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RELIGIOUS FACTORS IN
MENTAL ILLNESS

Religious Factors in Mental Illness

WAYNE E. OATES

LONDON · GEORGE ALLEN & UNWIN LTD

*First Published in Great Britain
in 1957*

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*Printed in Great Britain
by Bradford & Dickens, London W.C.1*

TO
ANTON BOISEN

PREFACE

THE •RELIGION of the mentally ill person often matters greatly to him. He struggles with the need for meaningful identity and with the threat of destruction. Amid his struggle, his religion often becomes a matter of life and death for which he is willing to risk all. The plain intention of the following pages is to present a discriminating but sympathetic understanding of the religion of the mentally ill person from his point of view, to interpret his religious experience as it goes on within him and between him and his spiritual community. Naturally such a discussion will involve both theological and psychiatric information. An attempt will be made, however, to discuss the religion of the mentally ill with as little reference as is possible to the sectarian elements of both religion and psychiatry.

An interpretation of the religion of the mentally ill has much to offer toward developing better communication between the minister and the psychiatrist in their co-operative endeavor to understand the patient as a person and to make this understanding count toward his recovery. The education of both the psychiatrist and the minister is so highly specialized that neither has had much time or infor-

mation to consider the particular ways in which their disciplines overlap at the point of the religious life of the mentally ill patient. Such a deficiency in the education of both the minister and the psychiatrist handicaps communication between the two professions. An interpretation of the religion of the mentally ill, therefore, should help in the clarification of the relationship of both the minister and the doctor to the mentally ill patient at the point of his specifically religious needs.

Furthermore, a careful consideration of the religion of the mentally ill should offer constructive suggestions in the direction of the purification of religion itself. The cleansing of the inner motives of religious teaching and practice is a spiritual exercise continually demanded by the prophets, the apostles, and Jesus himself. Such a discipline is implicit in any attempt to understand the religion of the mentally ill, and has certainly been a challenge to this author in his efforts. But the first fruits of such discipline is to bring the resources of religious faith antiseptically nearer to the inner wounds of mentally ill persons. These are the wounds, as William C. Menninger says, "that draw no blood," and as Isaiah says, "have not been closed, neither bound up, neither mollified with ointment." The end results of an understanding of the religion of the mentally ill obviously point toward the prevention of the damage done by emotionally contaminated religious teaching and practice. For it is not the will of the Father which is in heaven that little children, questing youth, and struggling adults should perish or

have heavier burdens bound upon them by an exploitative kind of religion.

Finally, an interpretation of the religion of the mentally ill should contribute materially to the psychological understanding of religious experience. However, especial care has been taken here to avoid making unwarranted generalizations about religion on the basis of a study of the religion of the mentally ill. Lines of continuity can be drawn from the experience of the mentally ill to that of the populace in general, *but they are not easily drawn*, and if they are drawn accurately, they are not usually straight ones. This conviction grows out of the author's concern, shared by many others, as to the confusion caused by the easy generalizations upon second-hand reports about the mentally ill which are prevalently discussed in the popular press today. Nevertheless, much of what is said in these pages applies with a dependable accuracy to religious experience in the lives of persons who are not mentally ill. Many of the difficulties in living and the ways through those difficulties that are discussed here are "such as are common to man." They are not solely the troubles of mentally ill persons. Rather, they reveal the kinship between the mentally ill and the mentally well in their basic humanity.

Stated briefly, then, the purposes of this book are threefold: (1) to interpret the religion of the mentally ill as nearly as is possible from the patient's point of view; (2) to provide through such an interpretation another basis of communication between ministers, psychiatrists, and social workers in their

work together in understanding and ministering to the mentally ill; and (3) to contribute to the psychological understanding of religion itself. In this way, mentally ill persons are not only ministered unto but also minister to the larger community. By their suffering are we made more mature.

WAYNE E. OATES

ACKNOWLEDGMENTS

Particular expressions of gratitude are due many persons for invaluable assistance in the development of this book. Association Press, under the able guidance of James Rietmulder, suggested the subject and followed the development of material step by step in the whole process of writing. The psychiatric clinic of the Norton Memorial Infirmary, under the direction of Spafford Ackerly, M.D., and E. E. Landis, M.D., has given the author full access to their technical assistance and institutional resources. They provided a learning situation for students of the author in relation to their clinic. They have contributed to the author in innumerable ways over ten years of professional interrelationship in the ministry to mentally ill patients.

The author is especially indebted to Dr. Samuel Southard and a clinical training program which the author jointly supervised with Dr. Southard at Norton Memorial Infirmary in Louisville, Kentucky. Dr. Southard, and the students—Cornelius Davis, David Edens, Thomas Lewis, Robert Pinder, Chester Raber, and Rentz Thomas—worked with the author in the development of the outline of these pages.

During the actual writing of these pages, the author was teaching at Union Theological Seminary, New York City, in the summer session. The students

whom he taught were unusually helpful in permitting him to "try out" some of the ideas with them as an audience as he wrote the various chapters. Mrs. Wallace Denton, a member of the class, participated more specifically than others in that she typed the manuscript and made many helpful suggestions to the author.

Professor Seward Hiltner of the University of Chicago and Dr. Simon Doniger, editor of *Pastoral Psychology*, read the manuscript and gave detailed guidance to the author in many ways. Likewise, Spafford Ackerly and E. E. Landis have taken valuable time to read the manuscript and to make discerning suggestions for improvement. The pervasive influence of Anton Boisen, teacher and friend of the author, appears on the whole pattern of thought here. The dedication of the book is only a symbol of the deep respect and gratitude of the author to this intrepid explorer of the inner world.

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Many persons are quoted but not named because of the author's sensitivity to medical persons' need to be anonymous and avoid publicity. To this group the author has already expressed personally his appreciation.

W. E. O.

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ONE

The Hindering and Helping Power of Religion

PASTORS ARE ALWAYS HAPPY to find workers for a vacation church school. People are quite willing to have their children off their hands for the morning hours for a whole week. They are not as eager, however, to take the responsibility for teaching in the vacation church school that makes this possible. Therefore, the pastor of the Glenn Allen Church was elated when a total stranger, a tall, somewhat wistful-looking girl of about twenty years of age, came into his office and asked if there would be a place for her to work with the children. He immediately put her to work in the junior department. But he noticed some strange things as she went about her work that week: she took great care to ask each one of the workers if they were Christians; she kept herself apart during the recess period; she was not comfortable in talking with the other workers; she did not seem to want to let them learn more about her.

Wednesday evening came and the prayer service was in progress. In the middle of the pastor's interpretation of the Scriptures, the girl came forward and asked for the privilege of "giving a testimony." When she was permitted to have her say, she became speechless and broke into tears.

She was completely disturbed, saying, "The Holy Spirit made me do it." The pastor sought the aid of the doctors in the church. They worked with him in getting immediate hospital care for the girl, because, they said, she was in the throes of a psychotic episode. The members of the church became sensitively concerned about her and in co-operation with the doctors and their minister began to learn more about mental illness, and the way religion hinders and helps in the integration and disintegration of the personality of such a person as they had encountered here. Immediate psychiatric attention brought dependable results of healing to the girl. In about two months she returned to her work. Her perception of her religious duties had been clarified, and the resources of the Christian faith had been brought to her aid by her pastor and her church in such a way that she found it easier and more secure to live in the community than she had ever found it. She has enjoyed six years of restored health thus far. The church became a sort of family to her in which the power of Christian love was incarnated and made real to her.

However, the pastor, in reflecting upon this with his doctor friends, could legitimately ask the question: "Was the girl's religion helping her or hinder-

ing her in her search for the meaning of life and the direction of her work?" The physician knows that his therapies are sometimes as dangerous as they are useful. Proper quantities of a drug, rightly administered, can bring health and renew life. Overdoses, clumsily and ineptly administered, may bring disaster. The healing truth of the Christian gospel, the Apostle Paul said, "is the power of God for salvation. . . ." His word "power" comes from the Greek word from which is transliterated the English word "dynamite." Religion is just like dynamite; equally as dangerous as it is useful. Therefore, the psychiatrist is wise in recognizing that religion *can* be dangerous to his patients; he calls the attention of the teacher of religion to that which he tends to forget: the dynamic character of the religion he professes and teaches. Religious educators, being reminded of the power of religion to hurt as well as to heal, have begun to re-examine not only the theological nature of the gospel proclaimed but the ways in which that gospel is communicated and administered to the growing lives of children and the imponderable difficulties of adults.¹ Personal acquaintance with mentally ill persons dramatically clarifies the "hindering power" of religion as it appears in the lives of psychiatric patients. But even closer study of the needs of the patient enables one to re-evaluate the "helping power" of religious truth. Thereby the character of sound religion is better understood in the light

¹ See Paul Tillich, "Communicating the Gospel," *Union Seminary Quarterly Review*, Vol. VII, No. 4, June, 1954, pp. 3-10.

of the prevention, amelioration, and healing of mental illness.

A vast quantity of superstition and pseudo information associated both with mental illness and religious experience clings to the attitudes of persons toward a religiously concerned mental patient such as this one. Popular misconceptions concerning mental illness are legion. Probably the "one-cause" error is characteristic of most interpretations of mental illness—that *all* mental illness is caused by *one* particular factor. For instance, one of these popular misconceptions is that "people go crazy over religion." Occasionally highly educated persons who, for some reason or other, have found the religious quest alien to their own purposes in life hold this misconception uncritically. Underlying such thinking, however, is the basic question: What role does religion play in the formation, precipitation, and maintenance of mentally ill reactions to life? Another thought-provoking question is also implied: What can we learn from mental illness as to specific ways whereby Christian teachings may enable the religious person, with all his believing, to be mentally healthy?

The word "sound" when applied to religious doctrine today too often means "conformity" to a particular interpretation of a Christian teaching. Those who proclaim most loudly the soundness of their doctrine are often driven to mutilate the personality of others, alienate Christians from each other, and make ineffectual the witness of the controversialists to persons who are not Christians. But, in the New Testa-

ment, the word translated "sound" (Titus 1:9) means "health-giving" or, in other words, a teaching that is "hygienic."

Careful analysis of the actual experience of religion among mentally ill patients will reveal some of the differences between "health-giving" and "health-destroying" religions. A knowledge of these differences will increase the psychiatrist's understanding of the religious living of his patients. Parents, teachers, and ministers should be enabled more adequately to communicate a wholesome religion to children, youth, and adults. An understanding of religious experience can be developed that goes beneath the externals of religious caste, class, and creed to the inner appropriation of religious truth whereby men find access to each other by reason of their personal relationship to God.

A group of 10 students under the supervision of the author, as chaplain at the Kentucky State Hospital, Danville, Kentucky, studied the religious experience of 68 mentally ill persons. The study was really a quest for "leads" as to the role that religion played in the psychotic conditions of the patients. These findings have been written up more extensively,² but a summary of some of them is appropriate here. The procedure consisted of interviews with patients. The results of the interviews were later compared with the psychiatric diagnostic data and the social casework history, and discussed with the psychiatrists.

² See *Religion and Human Behavior*, Simon Doniger, ed. (New York: Association Press, 1954), pp. 88-106.

Eleven, or 17.2 per cent, of the 68 cases showed a conflict of long-standing rebellion or submission on the part of the individual toward the religion of his home. Sometimes they alternated between rebellion and compliance toward the religion of their family. In most of these instances the religion was not an inner spiritual discernment, but an experience tied up with the individual's anxious rebellion toward his parents.

