sexual deviation in the sample.
3. There were no specific environment stress factors found common to the majority of these clergymen.
4. It is perhaps of interest that over forty-five per cent of the sample were unmarried.[12]

Priest 'drop-outs' in the United States

Though leaving the ministry and then getting married is not necessarily a sign of emotional disturbance, a Harvard priest-psychiatrist, Fr. James Gill, has concluded that the catholic priest who marries usually does so because of an occupational hazard which leaves him an easy prey for the first sensitive woman who comes into his life.[13] Fr Gill's findings became public at a time when

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[9] Cf footnote 10, *infra.*

[10] Bier, W.: *Psychological Testing for Ministerial Selection* (London, 1970), pp 77 ff.

[11] McAllister, R. J. and Vandervelt, A. J.: 'Factors in mental illness amongst hospitalized clergy', in *Journal of Mental and Nervous Diseases* 132 (1961), I, pp 80–88.

[12] Cf a'Brook, M. F., Hailston, E. J. D. and McLauchlan, I. E. J.: 'Psychiatric illness in the clergy', in the *British Journal of Psychiatry*, Vol 115 (1959), no. 521.
Only seven of this group of fifty-one were roman catholic (the doctors assumed that catholics are usually treated by fellow-catholic practioners). Special attention was drawn to the way the Church seems to deal with its members who show undesirable behaviour – e.g. chronic alcoholism or sexual deviation: the individuals seemed to have been moved from parish to parish with almost undignified haste. The remarks apply to both anglican and roman catholic. The authors also suggest that it would be of great personal as well as professional benefit to the clergy if their training included the basic principles of psychology and psychiatry.

[13] Fr James J. Gill S.J. is on the staff of Harvard University health services. His findings

the Church in the United States was losing an estimated 2,500 priests annually. The study suggests that these losses reflect not a mild moral breakdown among some priests but a serious loss of priestly morale. Most priests who abandon their vocations in order to marry suffer from a deep depression, fed by an institutional climate which fails to cater to the 'ego'.

Gill dismisses the notion that celibacy in and of itself is a major causal factor in the decision of priests who leave the ministry. 'I find that the priests who are leaving and marrying are virtually all depressed'. This is not to say that every drop-out priest interviewed falls into this category; but that the statistical predominance of those who do is very striking.

The priest drop-out is most often a man who finds himself taken for granted in a crowded system that often denies the human need for a pat on the back. This discovery causes some of the Church's most dedicated and talented priests to become sad and lonely, disillusioned and resentful; 'These are task-orientated men who were raised by their parents in such a way that the achievement of goals – particularly difficult ones – appeals strongly to them. They go about their work in a compulsive, perfectionist way, not seeking or enjoying pleasure from it, but aiming unconsciously at the recognition and approval they will gain from those they serve'. When this recognition and approval elude him, the emotionally vulnerable priest is in serious trouble, often without even knowing why.

The Gill findings reveal that it takes between five and fifteen years for a priest to experience the disillusionment that inevitably leads to a crisis. Priests begin to feel that they are being taken for granted when they find nobody who seems to care how hard they work to prepare a sermon or teach a class. They have so consistently performed in a better than average and reliable manner that their bishops and religious superiors simply expect them to do a good job. Applause comes less frequently as the years go by. They begin to feel more and more dissatisfied with themselves, with their role in the Church and with their requirement of celibacy. The priest then becomes unhappy with his lot in life and pessimistic about his future; and this is when the emotional explosion comes.

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are based on a survey he conducted by means of interviews with about a hundred priests who have left the active ministry. His report was quoted extensively by James Stack in an article in the *International Herald Tribune* for 10 March, 1970.

Personality and the religious life

There are many ways, largely determined by constitution and early experience, in which individuals try to adapt to situations. These efforts at adaptation have been described as defences: they are unconsciously aimed at protecting the individual from anxiety. Four main types may be distinguished: hysterical, obsessional, depressive and paranoid. Since all of these occur in religious who encounter difficulty of personal adjustment, it will be useful to consider these types singly.

Hysterical This is the reaction *par excellence* of the immature person to real or imagined deprivation of love in early life, to an unsatisfactory dependent relationship with parent figures in childhood.