In 10.3 per cent, religion was taken as a "last straw" attempt to solve otherwise unmanageable problems, and to justify failures in personal relationships and losses of self-control. The religious responsiveness of these patients was viewed both by psychiatrists and chaplains as a precipitating factor, a sort of counsel of despair, setting off the crisis stage of illnesses which were already in motion before the individual was influenced by a religious individual or group. Then the individual or group would suggest religious ideas and practices that in themselves became a problem to the patient. For instance, a girl lost her job, and was deserted by members of her family in a large city after the death of her mother. She told her trouble to a middle-aged woman, an ardent participant in the Oxford Group, or Moral Rearmament. She was told that she should concentrate on being "compelled by the Holy Spirit," following divine guidance in every detail of life, and making Christians of others. The girl came to the hospital after having stayed up all night for three weeks going from door to door in her neighborhood, asking people if they were Christians. She would not

turn a corner of the street without asking divine guidance. Obviously, the religious woman inadvertently had supplied a psychotic girl with a set of religious symbols that she took literally at the onset of her illness. Her doctors felt that the conversation served as a "trigger" for setting off the illness. She would have been ill without this trigger; however, the manifestations of her illness might have been quite different, even though religious in character.

A third group of the 68 patients in this study indicated that 20.5 per cent of the patients' psychotic conditions were simply "clothed" with religious ideas. These patients quite often picked up their ideas from other patients or talked to the chaplains with religious "chatter" simply because they were ministers, or used religious expressions as a means of getting attention, approval, or favors. Little or no religious concern appeared in the pre-psychotic history of the persons. In about half of these cases the chaplains were able to develop a real religious interest in them. Apparently, patients who were this conscious of how the chaplains felt about them had gone a long way already toward recovery. Seven of this group of patients were dismissed from the hospital during the ten-week period of the project.

The study of this group of 68 patients, however, revealed that 51.5 per cent of them showed no evidence at all of religious interest or past religious influence. This is true even though they came from rural communities in southeastern Kentucky, which is supposed to be a very active "Bible belt" area, and which is also highly productive of independent reli-

gious sects of an ecstatic nature.³ Whereas much has been written about the repressive effect of religious teaching, these theories are inadequate to explain how over half of these patients were suffering from essentially the same kind of illnesses as were their more religious fellow patients.

Several reflections may be noted here from this study with reference to the religion of the mentally ill. However, these are reflections in every sense of the word and not conclusions, because statistics at best are not too convincing. One comment that stands out is that religion can often hinder the growth and mental health of persons if their parents have depended solely upon religious precepts as a means of dominating and controlling their children. Religion becomes an external burden to the growing child and something from which he seeks deliverance, even as he tries to achieve independence of his parents. The failure to achieve a wholesome and autonomous selfhood may take the form of mental illness, and religion is likely to be a maintaining factor in the illness.

Another reflection, however, counterbalances this observation. The absence of any form of control and the unbridled freedom of a parent-child relationship can be equally unhealthy. The extensive absence of religion in the group of mental patients was as noteworthy as the unhealthy presence of religion. The meaningless, uncurbed, and unguided anxiety evi-

³ See Harold Pierce and Celia Kraft, *Dew on Jordon* (New York: E. P. Dutton & Co., 1946) for a description of the religious frame of reference evident in this area.

dent in the patients to whom religion meant nothing was equally as poignant as the bondage to the dead forms of religion evident in those to whom religious living had been misrepresented. As long as a person has not discovered the limitations of his own desires, the binding power of personal responsibility, and the inner discipline of an all-inclusive loyalty, he is particularly vulnerable to the ravages of mental illness as he grows older. But on the other hand, as long as another person must maintain a denying spirit toward religion in order to affirm his freedom of tyrannical parents, the form of religion given him by his parents remains a dead tradition from which he seeks deliverance. His wretchedness in mental illness may be a part of his prayer for deliverance from the "form of godliness," the power of which he has not discovered (II Timothy 3:5). The power of religion is consumed in the denying spirit, and the form becomes an offense and a hindrance.

Samuel Southard made a second study of 170 patients with whom he conferred as chaplain of the Central State Hospital at Lakeland, Kentucky.⁴ This hospital serves the Louisville (Kentucky) area, an urban community of 400,000 people. Most of the patients are drawn from the city of Louisville, and their denominational background was more diverse than that of the patients in the Danville hospital. Southard discovered that denominational clashes between parents and their children figured considerably less

⁴ Samuel Southard, "Religious Concern in the Psychoses." Unpublished paper, 1954.

than was evident in the Danville group. He attributed this difference to the fact that the concerned patients in the Danville hospital were more often from a rural environment, whereas the Lakeland patients were predominantly urban persons; he also enters the fact that the Danville observations were based on work done by students who had only short-term contacts in interviewing, whereas he had long-term association with his patients as their chaplain. It is also worthy of note that more urban than rural patients had no particular religious interest—66.4 per cent in the Lakeland group as compared with 51.5 per cent in the Danville group.

Combined observation in these two studies indicates several things with regard to the role and function of religion among mentally ill patients:

1. Religious affiliation with this or that group has little or no correlation with mental illness, neither in terms of the particular denomination of the patient nor in terms of the fact of church membership.

2. However, *the way in which religious teachings* are presented to the person has much to do with the way he accepts, rejects, or falls into interminable conflict over the teachings.

3. Particularly important in this experience of communication of religious teaching are the mother and father of the individual (or persons who fill the role of the parents in the event of their death or defection). The concept of God and the concept of parents can easily develop obstructive "adhesions" to each other in the religious perception of the patient.

Another opportunity to reflect upon the role of religion in hindering and helping persons was given to the author in his work with a group of prospective missionary appointees under the auspices of the Foreign Mission Board of the Southern Baptist Convention. Each of these candidates was required to confer with the author as a pastoral counselor and with a psychiatrist as a medical examiner. These conferences were prerequisite to appointment as missionaries. Nearly 200 theological students were interviewed by the author in co-operation with four psychiatrists employed at different times by the Foreign Mission Board in terms of their availability as to schedule. This group presented a more positive view of the role of religious experience in the mental illness and health of an individual. Some of the differences and similarities between missionary candidates as a group and the mentally ill patients in state hospitals were observed:

1. Many of these students had suffered some of the same shocks, emotional deprivations and exploitations, and distorted parental relationships which had also been experienced by the psychotic persons. These candidates showed psychotic and neurotic symptoms in a percentage far less than the national average of mental illnesses. One of the explanatory factors was the positive action of the religious community offsetting the malignant influence of defective home relationships. For instance, the child of an alcoholic father found in her pastor an understanding and adequate person to neutralize some of the brutality she received from her father. The child of

a deserting father found in his college teachers, in a small church-related college, persons who restored his sense of confidence in authority-persons in life. The rebelling teen-ager found through the religious fellowship of the church a larger family of persons who both protected him from isolation during his rebellion and gave his rebellious spirit something positive with which to aim his aggressiveness. They added meaning and direction to his life both by finding him and helping him to find himself.

2. In the second place, these missionary candidates indicated the reverse of the kind of sense of mission we found in mentally ill persons. Their statements about their motives for being missionaries were ordinarily not in highly symbolic language, but rather in terms of the relationships they had to significant persons with whom they had identified. Rarely did they express fear of what God would do in the event they were not permitted to serve as missionaries, but usually they had confidence in other available means in the churches whereby these needs of people abroad might be met. And finally, their statements about their sense of mission were usually the end result of a long period of testing, first with their mothers and fathers, then with their fellow students in school, and finally with the representatives of the Mission Board. They did not arrive at their decisions in isolation and out of communication with the larger community of Christians.

One presenting problem of the missionary candidates who later were rejected was also evident among the mentally ill patients. The hospital patients, as

well as the missionary candidates who were adjudged emotionally unprepared for missionary service, had similarly failed to mature and to achieve autonomy from their parental homes. The missionaries about whom obvious question was raised showed in many instances violent conflicts between the candidate and his or her parents over their choice of missions as a vocation. This quite often delayed the appointment of the person for a time, until the conflict could be "worked through." In some instances, emotional stability of the person was so damaged as to necessitate permanent rejection as a candidate.

Furthermore, candidates who had anxious and defensive moral attitudes that made them fearful of and hypercritical toward other people were considered to be poor risks for missionary service. The wide variation between the ethical and moral standards of the missionary and the persons with whom he works on the mission field calls for a measure of flexibility and patience in relationships to persons who do not have Christian standards. Students who were unbending and brittle in these respects in this country would be in danger of either becoming compulsive-hostile or of openly surrendering to the standards of others under pressure. The rigid and impatient missionary candidate was reminiscent of the mentally sick person who presented bizarre ideas of cleanliness and sinless perfection, and yet struggled with one sexual temptation after another. A case in point is the patient who said that he felt that a person *either* had to live life "absolutely pure" of all sexual desire so that it did not bother him at all, *or* he had

to go out and live as if he had nothing but desire. Along with this he felt that he was about to be put into jail for some cause, and that this was fatedly necessary because all *great* Christians had been in jail at one time in their lives! (Such a dilemma is artistically presented in Somerset Maugham's *Rain*, in which the crusading, converting, condemning Protestant missionary is drawn into sexual relationships with an island prostitute in the mission area after having successfully converted her to his religion.)

A very careful study of the role of religious experience in the prognosis of the recovery of the 78 patients whom he and his students considered has been published by Anton Boisen in *Psychiatry: Journal for the Study of Interpersonal Processes*.⁵ In this study they moved on the assumption that "mental illness is the price which we pay for being human and having the power of choice and the capacity for growth." They distinguished between the patients who had adopted reaction patterns of defeat and those who showed reaction patterns of acute concern and anxiety. The acute anxiety was evident among those who also showed profound religious concern, and this group showed a much higher percentage of accentuation in the direction of recovery than the group who showed no such religious concern and acute anxiety. According to Boisen's typical thesis, the religious concern was a part of the healing force in the life of the patient, and the anxiety was a clue to the prognosis.

⁵ Vol. 15, No. 3, August 1952, pp. 287-296.

However, to return to the group of missionary candidates, as a whole they deepened one's appreciation for the balance between the cohesive and the freeing power of religious living in the families of the students. It was nothing unusual to interview a student who was born and reared in a rural home and whose parents had rarely been beyond the boundary of their home county. However, these parents had at one and the same time provided a steady emotional diet of love and understanding for their children, instilled into them the value and importance of people of every race, and gently taught the necessity of taking the gospel to people of every nation. As one farmer put it, "Children are s'posed to leave home, and we cain't keep them forever. No good farmer ever tries to harvest a crop in the seed bed. The field is the world."

A fourth group of persons dealt with clinically by the author and his students was the patient-community of the Norton Infirmary Psychiatric Clinic in Louisville. This is a voluntary, nonprofit hospital where the emphasis is upon early treatment and intensive ward care. The clinic administration aims at the development of a therapeutic community in which every person who is in contact with the patients shall be aware of the therapeutic implications of his own relationship to them.⁶

The observations were of a quite casual nature,

⁶ This point of view has been carefully evaluated in a research project published under the editorship of Maxwell Jones, entitled *The Therapeutic Community* (New York: Basic Books, Inc., 1953).

inasmuch as the student was cast in the role of a psychiatric aide and had no interviewing access to the patient. The fact that they were theological students was not emphasized. They participated as friends who ministered to the more elementary needs of the patient. Therefore, the conversation of the patients was not unlike that which one hears in casual social conversation in the market place. Discussion of religion came about through chance references when patients were reminded of religion by some external situation, such as saying grace at a meal. The religious expressions in 76 observation sheets were of a somewhat "pedestrian" variety. Many of these expressions intersperse this whole discussion of the religion of the mentally ill. At this point, however, some observations may be noted concerning these patients and their religious concern:

This group tended to "use" religion as a means of allaying anxiety and comforting themselves, more than did the other three groups studied. "Peace of mind" and "positive thinking" religion was very popular with these patients. In many cases they had read the books of Norman Vincent Peale and devotional tracts gathered from many sources. They tended to depend upon prayer to help them get to sleep nights, to ward off nameless dreads, and to "calm their nerves" in many ways. Religion was less of an ethical concern and more of a means of reassurance, less of demanding power and more of an attempt at releasing tension. For instance, a patient fretfully says: "I have read the Ninety-first and the Twenty-third Psalms all morning. I got myself all

built up. Then something terrible happened: I thought I wanted to die! Then I was down, down, down! Why do these negative thoughts bother me? I can't stand myself for thinking them!"

The Norton group, in the second place, showed more estrangement from their earlier religious culture. Along with this, they showed more results of "social climbing." They had rejected the social mores that go with their earlier social class, such as the taboos against smoking, dancing, drinking. Yet no secure and meaningful moral structure had taken the place of the rejected patterns of living, and the individual was "swinging loose," so to speak. The anxiety of this suspended sense of meaninglessness was evident in the patients' feverish requests of the aides: "Do you think it is wrong for me to eat without saying my prayers?" "Don't you think it doesn't make any difference what religion you have?" "I wouldn't speak to a theological student who condones playing cards [among the other patients]." Or, "Dammit, anyway. Oh, excuse me. I just feel like cursing; do you swear?"

Nevertheless, the legalism of the earlier religious training of the individuals endured as a sort of "negative after-image" of the teachings of their early home. The preoccupation of the patients with religious teachings about social customs revealed some of the after-effects of the rapid ascent of some of these patients up the social ladder in terms of economic, educational, and social status. All the while, however, the religious heritage of the individual had apparently not undergone any refinement or sophistica-

tion. Religion remained, in essence, a set of external symbols whose meaning the patients had lost in leaving the social class from which they had originated. Thus religion, to them, was a sort of "reminder" of all that they had hoped to "leave behind" in their rush toward success.

One vital factor was evident in all four of the groups studied: the family-culture manifested itself in both the religion and the mental illness or health of the person involved. The God-concept and the family-relationship pattern were tightly interwoven with the illness of the patient. The family tradition and the religious heritage so adhered to each other that the relevance of Freud's illusion-hypothesis concerning religion was inescapable. Among the mentally ill, religion is often a projection of the distortions of the parent-child relationship. For instance, the religious experience of a parent may have served a highly protective function *for him*. However, the repressed concerns from which the parent's own religion protected him become fears of peril which he projects upon his children. As a result, his own efforts to transmit his religious belief to his children as a heritage become negative, anxious, and fearful. He is likely to become as harsh with his children as he was with his own rejected "irreligious" self. Thus instead of producing in his children religion of understanding and tenderness, joy and insight, the parent may express to them a negative religion of rejection and harshness, dogmatism, and self-righteousness. As Lewis Sherrill once said, "he may even

preach the love of God in a vicious sort of way" to his children.

However, the Freudian theory of religion needs some correction at several points. First, what has been said here by way of agreeing with Freud is predominantly true of folk-religions, the religions of authoritarianism, and the religion of the mentally ill. They are not characteristic of the personal religion described in the prophetic teachings of the Bible, nor are they true of the religion of mentally healthy persons.

The teachings of Jesus clarify the basic fallacies in the Freudian criticism of religion. These teachings give a very different concept from that of Freud. At the same time they take into account the measure of truth in his theory. Freud himself said, in expressing this theory, that he was "concerned much less with the deepest source of religious feeling than with what the ordinary man understands of his religion."⁷ In opposition to this, Jesus gave his life, having openly made the distinction between the spiritual intention of God and the "traditions of the elders." Therefore, his teachings concerning the family were a radical therapy in and of themselves for his hearers. They still remain so to those who take the time and pains to learn what they are.

The prophetic utterances concerning the purposes of Jesus in the world said that he would be in the company of those "who turned the hearts of the fathers to the children. . . ." He himself portrayed

⁷ Sigmund Freud, *Civilization and Its Discontents* (London: Hogarth Press, 1946), p. 23.

the will of God as being that not one little child should perish, and that the sensitivity and perception of little children was the criterion for those who would enter the kingdom. The spiritual stability of growing children was more important than "who was greatest in the kingdom." He rebuked his disciples for their religious contentiousness in the presence of children. He told them that real judgment was measured against adults who caused little children to stumble. In a day when human flesh was cheap, particularly the flesh of little children, Jesus taught a gospel that centered in the importance of children in the sight of the heavenly Father.

In speaking to growing adolescent boys and girls, Jesus gave precedence to the claims of the productive work of the kingdom of God, and priority to the claims of maturity in Christian marriage as over family loyalties. Psychiatrists, such as Edward A. Strecker, who deal with the failures of maturation among their patients, have said that maternal and paternal possessiveness often produces much of this emotional immaturity. This is not a new but a forgotten theme of the Christian faith. Jesus encountered this in his own life and decided early that the claims of the heavenly Father took precedence over those of his mother and Joseph. One incident in his early ministry illustrates this:

And his mother and his brothers came; and standing outside they sent to him and called him. And a crowd was sitting about him; and they said to him, "Your mother and your brothers are

outside, asking for you." And he replied, "Who are my mother and my brothers?" And looking around on those who sat about him, he said, "Here are my mother and my brothers! Whoever does the will of God is my brother, and sister, and mother." (Mark 3:31-34)

Likewise, in interpreting this kind of relationship to his followers, Jesus said:

He who loves father or mother more than me is not worthy of me; and he who loves son or daughter more than me is not worthy of me; and he who does not take his cross and follow me is not worthy of me. He who finds his life will lose it, and he who loses his life for my sake will find it. (Matthew 10:37-39)

Furthermore, he applied this same principle to the maturing demands of marriage when he quoted the creation story:

He answered, "Have you not read that he who made them from the beginning made them male and female, and said, 'For this reason a man shall leave his father and mother and be joined to his wife, and the two shall become one?'" (Matthew 19:4-5)

Jesus, however, knew that such loyalty to the larger claims of the spiritual maturity would, in some instances, bring real tension between a person and his mother and father if they demanded a kind of servility of him. In such cases, the Christian teachings

would call for a crisis in which the child would have to establish spiritual autonomy of his parents. This inevitably brings conflict. Long before Freud drew the lines of these conflicts in his studies of neurotics and psychotics, Jesus said:

Do not think that I have come to bring peace on earth; I have not come to bring peace, but a sword. For I have come to set a man against his father, and a daughter against her mother, and a daughter-in-law against her mother-in-law; and a man's foes will be those of his own household. (Matthew 10:34-35)

Applications of these teachings are abundant in the biblical record. For instance, Jesus almost sternly said to one man: "Follow me." But this man said: "Lord, let me first go and bury my father." But he said to him, "Leave the dead to bury their own dead; but as for you, go and proclaim the kingdom of God." Another said, "I will follow you, Lord; but let me first say farewell to those at my home." Jesus said to him, "No one who puts his hand to the plow and looks back is fit for the kingdom of God" (Luke 9:59-62).

However, Jesus was aware of the way in which some religious teachers had made a one-sided interpretation of such commands, which also appear in the Old Testament. He saw how such an emphasis had been used by religionists to establish priority-claims for institutional religion, justifying people in neglecting the real needs of their parents. He was talking to the Pharisees:

And he said to them, "You have a fine way of rejecting the commandment of God, in order to keep your tradition! For Moses said, 'Honor your father and your mother'; and, 'He who speaks evil of father or mother, let him surely die'; but you say, 'If a man tells his father or his mother, What you have gained from me is Cor-ban' (that is, given to God)—then you no longer permit him to do anything for his father or mother, thus making void the word of God through your tradition which you hand on. And many such things you do." (Mark 7:9-13)

Here Jesus accents an insight which comes afresh to the chaplain and the psychiatrist at work in a state hospital. They see large numbers of old people who have been neglected by their children, "ditched" upon the protective care of the state to live their latter days in the oblivion of a state institution. They are not really psychiatric problems at all but service problems. Devoting money and time even to religious causes is no substitute for responsibility to aged parents. Jesus carefully distinguished between emotional dependency upon parents and the callous neglect of parents when they are in real need.

This points to a distinctly Christian value as to responsibility between parents and children. The infinite value that Jesus laid upon personality is epitomized in his regard for little children and old people. He would have parents be so mature as to consider their adult children as they would any child; no more, no less. Likewise, he would have children con-

sider their parents as they would *any* other needy adult; no more, no less. This states an ideal for interpersonal relationships of the "family of God." In the realm of the spiritual community, Christians draw kinship from their relationship to God and not from claims to ownership of each other by reason of their blood kinship through having been born to each other.

In clinical practice, the minister and the psychiatrist have to deal with ethical contradiction which patients feel about God's commands as to how they should react to their parents. For instance, a patient told her minister when he referred her to a psychiatrist: "My mother has forbidden me to go to a psychiatrist. She says that this is a lack of faith and that she is counting on her prayers to heal me. [This patient was a thirty-year-old married woman who was afraid to look at her child because she thought it to be turning into a prehistoric monster.] The Bible says to honor our father and mother. I can't do what you suggest."

Her minister found the exhortation of the Apostle Paul very helpful at this point: "Children, obey your parents *in the Lord*, for this is right." This puts some obligation and freedom upon a child to use some judgment on his own as to whether the parent's commands were "in the Lord." (See Ephesians 6:1)

The teachings of Jesus become quite clear in the pastoral counseling situation where a loved one whom parent or child, husband or wife, has literally idolized is suddenly taken by death. The structural center of the individual's life is shattered. Unless the

person can be "weaned" from this worship, the prelude to a mental illness is at hand. A dramatic illustration of this is seen in the play by Tennessee Williams, *Rose Tattoo*. A truck driver's wife has an intense need for him to be perfect. She idolizes him, although the fact of the matter is that he is quite human and has another woman whom he meets on his trips. The truck driver is killed in an accident, his ashes are given to his wife in an urn, which she places in the center of her living room. She prays to her dead husband regularly. The story reaches its climax when her husband's past infidelity is made known to her. She crashes the urn to bits, and plunges into a psychotic episode.

This dramatic depiction is paralleled in real life by a certain man whose son was killed in World War II. He refused to leave his house, lost interest in his work, and broke his relationship to the church when his son was killed. He spent much of his time praying before the picture of his son in his home. Such examples of the worship of the dead appear in the folk-religion in the mountain and Piedmont sections of North and South Carolina where some of the people of certain communities gather periodically for what they call "decoration days," when the people hold religious services in the graveyards of their departed loved ones. They know folk songs by memory, and sing of the religion of Mother, Daddy, and the "unbroken circle" of the family. They appeal for dedications to religion by asking if the hearers want "to see your dead mother alive again." Appeals are made in song by the less "religious" to those who have

made such dedications, "to shake my mother's hand for me."

Another example of this is cited by C. Macfie Campbell:

A person of unusual intellectual endowment may manage to combine his personal ritual and beliefs with the maintenance of sound personal relations, and through his prestige may even impose his own creed upon others and organize a group as did Comte with his worship of Clotilde de Vaux. . . . He erected the chair in which his dead friend had sat into a domestic altar. Three times a day he went through prolonged religious exercises in her honor. He repeated numbers with their mystical significance. He had stereotyped and complicated phrases of adoration to the departed beloved.⁸

Studies of folk-religions such as these validate the hypothesis of Freud that such religion is a projection of intrafamily relationships in many instances. The sources of Freud's information were primarily studies of folk-religion. He depended too heavily upon the phenomenological research of Tylor, Frazer, and Wundt for his data. He did not adhere to a clinical method in reaching these conclusions. From a research point of view, Freud's *Totem and Taboo* is a secondary and not a primary source. However, the teachings of Jesus, springing from the heart of re-

⁸ *Destiny and Disease in Mental Disorders* (New York: W. W. Norton & Co., 1935), p. 178.

ligion at its best in the prophetic insights of both the Old and New Testaments, contradict Freud's reductionism. What Freud called religion, as Fosdick has said, Jesus called sin. The eighth-century prophets called it idolatry in the Baal-worship of the high places of the fertility cults of Israel. They said that Israel had forsaken the Eternal for the temporal gods of men's hands and fireplaces. Such religion Hosea called "altars for sinning" (Hosea 8:11).