Obsessional As this reaction type, in its milder manifestations at least, passes so often for normal in the religious life, it merits some detailed attention. The following pen picture describes it: the cautious, reliable, conscientious, often over-serious man who is ambitious and self-driving, finding it difficult to relax. He frequently finds his only outlet in work and when perforce not at this, he attacks his leisure time with the same relentless fury. A stickler for order and routine, he is characteristically neat and tidy, not only in his work but also in his appearance and even handwriting. When in charge, he tends to drive his subordinates at the same pace as he drives himself, sometimes with unfortunate results. He dislikes change and prefers to work against a familiar background. His susceptibility to rebukes and fear of failure makes him take every step to avoid these, hence his value as the reliable subordinate. A prey to indecision and scrupulosity, the responsibility which entails the taking of risks and dealing with the unusual tends to cause him more than ordinary anxiety. Typically unaggressive, he tends to hide his inner emotional insecurity behind rules and regulations, which are for him both a weapon and a refuge.

Depressive These are the charmers of the world; self-effacing, non-challenging, they endear themselves to their colleagues but are a pain often to themselves. Their self-effacement gives little hint of the considerable aggression beneath the surface. These are the representatives in adult life of children who, discomfited by aggressive conflicts in the deeper strata of their personalities, find in acquiescence and conformity a safer way of life, less destructive and so less likely to lead to loss of love. Their social acquiescence, attributes of their *persona*, contrasts violently with their inner 'badness', which must not be allowed to reveal itself.

Paranoid An alternative, and to some a less anxiety-producing way of dealing with aggressive drives, is not by turning them inwards as in the depressive, that is, by introjection, but by projecting them outwards, so that the threat appears to come from without. These are the people with chips on their shoulder, the awkward customers, whose consequent repeated experiences of rejection lead to their progressive isolation and increasing unhappiness.

What happens to these people in religious life? All of them, when these traits are present in them in exaggerated form, give rise to unease in the group in which they operate: the hysteric by his incessant demands for satisfaction of his love-needs, the obsessional with his inflexibility which makes him a trial to his subordinates, the depressive with his diffidence and unrealistic self-effacement, and the paranoid with his feelings of persecution.

Group situations magnify difficulties of adjustment, for these are more difficult to handle than one-to-one relationships. How often do we hear: 'Oh, he isn't a bad sort, really, when you get to know him'? In a group situation, the effect of individual maladjustment can be very disruptive. Hence the well-recognized fact that in religious life it is the small rather than the big things that test one's emotional resources. The struggle with the devil may pale into insignificance when compared with the struggle with one or other of one's colleagues.

The above character traits are present in many if not most of us. And of course when present in moderate degree, they allow of adjustment to most situations. Where, however, their presence is very marked, overtly or covertly, it can be seriously questioned whether they will permit the necessary psychological adjustments to community life. Until recent years, the relatively rigid structure of religious life has tended to conceal personality problems; this is why great anxiety has been caused to some individuals by the removal of the old familiar supporting structures.

So, in the consideration of personality structure and religious life, the necessary action would appear to be twofold: the screening of candidates and the availability of expert help for those already committed who are in need of such help. It cannot be stated too often that one is not responsible for one's feelings, the roots of which are outside conscious control; but that one must accept responsibility for what one does about them. This needs emphasizing, if only because it is feelings that give rise to so much irrational guilt and thus to so much unhappiness.

Another cause of disturbance among religious is the accelerated pace of change in the Church. This subject belongs to a relatively new discipline in psychiatry, transcultural psychiatry. An american psychiatrist, Dr. Thomas Doyle, has written on its implications for religious life.[14] There are indications that sudden socio-cultural change in any group causes profound disturbance in the individuals of the group; and the consequent reactions depend on the personality structure and varying strengths and weakness of the individuals concerned.

The catholic Church, and indeed all christianity, is involved in such a major and sudden socio-cultural change at the present time that adjustment problems – sometimes serious ones – present themselves to all alike. Insight into these cultural impacts may contribute to new personal insights, thus stabilizing the process itself; whereas maladjustment may lead to emotional disturbance in more vulnerable individuals.

Dr. Doyle then proceeds to consider the effects of the socio-cultural explosion resulting from Vatican II on three groups, in ascending order of emotional maturity.

Group I – Most immature

Personality traits: Are often direct, naive, agreeable, passive, dependent, emotionally unsure, obsessive and rigid: but can have partial insight.

Explosive reaction: Withdraw, become tense, the original personality traits show in greater force, may manifest symptoms such as anxiety, attraction to alcohol, sex preoccupation, or also capacity for growth.

Group II – More mature but still with limited insight

Personality traits: Are often bright, quick, dependent, artistic, idealistic.

Explosive reaction: Become tense, fly off in different directions, go for anything new, underrate themselves and the Church, have unconscious hostility which comes up in hidden ways. Take refuge in the views of others. Range from feeling superior and wanting to disrupt the Church to chronic arguing and paranoid reacting; or can rise to more growth, with ability to contribute new christian concepts and to relate better.

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[14] Doyle, Thomas L.: 'A Psychiatrist reflects on the changing Church', in *America*, 7 March, 1970.

Group III – Most mature

Personality traits: Are often well organized, good contributors, handle sexuality and instincts well, sublimate impulses readily and make choices freely, handle ideals flexibly.

Explosive reaction: Undergo tension and groping, but generally move to more growth and fulfilment; if subject to excessive stress, may reach for free sex life; can turn against ideals and the structure on the grounds that they have deprived one of some values and satisfactions.

Dr. Doyle describes a basic structure for healthy and complete christian life:

1. Help make a true community marked with christian sharing; do good to others, worship together with others around the central reality of the Mass.
2. Establish true feelings and behaviour on the basis of what we know to be good – out of the commandments, traditions, the Church, our culture.
3. Practise an ever maturing use of one's instincts for good, while avoiding abnormal guilt.
4. Love oneself and others.
5. Show a willingness to assume responsibility and to serve Christ by one's actions, counting on the aid of sacramental grace.

Emotional maturity

It has been held that one can dispense with diagnostic categories in the neuroses, labelling them all emotional immaturity in greater or lesser degree. This does no more than pay due recognition to the fact that it is the immature personality that is vulnerable to stress: the only distinction between the immature and the neurotic being that the latter develops symptoms, either physical or social.

The various schools of psycho-pathology have analogues, and there are meeting points between the behaviourists, the freudian and the gestalt schools, to mention only a few. Both the freudian and gestalt schools recognize tasks of childhood which have to be completed before adulthood can begin. If they are not completed (that is, in analytical terminology, worked through), then they can interfere under certain circumstances with adult life.

The all-important task of childhood is to achieve a satisfactory resolution of the early significant inter-personal relationships; that is, to achieve a balance between our needs as growing children and the

needs of our parents or surrogates, and to learn that the expression of our needs does not necessarily bring us into such conflict with our parents that we lose the feeling of security so necessary to the developing child. Childhood can be regarded as the time for receiving love, and this love must be unconditional, given regardless of our looks, skills or achievements. Adulthood is a period of giving love, although there is, as in childhood, a certain reciprocity of give and take.

Early childhood is a time of needs; if these are inadequately met in the early developmental period, they may, although repressed from consciousness, exert pressures on the presonality later on. Here it may be useful to distinguish between need which may or may not be conscious, and wishes and desires which we can look upon for our present purposes as acting on a conscious level; that is, needs, infantile, and desires, adult.

The important thing here is the extent to which these drives come under the will and are therefore disposable. Take for instance the child who has been emotionally deprived. Here the need to be loved or accepted may dominate the whole life-pattern, and attempts at control of this need may be ineffective, or lead to depression or symptom formation. Love is, so to say, not at our disposal, so that we are unable to give it. It is axiomatic that we cannot give what we have not got, and one of the characteristics of adult status is the capacity to give love. If we are mature, we are free; free to make decisions and to act, untrammelled by the intrusion of infantile needs. We are able to achieve objectivity, to make rational judgments, more or less. More or less, because the intrusion of emotional elements is difficult, if not impossible, to eliminate completely. The more these emotional elements intrude, the less objective our judgment becomes.

What then are the characteristics of the mature adult? This list, which is not comprehensive, is an attempt to describe the important ones:

1. A capacity for satisfactory inter-personal relationships.
2. A capacity to make rational judgments and decisions; that is, those determined by the needs of the situation, more or less, rather than by our conscious desires or unconscious needs.
3. A capacity to identify with the needs of others in a controlled way, and to respond to them.
4. A capacity to maintain a consistent and predictable pattern of behaviour.

5. To give in love rather than to take; to have more concern and respect for the personality and needs of the loved one than for our own.
6. To be capable of a satisfactory object-choice in marriage.
7. To have a fair degree of insight into our own motivation.
8. To have come to terms with our instinctual drives, so that we can exert an adequate measure of control over them, rather than be controlled by them.