Folk-religion is the binding and hurting kind of religion whereby a spirit made for freedom is in bondage to what Paul calls "no-gods." The transcendental and world-wide demands of the religion of the Spirit, communicated by Jesus, on the contrary loosen the bonds of these finite idolatries in favor of the eternal loyalties which Jesus epitomized in himself. Christians are in the constant peril of clothing an essentially pagan and idolatrous concept of God with Christian symbols. As May puts it:

A mother and daughter had agreed when the daughter was very young that her life was always to be directed by the will of God, which, it was further agreed, was to be revealed to the daughter through the mother's prayers. One can well shudder to think how thoroughly this would open the girl to domination in every act and thought by her mother! How then could the girl's own capacity to choose be anything but stifled—which the girl painfully discovered when, in her late twenties, she was caught in an insol-

able dilemma because she could not make an autonomous marriage decision.⁹

The more basic question to ask about the girl's religion is: How could the girl get a free access to think her own thoughts about God and discover a personal relationship to God in her own right as long as her mother was the sole appointed reflector of his will?

Paul cautions the Galatian Christians about turning back again to the "weak and beggarly spirits," whose slaves he feared they wanted to be once again. The central note of the healing faith of Christ strikes hardest when he says: "For freedom Christ has set us free; stand fast therefore, and do not submit again to a yoke of slavery" (Galatians 5:1). The "escape from freedom," to use Fromm's phrase, is the perversion of the freedom of the Christian faith into the binding of the finite loyalties of a family-religion.

The binding and hindering power of folk and family religion is built into the personality of its adherents without much insight, personal choice, or affirmation of freedom on the part of the individual. Freud's concept of the superego was built out of observations of such primitive thinking, in his patients, of the Viennese culture about him, and of the research of students of primitive religion. These built-in taboos, he felt, snuff out personal freedom and enable the individual to project personal responsibility upon the culture about him and upon

⁹ Rollo May, "Religion—Source of Strength or Weakness?" *Pastoral Psychology*, February, 1953, p. 68.

the occult forces which he fears tremendously. The Apostle Paul described this in Ephesians 4:17-19 when he spoke of the darkened consciences and the futility of mind of the nature worshipers among the Gentiles. He further described the callousness of the consciences of those who had ceased to sense moral strivings.

But the contrast between the religion of Jesus, on the one hand, and the folk-religion of contemporary life also raises a valid criticism of Freud's equation of the superego with the conscience. Freud "assumed that the superego always makes the one-side selection of the harshness, severity, and restrictiveness of the parents, and that their loving care is not taken up and continued."¹⁰ Yet, to equate this negativism with conscience is too partial a concept of the moral wholeness of a personality. The matter of a free conscience and a "good" conscience is built upon positive, more conscious, and more creative relationships, and exercises guidance and direction in the life. It does not rest merely upon repression and blind control.

The Freudian concept of the superego, although it has been revised in the thinking of persons like Franz Alexander and Gregory Zilboorg, remains in practical therapeutic action as an equivalent of conscience. The main criticism here is that when applied to religion, this easy reductivism does not consider that religion has equally as often served as the

¹⁰ Robert Crapps, *The Nature and Function of Conscience*. Unpublished doctoral dissertation, Southern Baptist Theological Seminary, 1954, p. 55.

driving force of rebellion as it has been used as the negating force of conformity. Religion has been a "level of aspiration" of freedom and insight which has enabled men to break the chains that bound them. Likewise, the conscience of an enlightened religious person arises out of contemplative ideals that transcend the primitive provincialism of family, cultural, and racial idolatries. The missionary impulse of the Christian religion, as well as other religions, has often been the mere transportation of culture-religions from one place to another. However, the main stream of Christian missions has been characterized by the worship of a transcendent God "after whom every family on earth and in heaven is named." Obedience to this insight prompted the Apostle Paul to leave the narrow confines of Jewry to proclaim a message in which there was neither Jew nor Gentile, bond nor free, barbarian nor Scythian, and which had transcended the compulsive slavery to sex worship of which Freud spoke repeatedly. In Christ, the antitheses of male and female had also been reconciled. Such a conscience certainly has larger dimensions than the Freudian superego can ever have. The very difference between the Freudian concept of the superego and the Christian concept of conscience dramatically distinguishes the religion that hinders from the religion that helps.

TWO

Self-Deception and Self-Encounter in the Religion of the Mentally Ill

PSYCHIATRISTS HAVE BEEN ASTUTE to observe that patients often "use" religion as a self-concealment device. Yet, on the other hand, theologians have always been concerned about the self-revelatory character of religious experience. The depth psychotherapists have made one of the most trenchant criticisms of religion by empirically describing the various concealment and defense devices whereby the sick person defends himself from reality. As Karl Menninger puts it, "From the standpoint of the psychiatrist a religion which merely ministers to the unconscious repudiation of reality . . . cannot be regarded as anything other than a neurotic or psychotic system."¹ He observes that religion may mean different things to different people; ". . . psychological mechanisms determine what type of religion will satisfy a par-

¹ Karl Menninger, *The Human Mind* (London: George Allen & Unwin, 1947), p. 466.

ticular individual.”² Flugel, in addition, says that ever since Adam and Eve, mankind has “endeavored to escape the consequences of their guilt by projecting upon one another.”³ The utterances of Jesus, however, even more trenchantly criticize popular religion. For instance, he said:

Woe to you, scribes and Pharisees, hypocrites! for you tithe mint and dill and cummin, and have neglected the weightier matters of the law, justice and mercy and faith; these you ought to have done, without neglecting the others. You blind guides, straining out a gnat and swallowing a camel! (Matthew 23:23-24)

Jesus and the prophets before him were acutely aware of the deceptive uses of religion. He spoke to men of being as whited sepulchres without, but full of dead men's bones within; washed clean as a cup without, but contaminated within. He warned his disciples of persons who were the servants of the one whom he chose to call the “Father of Lies.” He said: “Have no fear of them; for nothing is covered that will not be revealed, or hidden that will not be known” (Matthew 10:26). Obviously, therefore, Jesus' mind was passionately in love with reality and abhorred the circuitous deceptiveness characteristic of much religious behavior. He knew the unlimited capacity of the human mind for self-deception as well as its capacity for reality.

² *Ibid.*, p. 467.

³ J. C. Flugel, *Man, Morals and Society* (New York: International Universities Press, 1945), p. 166.

Religion at its best and psychiatry at its best join, then, in the search for an understanding of the concealing and revealing power of religious ideas. Menninger speaks well again when he says:

The manner in which a man utilizes his religion—whether it be to enrich and ennoble his life or to excuse his selfishness and cruelty, or to rationalize his delusions and hallucinations, or to clothe himself in the comforting illusion of omnipotence—is a commentary on his mental health.⁴

If Menninger's statement is true, then religious ideas may not only conceal from a person his true motivation, as is true in the religion of the mentally ill, but a mentally ill person's religious attitude may also reveal to his psychiatrist and to his pastoral counselor something of the nature and direction of his illness. The mental hospital chaplain and the psychiatrist, working with sick people most of the time, may become so accustomed to identifying the religious experience of the patient with concealment devices that they may overlook the realities which the religious attitudes represent. They may even jump to the reductivist error again by assuming that in *every* case all religious manifestations are unreal and to be viewed as "symptoms of something else." Likewise, theological students "raw green" from their first twelve weeks in clinical training situations in a mental hospital are likely to assume that a frank statement of religious interest and concern is a re-

⁴ Menninger, *op. cit.*, p. 467.

flection of *something else*. This could not be the person's real problem!

Anton T. Boisen has a fond saying worthy of acceptance by both the psychiatrist and the clinically trained minister: "It is our task to discover the sense hidden in the nonsense of the patient!" Close study of the religion of the mentally ill patient tends to be highly picturesque, filled with cryptic symbols. These symbols are vitally related to the disruptions of living and loving in the patient's significant interpersonal involvements with those about him whom he loves, fears, and hates. As C. Macfie Campbell says:

The schizophrenic may have personal needs which are not satisfied by the standard procedures and beliefs of his fellows. He works out his own creed and constructs his own ritual. To the uninitiated and the unsympathetic this ritual may appear as meaningless disorder, the product of diseased neurones, the symptoms of an underlying disease. Catatonia, in some cases, will have to be studied not as a disease, but as a religion is studied; it may represent the attempted adaptation of human nature to its special inner needs and external demands. This individual adaptation, however, is a religion to which there is only one adherent and in an intolerant community the only place for worship available may be within the walls of the mental hospital.⁵

In this sense, the religious ideas and behavior of the patient may be looked upon, not merely as conceal-

⁵ *Destiny and Disease in Mental Disorders*, p. 177.

ment devices, but also as media of communication. They are, in a sense, attempts to communicate that which is unacceptable, both to the person himself and to his closest associates, in a language and thought that is more likely to be acceptable. Symptoms, in many instances, are signs in the semaphoric relays of persons who feel themselves to be "far off" from others. They may be rituals of confession for the guilt-laden persons who feel alienated from their meaningful community. The symbolism of "depth" psychology leaves us with the picture of these religious symbols as periscopes extending out of the depths that have covered the patient. A biblical figure, drawn from a description of the positive power of religion to establish communication and fellowship, depicts the symptoms of the mentally ill as "the dividing wall of hostility" or "the middle wall of partition" which separates individuals and groups from effective and productive fellowship with each other.

Therefore, the mentally ill patient *needs someone who will take his ideas seriously without taking them too seriously*. Naturally, such an attitude of balanced seriousness reflects much about the quality of relationship existing between the patient and his doctor or minister. What Sullivan has called "parataxic distortions" seem to rush more readily alongside the patient's presentation of religious ideas than to many other types of ideas. This is true both of the patient and his counselor or therapist. For instance, the minister may invest the bizarre religious concepts of the patient with his own religious meanings, and engage in a battle of theological wits with the patient. On

the other hand, the psychiatrist may reject the ideas altogether as foolish, irrelevant, or deceptive, invest them with meanings drawn from his own personal religious pilgrimage as he remembers it, and fail to take the ideas seriously at all. The community that participated in the hospitalization of the patient may reject his ideas as signs of his "having gone crazy over religion" and in turn isolate him. In each instance, the demonic aspects of the patient's intolerably low estimate of his personal worth have been confirmed by the witness of minister, doctor, and community. Therefore, the minister and doctor are called upon to circumvent the offensive stumbling blocks of the religious ideas of the mentally ill and reach the patient himself as he attempts to find an understanding person with whom he can communicate.

Some roughly hewn interpretations of typical religious ideas of the mentally ill (admittedly in need of much criticism and refinement) may help ministers and doctors toward establishing contact with the patient and his meaning to others. These motifs of religious living appear quite negatively here because they are taken from the distortions of the mentally ill person's experience. Nevertheless, each of them has its more positive counterpart, as will be seen.

The Unpardonable Sin

One of the prevalent religious ideas among mental patients is the conviction that they have committed the unpardonable sin. A teaching fellow in the department of the author, Helen Armstrong Wright,

analyzed the common factors in the histories of 12 patients who presented this idea during varying types of hospitalization and psychiatric care. Six of them were men and six were women, their ages ranged from twenty-four to seventy. Nine of them had been exceptionally active religiously. They came from varying psychiatric diagnostic categories: obsessional neuroses, depressive reactions, paranoid schizophrenic reactions, and anxiety neuroses.

These 12 patients stated their problem as being that "they could not get through to God," as being "unable to pray," as being bothered by "cursing thoughts toward God," as "just not being able to get saved," and as being "beyond the forgiveness of God." In most instances, these patients had made a long tour of a variety of ministers and religious authorities, seeking—to no avail—for a formula for the solution of their problem.

Several factors were evident in the background situations of these patients: (1) *Emotional deprivation*. Half of them lost one or both parents before they were seven years of age. One patient developed this idea upon separation from his parents, and denied ever having had it when he was reunited with them. Another was rejected by his well-to-do family at an early age. (2) *Sexual conflict*. This was obvious in 11 of the 12 cases. The unremovable barrier between them and their "god," apparent in their religious consciousness, appeared to be an ingrained sense of being permanently "lost" after the "loss of sexual perfection" or, in crasser terminology, the loss of virginity. (3) *Bereavement*. The idolization of de-

parted or separated loved ones was in addition to the deprivation mentioned above. These bereavements appeared in half of the instances as a central point of organization for the weariness of the individual with reality. (4) Five instances of the feeling of "having sinned beyond the hope of forgiveness" appeared in connection with lost or unwanted babies in the family experience of the individual. (5) Quarrels with close friends, employers, and others outside the immediate orbit of the family were associated with the unpardonable sin idea in the histories of five of the patients.

The psychodiagnostic factors involved in the history of patients suffering this feeling of having committed the unpardonable sin are medical questions. However, this observer has seen them struggling with the refusal to accept unalterable situations, such as the death of a loved one, the desertion of a parent, the fact of an untimely birth, an organic inferiority, the advent of old age, or the heavy limitation of a chronic infirmity. They cannot be talked out of their idea by rational argument. If they could, the numerous ministers who attempt to do so would report more success and less helplessness. Rather, this is an area for the more radical therapies of psychiatry to precede the conversations of a minister with reference to the ideas involved. For instance, four out of six of the patients studied received real help from a combination of shock therapy, re-educational psychotherapy, and religious counseling. In one instance, well-planned family attention, careful interpretation of the variety of factors behind the concern

both to the patient and to the family, and thorough religious instruction of an interpretative nature served to prevent the person from having to be hospitalized. However, these persons seem to be "spiritual hypoglycemia" patients. They need to be given a good deal of "tender loving care" at regular intervals, to "sweeten up" life for them. Otherwise they "black out" spiritually, so to speak. Pastors, for instance, should spend a little time often rather than much time occasionally with such persons. The symbolic acts of thoughtfulness such as a pastor is in a position to do often lessen the grip of this obsession. In some few instances, the unpardonable sin idea actually has served to get for the patients the consideration from their pastor and friends of which they have been deprived.

The biblical passages that are used to re-enforce the feeling of having committed the unpardonable sin need to be noted here:

But whoever blasphemes against the Holy Spirit never has forgiveness, but is guilty of an eternal sin—for they had said, "He has an unclean spirit." (Mark 3:29,30)

Therefore I tell you, every sin and blasphemy will be forgiven men, but the blasphemy against the Spirit will not be forgiven. And whoever says a word against the Son of man will be forgiven; but whoever speaks against the Holy Spirit will not be forgiven, either in this age or in the age to come. (Matthew 12:31,32)

And every one who speaks a word against the Son of man will be forgiven; but he who blasphemes against the Holy Spirit will not be forgiven. (Luke 12:10)

For it is impossible to restore again to repentance those who have once been enlightened, who have tasted the heavenly gift, and have become partakers of the Holy Spirit, and have tasted the goodness of the word of God and the powers of the age to come, if they then commit apostasy, since they crucify the Son of God on their own account and hold him up to contempt. For land which has drunk the rain that often falls upon it, and brings forth vegetation useful to those for whose sake it is cultivated, receives a blessing from God. But if it bears thorns and thistles, it is worthless and near to being cursed; its end is to be burned. (Hebrews 6:4-8)

For if we sin deliberately after receiving the knowledge of the truth, there no longer remains a sacrifice for sins, but a fearful prospect of judgment, and a fury of fire which will consume the adversaries. A man who has violated the law of Moses dies without mercy at the testimony of two or three witnesses. How much worse punishment do you think will be deserved by the man who has spurned the Son of God, and profaned the blood of the covenant by which he was sanctified, and outraged the Spirit of grace? For we know him who said, "Vengeance is mine, I will

repay." And again, "The Lord will judge his people." (Hebrews 10:26-30)

Of course, the interpretation of the real meaning which Jesus had in mind is made clear by Major, Manson, and Wright when they say that these words have needlessly troubled "many sensitive consciences. These words are not directed against sins of unbelief or sins of sensuality but against the malignant moral blindness which deliberately affirms that that which is good is evil." ⁶

Flesh versus Spirit

Another common religious attitude of the mentally ill is exaggerated contradictory feelings between the flesh and the spirit, the carnal man and the spiritual man, the "worldly" person and the "heavenly" person. These are all different ways of saying the same thing. For instance, one patient came in counting everything in two's. She felt that she had two minds and two hearts. She was questioned at the staff conference by both the clinical director and the chaplain. She was apparently using biblical symbols fairly accurately and in keeping with the relatively good insight she had into her total situation. She was in deep conflict between her instinctual strivings for sexual gratification and outlets for her hostility on the one hand, and her need to belong to a perfec-

⁶ *The Mission and Message of Jesus* (New York: E. P. Dutton & Co., 1938), p. 65.

A further discussion of these passages may be found in *The Bible in Pastoral Care*, Wayne E. Oates (Philadelphia: Westminster Press, 1953), p. 54.

tionistic religious sect on the other hand. She knew this in her own way, however. Her conflict was so intense and evenly matched on each side that it stalemated her function as a wife and mother.

Another patient expressed the feeling that sexual intercourse with his wife was unclean and made a prostitute of her. Another patient bared the conflict in a more complex manner when he said that he was *either* going to live absolutely clean of all desire, *or* he was going out and take sexual advantage of every woman he met. To use Søren Kierkegaard's phrase, this was an "either—or situation." His sexual immaturity conflicted with his identity as a prospective minister. The conflictual anxiety here was "bailed out" by a delusional sense of mission in which he felt called to have himself jailed, inasmuch as all truly great Christians have been in jail at one time or another. The dynamics of his situation indicate the struggle between the patient's fears and his desires. The "imprisonment" idea cloaked his fear that he would lose control of his sexual impulses. If he were in jail, then *external* controls would protect him wherein *internal* controls failed.

Flesh-spirit conflicts appear vividly among psychotic persons in the structures they use to defend themselves. More subtle manifestations of flesh-spirit dichotomies, however, underlie some of the fairly sophisticated "dead-level abstracting" among theological students and their professors. Manifestations of both a morbid and a celibate asceticism appear here. The history of hospital patients, however, reflects several common factors: (1) unresolved con-

flicts with maternal figures; (2) confused roles of sexual identity; (3) partial or total sexual impotence, although they were remarkably evasive in communicating this. These three problems tended to be predominant at the early-adolescent, late-adolescent, and post-marital stages of development, respectively.

This conflict between flesh and spirit is usually given a biblical "re-tread," to use a crude figure. The woman with two hearts said, "But preacher, don't you know where it says a double-minded man is unstable in all his ways? And Paul says there is a carnal man and a spiritual man in all of us." The man who felt that he was causing his wife to be a prostitute referred to the same teachings of Paul. Those teachings are as follows:

For God has done what the law, weakened by the flesh, could not do; sending his own Son in the likeness of sinful flesh and for sin, he condemned sin in the flesh, in order that the just requirement of the law might be fulfilled in us, who walk not according to the flesh but according to the Spirit. For those who live according to the flesh set their minds on the things of the flesh, but those who live according to the Spirit set their minds on the things of the Spirit. To set the mind on the flesh is death, but to set the mind on the Spirit is life and peace. For the mind that is set on the flesh is hostile to God; it does not submit to God's law, indeed it cannot; and those who are in the flesh cannot please God.

But you are not in the flesh, you are in the Spirit, if the Spirit of God really dwells in you. Any one who does not have the Spirit of Christ does not belong to him. But if Christ is in you, although your bodies are dead because of sin, your spirits are alive because of righteousness. If the Spirit of him who raised Jesus from the dead dwells in you, he who raised Christ Jesus from the dead will give life to your mortal bodies also through his Spirit which dwells in you. (Romans 8:3-12)

For the desires of the flesh are against the Spirit, and the desires of the Spirit are against the flesh; for these are opposed to each other, to prevent you from doing what you would. But if you are led by the Spirit you are not under the law. Now the works of the flesh are plain: immorality, impurity, licentiousness, idolatry, sorcery, enmity, strife, jealousy, anger, selfishness, dissension, party spirit, envy, drunkenness, carousing, and the like. I warn you, as I warned you before, that those who do such things shall not inherit the kingdom of God. But the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, self-control; against such there is no law. And those who belong to Christ Jesus have crucified the flesh with its passions and desires. (Galatians 5:17-24)

For he who sows to his own flesh will from the flesh reap corruption; but he who sows to the

Spirit will from the Spirit reap eternal life.
(Galatians 6:8)

A "plain-meaning" interpretation of such teaching has been obscured by the sexual needs and control-anxiety of many popular teachers. The main brunt of the whole biblical message identifies the "flesh" with that which is temporary, finite, changing, and purposeless in the realm of human loyalty, devotion, and worship. To give oneself to the flesh—and it may be anything, not just sex—is idolatry. The message, on the other hand, refers to "spirit" as that which is permanent, infinitely promising in growth, unchanging, and purposefully meaningful in God's plans for the ages. To give oneself to the spirit, therefore, unbinds him, loosens him of "that which today is and tomorrow is cast into the oven," or, to use another biblical phrase, "perishes."

The Unforgiving Legalist

An unforgiving legalism closely aligns itself with the kind of religious feeling expressed in the ideas of the unpardonable sin and the irreconcilable nature of flesh and spirit in a perfectionistic order. These are companion reactions. The heavy demands of a condemning God and the rigid boundaries of a relentless law are thrust outward and upon the total realm of the patient's interpersonal relationships. As the illness intensifies in the open environment, the patient crystallizes his legalistic structure around some real or imagined injustice which some particular individual or group has supposedly done to him.

He organizes his life around a conscious hostility for these persons, represses his deeper and less conscious affections for them. His legalistic religious ideas are the "upholstery" of his feelings of persecution. To change the figure of speech, they become a protective structure relieving him of the responsibility of permitting others to be ordinary human individuals with imperfections, weaknesses, and shortcomings like himself. At the same time, the person burdens himself with the necessity of developing finer and finer distinctions to assure himself of his own perfection and freedom from error. He may suffer profound persecutory depressions and have a sort of "my-head-is-bloody-but-unbowed" attitude toward life.

Persons with this particular pattern of living are not always sufficiently disturbed and disturbing to be hospitalized. Nevertheless, the age of McCarthyism, orthodoxy hunts, and close academic distinctions in colleges, universities, and seminaries provides sociological spawning ground for this particular kind of religiosity to grow. Only a small percentage of such persons find their way to the diagnostic wards of state and private hospitals.

The Confusion of the God Idea and the Self

The patient who pushes his own need to be perfect to the extremes of the unforgiving legalist may also confuse his concept of God with his concept of himself. In losing communication with all those about him, he loses sight of his real self. The grandiose backdrop of the legalism of the perfectionist

is woven out of his own fond expectations to achieve perfection himself. It is only a leap of surmise from this to the assumption that this perfection has actually come to pass, giving the legalist *the right* (never to be taken from him) to judge everyone in all matters great or small.

This was dramatically portrayed to a state hospital chaplain one evening as he entered the chapel office. A woman of about forty-five years of age sat at the desk. The chaplain asked her who she was. She replied, "I am your God." He realized that she was a patient with ground privileges who had found her way there prior to the chapel service. He asked her which ward she came from and she said: "You are a man of God and you are supposed to know all about me." The chaplain told her to make herself comfortable and if she wanted to come out and attend services to feel free to do so. She chose to sit motionless in the chair for the whole period of the service held in the chapel for the other patients.

After the services, the chaplain went back into the office and she said: "Your God is highly displeased with you." He asked her what she meant. She replied: "I was waiting here for my people to be told to come and confess their sins to me and find my forgiveness, and you did not so direct them. Your God is displeased with you!" The chaplain gently resisted her and told her that he did not recognize her as his God. Yet, he told her that he wanted her friendship as one human being to another and asked her not to be afraid of him. He directed her back to her ward, and visited her from time to time. Shock

therapy, consistent pastoral visitation, and vital group relationships all combined to help this woman re-focus the distinction between her own shattered self-concept and her knowledge of the reality of God.