Sexuality

If Freud and his followers had used the word sensuality[15] instead of sexuality, his theories might have found greater acceptability at the time they were propounded. The child lives his early years by feeling, seeking what is gratifying and rejecting what is not. The essence of sexuality is union; and although, clearly, auto-erotic practices do not achieve this, it is interesting that people tend to have recourse to them when anxious, depressed or rejected.

After the first rejection, which is birth, the first union is the child and its mother's breast or substitute. Much of freudian theory centres round conflict, love and hate, incorporation and destruction at this period.

Whether the anal phase, in which the child experiences pleasure in its excretory habits are, as the neo-freudian R. Fairbairn would say, merely important because of their effect on the relationship to the parents, is in doubt. Classically, of course, it is linked to the obsessional character, and the primary drive related to it is aggressive.

Much has been and will continue to be written concerning masturbation; and it would seem that some of the authorities have not had all the physiological facts available to them, for example the researches of J. Oswald in this country and Loomis in the U.S.A., into paradoxical sleep.[16] The freudians were naturally

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[15] Cf the *Note on Sexuality and Sensuality*, infra, pp 86–92.

[16] It is now recognized that sleep can be divided into ordinary sleep (the periodic condition of rest, during which consciousness is in abeyance) and paradoxical or dreaming sleep. Ordinary sleep is normally punctuated by several periods of paradoxical sleep. The objective evidence for this division is the occurrence during paradoxical sleep of rapid eye movements that can be picked up by electrical apparatus. It is during these periods of paradoxical sleep that we dream, and, if deprived of sleep, by drugs for example, the loss is made up in increased periods of the dreaming sleep. We all dream but we do not all remember our dreams. Cf Oswald, Jan: *Sleeping and Waking* (Amsterdam & New York, 1962), and Kleitman, N.: *Sleep and Wakefulness* (Chicago & London, 1963).

delighted to know that there was demonstrable evidence of sexual excitation, in the male at any rate, at intervals during the night, during the phases of paradoxical sleep.

It is, of course, impossible to make any generally valid statement about the moral culpability of masturbation as an occurrence. Whether or not we regard it as an event of an exploratory nature in the process of maturation, there is an increasing awareness of how many factors can affect responsibility for the occurrence of what is called masturbation.

In the same way, homosexuality may be regarded as a symptom of maladjustment, in which the object-choice may be the only one open to the individual. The evidence suggests that it is not constitutional (that is, inborn), and West and others have described certain observable familiar patterns. The theoretical explanation advanced is that there is an inability at the age of four to six years to transfer the identification with the mother to the father. Not all mother-fixated males are homosexuals, but in many male homosexuals an unusual relationship with their mother would appear to prevent them developing any satisfactory relationship with women in general.

An interesting point arises regarding responsibility for homosexual acts. It may be thought that if heterosexual adults are expected to exercise control, then why not homosexuals? At first sight this seems very plausible. The fact that they do appear to have more difficulty in doing so may be due to their immaturity and relative social isolation, and the lack of responsible control that tends to occur in these immature persons. The evidence, although conflicting, seems to suggest that overt homosexuals are, *qua* their homosexuality, untreatable. If this is in fact so, it would seem that this should generally disqualify them from entry into religious life. (The term homosexuality is used rather loosely; and certainly there are homosexuals who never give overt expression to their sexuality.)

There is a broad group to which the term 'latent homosexual' is applied, and this is a very important concept clinically. These are people whose interest in relationships is with their own sex, although the sexual component remains unconscious. The latent homosexual is one whose homosexuality is repressed into the unconscious, and is often compensated for by over-masculine attitudes in the conscious. There would not appear to be any necessary barrier to entry into religious life, if this type of person is otherwise stable. It would seem probable that many exemplary priests and religious would fall into this category. It has been held that the energy and drive

of the creative artists may arise from unconscious homosexual conflict.

The Don Juans, the nymphomaniacs, and many prostitutes are considered by many to be basically homosexual, their overt activities being regarded as defences. Certainly their incapacity for total commitment to their many partners is indicative of emotional immaturity, in which genital sex has become dissociated from the mature sexual inter-personal involvement which alone gives sexuality its proper moral place.