Anton Boisen avers that such a patient is half right in her idea that she is God. He calls attention to the great teachings of the living religion as to man's being made as God, in his image, a little lower than the angels, to become the sons of God, and so on. He further interprets the processes of schizophrenic thought by saying that the concept of the self is magnified in order to offset the intolerable threats to the patient's self-esteem. Of his 173 cases in his classical and monumental study, Boisen discovered that these "self-deceivers" comprised a total of 39 cases. They were making a "real effort to keep up outward appearances." He says that the "important characteristic in most of these cases is the surly, sulky, fault-finding, suspicious attitudes which have become more or less dominant."⁷

Furthermore, Boisen discovered that in 53 of his 173 cases, the patients presented ideas of exalted self-hood. "One announces that he is to be crucified. Two speak of themselves as the 'Son of God.' One man gets very excited when questioned about his religion and announces belligerently that 'Little Charlie can lick God.'"⁸ Boisen also notes that the exalted role may frequently shift to just the opposite. One patient with whom he conferred at length was a "zero quan-

⁷ Anton Boisen, *The Exploration of the Inner World* (New York: Harper & Brothers, 1952), p. 40.

⁸ *Ibid.*, p. 33.

tity and at the next moment the Almighty." Or, as one of Anna Freud's child patients put it, he may be "nobody's nothing" for a while.

The End of the World

An idea often confronted in the thinking of mentally ill patients is that the world has come to an end, is coming to an end, or will come to an end. In "polite" theological jargon, the concern about the end of time is called *eschatological* concern, having been taken from the Greek word *eschates*, meaning "end," or "last things." One patient thrust this at his chaplain with a solemn request that he bury him, inasmuch as he was already dead and the world was at an end anyhow. In 57 of Boisen's cases the idea of impending catastrophe and world change of some sort appeared. In 41 of his cases the idea of the exalted role of the patient in life was found in conjunction with these ideas of imminent catastrophe threatening the world.

This particular idea represents the way in which a sick personality handles the problem of complete frustration, of having been "boxed in" by life with "no exit" (to use Sartre's name for it), of having come "to the end of his rope," of having "encountered nothingness." He is thrust into a panic by the threat of nonbeing, or annihilation of his selfhood, and deploys what might be called "finitude anxiety." The schizophrenic person hotly pursues what Adler calls "fictitious goals," or "guiding fictions." They fear, or in some cases adamantly refuse, to adopt and pursue realistic or limited goals. *All* results must be as-

sured before they will risk any commitment. The courage of imperfection, of limited objectives, or the fallibilities of humanity are too much to ask of themselves. Of course, a study of the long-term dynamics of their development may show scar tissue of unreasonable demands or attacks that have been thrust upon them. Nevertheless, the situation-that-was does not wash out the situation-that-is by any kind of insight other than that which carries with it the courage to accept their own humanity. The therapist, the counselor, the fellow pilgrim of the patient, inspires or fails to inspire this kind of courage. Healing becomes a sort of "breathing the breath of life into the person that he may become alive once again." An old hymn, which many ministers have forgotten and some psychiatrists may have learned earlier, states it clearly:

*Down in the human heart, crushed by the tempter,
Feelings lie buried that grace can restore;
Touched by a loving hand, wakened by kindness,
Chords that were broken will vibrate once more.*

This happens often to patients under the care of psychiatrists, who, by their own disciplined faithfulness, re-establish the patient as *his* world ends and as he discovers with great apprehension the beginning of a new life.

The Messianic Idea

The word *messiah* basically means "an anointed one," or "one who has been chosen as a deliverer." In strict theological use, Christians apply the name only

to Jesus of Nazareth. Jews refer to the expected advent of the Suffering Servant of Israel when they use it. Less technical uses of the term apply it to the "sense of mission," to "having been called," to "having been sent," which refer more generally to these feelings in any person, not necessarily the founder of a faith.

This kind of religious concern undergoes a distortion similar to, but not necessarily identical with, the confusion of the self with God. The hallmark of the idea is the compulsive sense of necessity to carry out a certain plan, a certain task, a definite mission. Distinguishing the pathological from the typical and nonpathological expressions of his idea is not difficult. This will be discussed fully in a later chapter. The important thing here is to describe the idea as it appears clinically, before attempting criteria of distinguishing its pathology. The best way to describe the messianic idea among the mentally ill is to give the following report of the content of thought of a forty-three-year-old woman interviewed by the author:

She immediately began talking of her religious ideas when I suggested that would be interesting to me.

She was on her back porch working one morning and she felt that she *heard the voice of Jesus*. She did not know what the voice said but was impressed with the feeling that it meant she had a great mission to perform in the world. This involved her having "to go about." She

wondered how on earth that could be expected of her, because she was married and had children. Then she felt that this mission involved another person—her pastor, a Presbyterian minister. She went to this minister and explained it to him, and she could tell by the light in his eyes that he understood. But in his sermons he cautioned her, she felt at least, against leaving her husband. He said she should stay at home and work in the kitchen and with her children. She felt that she should go about. She says that as she sat and listened to his sermon one Wednesday night, she knew that he was talking about her and that she could feel her face changing as he talked. After the service his wife told her that she looked prettier than ever, but the pastor did not talk to her; however, she knew he was paying attention to her. As she got in the car to go home, he waved to her. That night she had a *vision*. She was lying flat on her face on her bed and she looked to the side and saw this vision:

There was a very beautiful garden with grass and trees all around. A holy light was all about. She saw a great big grave with little graves, which she took to mean that she would not have any more children, that she had lost her child. She says that she later verified this as true, in that she went to her doctor and he told her it was so. Walking on this grave was a beautiful woman with bobbed hair. The patient says that she does not know who this woman is, but that every time she tells this story she puts her hand on her own

hair. This she did in this recounting of the vision. She says that this vision kept her awake the most of one night.

The patient says that the next morning her little girl told her that she dreamed about her, and that she and all the children dropped down and had prayer together. Her husband did not quite understand.

She says that her pastor really understood and that she could tell it in the look in his eyes. She was sure that she had a mission and maybe it was to be a prophet through him. She says that he told his people that she was an example for them. She does not know whether he was to prophesy through her, or whether she was to prophesy through him, but there was some sort of relationship. He finally failed her. She wept as she said that she guessed she was going to hell, because he told her that she was. At least, she felt that he was hurling bricks at her in his sermon. He told her that she would have suffering in outer darkness. She feels that her attempts to carry out her mission to "go about as a prophet" had failed in her relationship to the pastor. She says that nevertheless she had the *gift of the laying on of hands*. She says that on one occasion she laid her hands on the pastor's breast. She blushed as she said this: "From the world's point of view, that was an exceedingly improper thing to do. But to me it was the most holy thing that has ever happened to me. I think it was wonderful."

When this effort to carry out her mission through the pastor failed, she turned to a man who was her boss for two weeks during the Christmas rush when she was working in his store. She had the feeling that he was a Jew, maybe a half-Jew. She came to feel that he was to become the father of a child. She hears now that his wife is pregnant; whether it has been born, she does not know. This child was to become a special sort of person; something divine about him. She explained her idea about this child to the man, but he did not understand. Every time, however, that she wanted his help, he always came to see her. He never failed her. However, he fired her from her job, and placed a younger woman on her job. She blames herself for this, and says that it was because of her false pride. She has always had too much temper and too much false pride. Along with this story about the storekeeper, she says that one night she had another religious experience, a *vision*. She says that the following thing happened:

She was lying on her bed one night, face down just as she was before. Then a brilliant, soft light came to her, and she heard the voices of angels singing the most melodious music. They were singing "O Love that will not let me go." She says that the light around her was beautiful. "It shone around me right here." She pointed around her pelvic bones and used a circular motion over her lower abdomen.

She once touched her Jewish friend also,

“right here,” and pointed to her thigh. She says that it was the most heavenly feeling. She also touched his wife’s hand, and she says: “I know that had something to do with the baby.”

She used to go around to the man’s store and tell Scriptures to him. And now she feels that her mission will be carried out through him. She says that she is sure of this. Here is how it happens:

The patient came to the conclusion that she was married to this man in a celestial union. It was holy, not legal, but holy. She says that for this reason, the merely legal marriage she has with her real husband is superseded. There she asked if the Scriptures do not say that the law is of no effect. The mission of God, nevertheless, according to the patient, is being carried out and she is married in a holy marriage to this Jew.

The messianic ideas of this patient conceal the unacceptable nature of the woman’s inner motivation. At the same time they serve as a sort of “smoke screen” of confusion for those to whom she tells them. On the other hand, the direct symbolism obviously suggests that the severe responsibilities and unbearable frustrations of her marriage situation are thinly veiled by her religious mission “to go about” apart from her children and her husband.

Yet, to write these ideas off as *just* what the above paragraph suggests, is to be superficial to the point of being blasé. The woman apparently, from a study of her social history, had encountered the emptiness,

meaninglessness, and pointlessness of life. She was grasping for a new meaning in life, and the spiritual soil and climate in which she lived did not provide this meaning. She could not emotionally reach whatever spiritual nutriment her realm of relationships did afford her. The messianic feeling was a desperate thrust of her whole existence into the search for a "new lease" on life.

The fallacy of much perfunctory religious activity appears here: it provides the form of religion but really does not give a sense of vocation and meaningfulness to the simpler tasks of housewives, industrial people, white-collar workers, and even some of the more mechanical professions. Because of the sheer boredom of their tasks and the monotony of their lives, many people are famished for a sense of meaningful purpose in life. Some of them, depending upon the particular store of emotional resources the person has to draw upon and the degree of real growth that took place in the developmental history, would prefer a full-blown psychotic solution of life's inevitable "dead end" existence to some of the more delinquent and unimaginatively crude solutions the so-called "average" person chooses. The "call" to some type of religious mission at such a time is not unusual among these patients. The theological professor, on the other hand, observes many of his students who have achieved success in various other professions and yet have chosen to enter the Christian ministry to achieve a more meaningful and wholehearted purpose for living. Southard found in his study of church vocations that 35 per cent of the

153 theological students who had been working at other vocations prior to entering the ministry had been in secular professions. This seems to explode some theories about ministers not having been able to succeed at other tasks. However, too many persons live the kind of rut-bound existence described by W. H. Auden in his poem:

THE UNKNOWN CITIZEN

*(To JS/07/ M/378 This Marble Monument Is
Erected by the State)*

He was found by the Bureau of Statistics to be
One against whom there was no official complaint,
And all the reports of his conduct agree
That, in the modern sense of an old-fashioned word,
he was a saint,

For in everything he did he served the Greater Community.

Except for the War till the day he retired
He worked in a factory and never got fired,
But satisfied his employers, Fudge Motors Inc.
Yet, he wasn't a scab or odd in his views,
For his Union reports that he paid his dues,
(Our report of his Union shows it was sound)
And our Social Psychology workers found
That he was popular with his mates and liked a drink.

The Press are convinced that he bought a paper
every day
And that his reactions to advertisements were normal
in every way.

Policies taken out in his name prove that he was fully insured.

And his Health-card shows he was once in a hospital but left it cured.

Both Producers Research and High-Grade living declare

He was fully sensible to the advantages of the Installment Plan

And had everything necessary to the Modern Man, A phonograph, a radio, a car and a Frigidaire.

Our researchers into Public Opinion are content That he held the proper opinions for the time of the year;

When there was peace, he was for peace; when there was war, he went.

He was married and added five children to the population,

Which our Eugenist says was the right number for a parent of his generation.

And our teachers report that he never interfered with their education.

Was he free? Was he happy? The question is absurd: Had anything been wrong, we should certainly have heard.⁹

Erich Fromm makes it clear in his book, *Psychoanalysis and Religion*, that both the religion and the psychiatry that take conformity to the least common denominator of society as the criterion of either righteousness or health are uncreative and sterile.

⁹ Reprinted by permission of Random House, Inc., New York. Copyright 1940 by W. H. Auden.

They lead not to health or goodness but to the stifling of health and the caricature of righteousness.

These remarks point toward the problem of "the economy" of the religious experience of the mentally ill. By "economy" of a particular symptom, psychiatrists usually mean that any particular set of symptoms, bizarre as they may be, has a particular value to the patient. They "save" for the patient something which he has not found any other way of saving. They protect him, gain advantages for him, and rescue him from what *to him* would be a much more destructive fate than the illness itself. The religious living of the patient helps him to handle his inner strivings to the greatest advantage with the least effort. Therefore, from this point of view, the religious ideas mentioned here may be said to fulfill at least four economic functions in the lives of mentally ill patients:

First, they are symbolic means of communication. The patient, in a sense vaguely like the revelators of most great religions, is imprisoned on a Patmos of exile from the community by which, from which, and often for which he suffers isolation. He fears to speak openly and without a symbol concerning his real self, either to himself or to others. His over-concretized and overliteralized symbols embody the strength of his message. The function of therapy is to discover the relation of symbol and reality and to decode the communications in such a way that the patient is not only understood but perceives that he is both understood and accepted.

Second, the function of self-preservation is obvious

in the religious ideas. As Gardner Murphy has indicated, the self-maintaining needs of an individual or a community are epitomized in the mores of that given society. When a person's needs for security are no longer met by group "supports," then highly individualized caricatures of these mores, teachings, and values appear in the desperate religious expressions of the disturbed, unhappy, and mentally sick person. His ideas, therefore, enable him to survive, just as community beliefs enable the group to survive. As such, in either instance, a defensive religious pattern of existence is developed. This pattern is characterized by anxiety rather than abandon, fear rather than love, and law rather than grace. Here, by both psychiatric criteria and the criteria of the Christian faith, religion gets sick or becomes "unsound."

Therefore, the third function of these religious experiences of the mentally ill is to silence anxiety. The search for peace of mind becomes paramount. The psychotic break amounts to a "peace-at-any-price" move for the person who is deadlocked within. His anxiety has taken from him the power of courageous action in changing his intolerable situation. As Shakespeare put it, "the pale cast of thought" glosses over his fear. The woman who felt called "to go about" is an example. She could not, however, bring herself to this. She shut herself within herself and the anxiety welled up in her beyond her power to resolve it. The religious ideas she had, it seems, served to allay and "bail out" her anxiety, lest she sink in despair.

Finally, the religious ideas discussed here may serve a positive and creative function. In other words, they have a *real* relationship to reality, as well as being detached from reality. For instance, when the woman said that she had never *really* been married, she probably spoke the truth in a way that she did not know. She pronounced a sort of prophetic judgment both upon her husband and herself in her feeling of the sheer contractual nature of their relationship.

Furthermore, care must be taken not to "write off" *all* of a disturbed patient's ideas as crazy. A simple illustration underlines this. A patient was standing at the hospital window muttering to himself: "All of the drain pipes have little people crawling in them!" The next morning the escape record showed that an exceptionally small patient *had* escaped by crawling through the drain pipe under the fence! A more serious illustration is the story told by Anton Boisen of his visions. Boisen, in the midst of his illness, saw a great wall, with doctors on one side and ministers on the other. He was called by God to break that wall down. The illness cleared up, but Boisen never forgot the obligating power of his vision. He has probably done as much as any other person in this generation to create a better understanding between ministers and doctors. This was therefore a creative idea, in that it had obligating power, referred to a specific human need in the larger community, and actually did come to pass in reality.

Somewhere Freud comments upon the relation of fantasy to art. He says that art is essentially that

means whereby fantasy becomes a part of reality through creative tension with the community. Concerning his own trip to America, when his ideas were warmly received, he said that at last his fantasy had become "a valuable part of reality." It may be said, therefore, that more than one generation is required to tell whether a person is crazy or whether his contemporaries were simply so conventional that they could not accept an unheard-of thing. Therefore, both the psychiatrist and the minister can bear in mind that even in the religion of the mentally ill, the Eternal may break through with some new revealing to mankind. As has been said often, it is by the wounds of the mentally ill that the whole community is healed.

THREE

Religious Culture in the Making and Breaking of Personality

EARLY ONE SUNDAY MORNING a chaplain was called to the hospital receiving ward to be introduced to a plain, talkative woman about fifty years of age. She talked vigorously of her belief that there is no hell, that every person should be a "witness," that ordained ministers and denominations were of the essence of evil itself, and that she had been sent to proclaim the message that "millions now living will never die." She was committed to the hospital because she had become an overzealous nuisance to her community with her religiosity. She was extremely overactive, had ~~not~~ slept or eaten properly for weeks, and was quite insensitive to how people felt about her actions. However, she did not present any hallucinatory or extremely delusional symptoms as she talked at that time or later.

The psychiatrists were not familiar with the particular set of ideas she was presenting and had not

heard of the Jehovah's Witnesses. The purpose of the chaplain's interview was to compare the content of this patient's thought with the actual teachings of her particular religious group. She exemplified the difficulty that both psychiatrists and ministers confront in separating such religious ideas as have been described in the previous chapter from the teachings of the particular religious group to which the person belongs. The patient was later discharged from the hospital as being without psychosis, but as belonging to a sect whose members are in constant conflict with their larger community environment.

C. Macfie Campbell states it clearly when he says:

Special symptoms which we are apt to associate exclusively with clinical pictures may also play a role in the setting of an efficient life. The symptoms are to be understood in the light of an analysis which includes not only the bodily functions, but the individual personality and the cultural beliefs in which the individual is steeped.¹

Anton Boisen, in an unpublished manuscript, has called attention to the role of religion in crisis and custom. He has drawn lines of continuity between what is called mental illness and what in some groups is acceptable as religious teaching. Religious culture (and culture more generally, for that matter) tempers what any given community identifies as normal or abnormal. Religious leaders are uneasily disturbed

¹ *Destiny and Disease in Mental Disorders*, p. 180.

and psychiatrists are likely to jump to early conclusions when they both realize that the religious ideas of mentally ill patients described in the last chapter can be reproduced almost verbatim from the teachings of various religious groups. This may be likened to the printing of counterfeit money. The print, the colors, the patterns, are much the same in both real and counterfeit money. However, the foundational paper and the finer details are quite different. Likewise, the counterfeit does not have the accrued resources of the whole community behind it! But even further than this, certain sections of the community as a whole may secede from the rest and begin printing their own funds, just as in this country the Confederacy published its own scrip!

Such a parable is applicable to the religious ideas produced by mental patients, smaller sects, and historical Christianity. Mental patients are rebel individuals, having adopted a religious world view understood by themselves alone. Smaller sects are rebel groups which have seceded from the larger community of Christians, usually on the basis of some criticism of the larger group. Historical Christianity may affirm the truth of many of the ideas expressed by the rebel group, but these truths are balanced in relationship to other truths of equal value to human living and destiny.

Some doctors refer to the processes of cultural influence in mental illness in something of the words of the following case interpretation by a staff physician:

I have seen this in the past diagnosed as schizophrenia, but if this is schizophrenia, it is certainly a socially acceptable form of it. . . . I feel that even though his areas of activity, his ideation, his attitudes and values approach the bizarre at times and are out of touch with the general cultural pattern, many small groups such as his follow these bizarre patterns and that it is a mistake to interfere and disturb them when they are reacting within and among themselves.

The psychiatrist and the minister alike need a basic appreciation of the cultural patterns of religious fellowships. Several valuable resource books have been written which are exceptionally useful in getting the cultural background of the religious ideation of mental patients. Two compact source books have been written which give brief digests of each of the identifiable religious groups as to their founding leaders, their historical development, their major teachings, and the relative number of their adherents. These two books are M. Phelan's *Handbook of All Denominations*² and Stanley Stuber's book, *How We Got Our Denominations*.³ A much more comprehensive interpretative analysis of the psychosocial factors at work in the development of denominations is H. Richard Niebuhr's *Social Sources of Denominationalism*.⁴ A penetrating research study of a community

² Nashville, Tenn.: Cokesbury Press, 1929.

³ New York: Association Press, 1948.

⁴ New York: Henry Holt & Co., 1929.

social class structure as it relates to the "in-groups" and "out-groups" of religious bodies was made by Liston Pope and published under the title *Millhands and Preachers*.⁵

The latter two books amply illustrate the fact that the class lines of a given community influence the kind of religious ideas, customs, and expressions which a group develops and counts meaningful. The caliber of the research of Pope and Niebuhr will appeal to the psychiatrist who wants something more than a few pious generalizations on the tangible problems of religious diversity among his patients.

Another book that gives more information on the less well-known cults which have a more tangential relationship to organized Christianity is that of Charles W. Ferguson, called *The Confusion of Tongues*.⁶ One of the most interesting chapters in this book is his discussion of atheism as a religious group! In popular, newspaper style, Ferguson says:

Atheism is by several howls the most fervent evangelical cult in the United States today. I am inclined to think that the student of religious abnormality in our times could safely overlook all others (cults) and confine himself to the zealous words and deeds of the "4 A's" (American Association for the Advancement of Atheism), as it is lovingly called in its pamphlets. . . . The movement parallels in every detail the growth of other sects and has the advantage of

⁵ New Haven, Conn.: Yale University Press, 1942.

⁶ Garden City, N. Y.: Doubleday, Doran & Co., 1928.

being sufficiently exaggerated and egregious to offer materials for a rare case study in pathology. (p. 427)

However, the book which most nearly parallels the research presented in the last chapter about the religious ideation of mental patients is by E. T. Clark, entitled *The Small Sects in America*.⁷ He gives a "cultural backdrop" for evaluating the particularly recurrent ideas we find among mental patients. These ideas have their cultural counterparts in the teachings of different groups of religious folk. A parallelism is drawn in the following pages, but several precautionary principles are in order as a pattern of interpretation of these parallels.

First, whereas the intellectual content of the ideas held by the religious group and the mentally ill patient may be the same, their emotional meaning may be quite different; i.e., the adherent of the religious group may hold the idea simply because his group holds it and not because it has any obligating power over his daily behavior. Second, the person who belongs to a group of people who adhere to a given teaching maintains his belief on a socialized basis, whereas the mentally ill patient too often holds his belief as if he alone of all the people in the world has this belief. As Boisen indicates, he lacks humility and the capacity for fellowship. Third, the mentally ill person is more likely to give a highly involved personal application to ideas which have little or no relation to a larger body of balancing teachings that

⁷ Nashville, Tenn.: Cokesbury Press, 1937.

offset the possibility of emotional eccentricities. Even an isolated teaching of mental hygienists, unless taken in dialectical tension with polar opposites which are equally true, may result in what Jung has called the "one-sidedness" of the neurotic. A careful study of the development of religious doctrines in history indicates that, like systematic views of personality, a particular doctrine taken from the larger context of related doctrines leads to a sort of "neoplasm" in the beliefs of the individual, difficult to absorb, to assimilate, or to maintain.

Perfectionistic Groups

Turning to the various types of sects, cults, and denominations which give context to some of the ideas of mentally ill persons, one first confronts the perfectionistic groups. As Clark says, "the underlying principle of perfectionism is that of natural depravity and the impotence of the individual to help himself morally and spiritually."⁸ These particular ideas are related to biblical verses such as Matthew 5:48: "You, therefore, must be perfect, as your heavenly Father is perfect," and to references quoted in Chapter 2 about the flesh and the spirit. The theological term "sanctification" is used by many groups to connote the belief that the individual has been "given the gift of the Spirit" and lives "above sin." The hope of achieving this condition and the demand for such perfection combine to provide the cultural spawning ground for such ideas as the unpardonable

⁸ *The Small Sects in America*, p. 70.

sin and the acute dichotomies of flesh and spirit apparent in the ideation of many mental patients. In communities where interpretations of the perfecting work of conversion and baptism have been taught, pastors regularly see persons who berate themselves for their lack of perfection and seek repetitiously to make confessions of faith and to be baptized many times.