Treatment

By reason of its high incidence, the mass of psychiatric illness in the general population has to be treated by general practitioners aided by the social services, and it is to these that referral of psychiatric casualties should be made in the first place. The work of the late Dr. Michael Balint at the Tavistock Clinic in London has helped to spread psycho-therapeutic skill and understanding among general practitioners, and has made up for much neglect in this respect in their undergraduate training.[17]

The general practitioner can get expert help from the consultant psychiatrist. Consultant psychiatrists have general training in psychiatry, but their skills and fields of interest tend to become polarized between symptomatic relief of their patients by the use of drugs, and of treatment by psycho-therapy, superficial or deep. The concept of dynamic psychiatry is central to psycho-therapy. H. H. Wolff has put on record some of the considerations that led the Society of Clinical Psychiatrists to set up a study group to consider the place of dynamic psychiatry in medicine:

1. The high incidence in the population of emotionally determined illness, both physical and mental.
2. The changing approach of the psychiatrist. Psychiatry, in considering mental illness, has developed beyond the classical model; in addition to its concern with biological factors, it now recognizes the equal importance of human experience, including psychological and social factors and their interaction; an integrated approach referred to as the dynamic approach.[18]

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[17] Balint, Michael: *A Study of Doctors*, Mind and Medecine Monographs, no 13 (London, 1966).

[18] Wolff, H. H.: *The Place of Dynamic Psychiatry in Medicine* (Society of Clinical Psychiatrists' Reports, London, 1971).

3. In spite of the growing recognition that in all branches of medicine psychological factors are often as important as biological ones,[19] the practical applications of this development are far from being properly implemented either in the practice of medicine or in the training of doctors.

Dynamic psychiatry commenced to all practical purposes with Sigmund Freud at the end of the last century. Primarily an organicist, he developed a system of treatment called psycho-analysis. This has developed from a biologically rooted instinct psychology, under the influence of the so-called neo-freudians, to an ego-psychology in which inter-personal relationships are the main field of study. There have been in addition numerous offshoots from the parent stem, for instance Jung and Adler. Classical psycho-analysis involves sessions of approximately an hour five times a week for several years, and for reasons of expense and time is available only to the few. Most psycho-therapy is limited to hourly sessions once to three times a week, with a duration of a few months to a few years.

Group psycho-therapy of various kinds has been developed and is useful in certain cases.

H. H. Wolff says that the term 'dynamic psychiatry' refers to an integrated approach which tries to understand the experience and behaviour of the individual, in health and disease, as the result of the dynamic inter-action of multiple forces or processes, including the biological and psychological, the intra-psychic and inter-personal, individual and social. It emphasizes the continuous inter-action of psychological and physical phenomena and the influence of personality development since childhood, as well as of social relationships, on present-day patterns of living and reacting. In the latter context, it concerns itself especially with the study of intra-psychic phenomena, including conscious and unconscious mental processes, with inter-personal phenomena, especially the doctor-patient relationship, with the relation of the individual to the family, society and culture to which he belongs; and finally with all the processes of human inter-action and social learning which this involves.

Emotional development cannot take place without satisfactory inter-personal communication in childhood. Psycho-therapy gives the emotionally immature another chance.

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[19] Vickers, Sir Geoffrey: 'Medecine, Psychiatry and General Practice', in *The Lancet* (1965) I, 1021–7.

There are three areas determining one's emotional health:

1. Constitutional – one's nature.
2. Development – one's nurture, the early dependent, largely non-verbal period.
3. Environmental – the present situation, emotional, occupational, with its stresses.

Dynamic, that is, non-directive, psycho-therapy is concerned with the second area, that is, developmental, and may have various goals, from an attempt at a radical change in personality to one which is limited to the reduction of symptoms.

An essential feature of the psycho-therapeutic situation is confidentiality. Defences are built up by the unconscious against anxiety-laden unconscious conflicts. These defences are in themselves unconscious, and will only give way in a situation special to psycho-therapy, that curious affective relationship between treater and treated: that is, the transference and counter-transference. This cannot be connived at; it has simply to develop when the inter-personal communication system between psychiatrist and patient is emotionally favourable to its development; confidentiality is a prerequisite of this.

Unconscious defences or resistance must not be confused with those conscious defences, implicit in such exhortations as: 'Why don't you get it off your chest, you will feel better'. The procedure of psycho-therapy, let it be said at this point, has only a superficial resemblance to the situation of the confessional; and it is one's general experience that priests recognize their limitations in dealing with emotional disorders.

Reports should only be given with the patient's knowledge and consent. Superiors do not send religious for treatment to make them better religious, any more than husbands send their inadequate wives to make them more adequate. They may become better religious; it is to be hoped they become better people, even where they cease to be religious.

Treatment may be twice or once a week for anything from a few weeks to a few years, depending on the nature and duration of the disturbance and the goal of treatment, that is removal of symptoms or more radical personality change, where this is possible.