“Second-Coming” Groups

Another example of the cultural context of distorted religious ideas among mental patients is the religious groups which overemphasize the “second coming of Jesus Christ.” These persons anticipate the immediate return of Christ to change the world over by a cataclysmic overthrow of evil. They build their system of thought around this central doctrine, tending to dislocate and disregard other biblical teachings in its behalf. These sects live in despair of obtaining spiritual benefits in this world. They live in the hope of the deliverance due them upon the return of Christ. The most renowned group of such believers was the Millerite group. Led by William Miller, they sold all their possessions, quit work, and went to a particular spot designated by Miller to await the end of the world. He calculated it to be on October 22, 1844. Severe confusion and unhappiness set in when the predicted event did not occur as he had said it would. Less severe, but more widespread, are the Seventh Day Adventists. Intense zeal is activated by this belief, which is a curious combination of profound pessimism in the world and

almost indefatigable optimism as to the truth of their belief.

Patients who live under eschatological fear, threatened by the end of the world, caricature the teaching of these pessimistic groups. However, note needs to be made here that mental patients rarely have much success at socializing these beliefs in such groups and quite often entertain them covertly. Nevertheless, the mentally ill patient is much more likely to "act out" his ideas, it seems, than is the member of the larger group in the culture. He is likely to oversymbolize the reality of the shortness of life, the finitude of his existence, and the set end to all of the phenomenal world.

Ascetic Groups

The ascetic groups often provide the most compatible cultural seedbed for overdeveloped feelings of contradiction between the flesh and the spirit. Examples of this kind of group are most classically seen among monastic orders of the Roman Catholic Church. Felix D. Duffey has clarified, to his own satisfaction at least, the differences between morbid asceticism which the psychiatrist confronts and the "happy asceticism" which he and G. K. Chesterton laud in St. Francis of Assisi. In his treatise, *Psychiatry and Asceticism*,⁹ he hotly defends the practices of asceticism among Roman Catholics, defining the "perfection of the spiritual life [as] the end and aim of ascetical effort" (p. 67).

⁹ St. Louis: B. Herder Book Co., 1950.

Among Protestants, asceticism took characteristic forms in New England Puritanism. Today asceticism continues as a motif in Protestant thought and action, exemplified in the banning of social practices of one kind or another, in "worldliness out" efforts of denominational groups. Such movements are set into action by a puristic attitude toward all human gratification. A close correlation between ascetic practices and economic privation enforced by poverty itself has been pointed out by Liston Pope in his book, *Millhands and Preachers*. Certain cults, such as the Shakers, have emphasized the specifically sexual content of ascetic practice. Ann Lee prayed for her mother to be delivered from matrimony and its impurity. On the basis of visions she saw, she founded her sect, which has as one of its main tenets the abstinence from sexual relationships of any kind.¹⁰ A deserted village named Shakertown, in Kentucky, indicates the self-annihilating character of these groups. Furthermore, Father Divine's followers, even apart from his own "celestial marriage," are enjoined to avoid all "unnecessary mingling of the sexes."

Examination of the teachings of the Apostle Paul reveals that perfectionistic and ascetic groups find in First Corinthians 7:1-16 a tendency to elevate the celibate state to pre-eminence. However, the Apostle does not at any point condemn marriage or sexual relationships in their context of Christian values. Nevertheless, the psychiatrists and ministers may

¹⁰ For a full account of this, read Chapter 15, pp. 321 ff., in Charles W. Ferguson's *The Confusion of Tongues*.

without much trouble find here the biblical basis for many of the beliefs they hear perfectionistic and ascetic patients express.

The perfectionist, the eschatological, and the ascetic groups of religious people, however, do not include in their interpretation of the religious life a biblical idea that is compatible with both mental health and sound religion. In many places, the term "perfect" in the older translations is more accurately and meaningfully interpreted as "mature." For instance, in First Corinthians 14, he enjoins his readers to be "babes in evil; but in thinking be mature." In Ephesians 4:13 ff., he speaks of the *unity* of the faith and the knowledge of the Son of God as being correlative with "mature manhood," calling his readers away from the instability of "children, tossed to and fro and carried about with every wind of doctrine."

Leader-Deification Groups

The confusion of the idea of God with the idea of the self, common among mentally ill patients, also has its cultural component in certain religious groups. The deification of a leader of a cult, a sect, or even a denomination, is evident in those groups where a leader, having the concept of himself as God, is able to get a following of others who believe about him as he does about himself. This is historically "always with us," in that Alexander, the Caesars, a motley procession of dictators, and a teeming horde of lesser lights have held themselves forth as gods. The most blatant example is that of Father Divine, who is worshiped as a god by his followers who be-

lieve that death will never touch their leader. He operates as Provider, Judge, and Counselor in his Harlem Heavens. Likewise, the female counterpart of God is seen in his young wife, who is similarly worshiped.

Careful ministers, psychiatrists, and social workers will begin to reflect at this point, and they will ask how it is that Jesus Christ also is worshiped as God, and what makes the qualitative difference between him and these other "gods." The Christian theologian would answer and say the difference lies precisely in the fact that Jesus of Nazareth reversed the pattern of an earthly kingdom in behalf of a spiritual one, even calling one of his most beloved disciples of the Evil One when he suggested the pattern set forth by these contemporary idolatries. He "made of himself no reputation," but "emptied himself," insisting upon the form of mankind itself (see Philippians 2:5-11). In the contemporary idolatries one finds man trying to become God; in the Christian knowledge of Jesus of Nazareth, God actually becomes man. This is the Incarnation, whereby the "Word was made flesh." Furthermore, a pattern of sustained consistency led Jesus away from the benefits of being an idol to the ignominy of one who laid aside all prestige prerogatives for a cross. This is a reversal of the pattern, for instance, of Father Divine, who has excused himself from the necessity of dying!

What then, are some common culture characteristics of these groups which have given communal expression to many of the ideas encountered in the thinking of mental patients?

Usually these groups are *protest* groups, rising up to rebel because of the neglect of some vital need by the older and more socially acceptable religious groups. For instance, long before many people were taking the relationship between emotions and bodily changes seriously, the Christian Science movement arose within the church at large to call attention to this neglect. The factor of stress and neglect of the wholeness of the gospel accounts for much religious diversity. Conversely, also, these groups hazard the necessity of emphasizing one aspect of the gospel to the neglect of the rest. Correspondingly, their survival depends upon their willingness to learn the elements of truth emphasized by historic Christianity, which they themselves have neglected. The "aging" process of religious groups indicates a pronounced protest in their infancy, with a strong and aggressive leader defining the uncared-for needs of his followers. As it moves into adolescence, the group begins to incorporate many of the teachings of other religious bodies. In the adulthood of its "respectability" and acceptance in the community, usually in the third and fourth generation of its adherents, the group becomes more inclusive and tolerant of the teachings of others. Along with this goes much social change and moving up the social ladder, as a result of the increased acceptability of the conforming members of the group. For instance, the sober, hard-working, self-sacrificing, and family-loving person tends to profit by doing so, both economically and socially. His changed status makes of his group a "good neigh-

bor," although people do smile at his funny ideas and strange customs.

Again, the religious group, apart from the coherence of its teachings, provides a sense of community for individuals who have hitherto been isolated and alone in the world. These groups provide relief from monotony, irrigate the deserts of boredom, and undergird the weak sense of selfhood of many people. In the study of the group of patients at Kentucky State Hospital, it was the person who failed to adjust to the group of "holy rollers" and "couldn't go home again" to his old grouping who became sick. He was caught in the "no man's land" of isolation between the churches of the dispossessed and the churches of the "respectable."

Furthermore, in Southard's Lakeland study, contrary to the popular opinion, the 173 cases studied revealed less than 4 per cent from the more extreme sects. One might venture a "horseback opinion" here in the direction of health, even though many of the ideas expressed are hopelessly naïve and unsophisticated both from a theological and a psychological point of view. These persons tend to feel as the early Christians expressed it. They feel separated, alienated, and "strangers to the covenants of promise, having no hope without God in the world" (Ephesians 2:12 ff.). Once they were "no people" but now they are "God's people" (1 Peter 2:10). Psychological relativism in the realm of theological ideas is not being set forth here; ideas and their correspondence to reality in truth are intensely important. However, *one* criterion of the validity of a theological idea is

its *fellowship* quality, i.e., whether or not it breaks down or builds up middle walls of partition in the individual's relationship to real people.

Finally, however, a religious group can, as Freud said, become simply the exchange of an individual sense of isolation for a cultural isolation. However, as has already been pointed out, he was referring to cultic or folk religion. The prophetic heights of the Hebrew-Christian message stand over against cultural as well as personal idolatries. Carrying around a cultic, a sectarian, or a denominational "mule's burden of earth" upon which to stand to worship is not the source of healing faith. Rather the healing faith is in the dramatic break-through of the Christian gospel as our provincialisms are shattered by the knowledge of a God in whom "there is neither Jew nor Greek, there is neither slave nor free, there is neither male nor female; for you are all one in Christ Jesus" (Galatians 3:28).

These transcendental reaches of religious experience are highly inspirational, but the "break-through" takes on a grimmer appearance in the psychiatric clinic and consultation room. The conflicts between these cultural expressions of religion become built-in walls within an individual personality. And as Dr. E. E. Landis has said, "A wall that will not let our minds know what our feelings know to be true, becomes a wailing wall for our feelings and these in turn are heard by others as mental symptoms." The cleavages within Christendom become acutely apparent in the rifts in personal relationships with which the psychiatrist has to deal. However,

these rifts do not appear clinically along the lines that the churchman would be most likely to expect. For instance, the churchman might assume that clashes between denominational loyalties might be a festering point for mental illnesses. However, the religious loyalty problem does not seem to run along denominational conflict lines as much as it moves within a given denomination in terms of the submission or rebellion of children to parental rule about religious affiliation. For instance, a depressed person with whom the author conferred about her religious conflicts had left a very strict perfectionistic sect to become the wife of a minister in one of the older, more established churches. Her mother disinherited her from the family will as a result. She was cut off from one group long before she found access to another meaningful community of faith.

In the Kentucky State Hospital study, 17 patients presented conflicts similar to the one just described. The denominational loyalty problem, however, was something of a "showcase" for the warehouse of parent-child conflicts.¹¹ The Christian pastor can very easily become a part of the problem rather than of the solution of such needs of the mentally ill person if he fails to perceive the family context in which these theological and ecclesiastical conflicts are lived out.

Another point at which religious tensions appear in mental illness is in the crisis of the interfaith marriage. Occasionally the illness of a patient clusters

¹¹ See the author's book, *The Bible in Pastoral Care*, which includes case material that illustrates this kind of conflict.

around the crisis of an impending Protestant-Roman Catholic marriage. For instance, an only son was recently bereaved because his father had committed suicide. He and his mother were left quite alone in the world, and she was emotionally anchored to her son. Within a year the son planned to marry a Catholic girl, although he himself was a Baptist. A severe conflict arose within him over the wisdom of his decision, and the impending wedding was the precipitating factor which brought him to the psychiatric hospital. The psychiatrist readily sees that many factors intertwine with the religious problem of Catholics and Protestants. However, these problems all converge in a religious definition.

The danger that confronts the Christian minister in such a case is twofold: he may, on the basis of psychiatric information from his fellow team member, the psychiatrist, assume that the religious conflict is not real, and therefore miss the patient's need to respond to him as a minister whose primary responsibility is to be a religious counselor. Or, in the second place, he may react in the opposite extreme and try to solve the problem purely on the merits of whether or not Roman Catholics and Protestants should marry. Thus he ignores both the psychiatric involvements and the necessity of teamwork with a psychiatrist. In either event he has both misinterpreted his role and failed to perform his function.

Therefore, clinical teamwork between ministers and psychiatrists is highly indicated in the working through of such a conflict as the patient described above presented. The task of disentangling the cha-

otic emotional situation from the more objective merits and demerits of Catholic-Protestant marriages was one, in the above case to say the least, which neither a minister nor a psychiatrist could have handled alone with the effectiveness achieved by the team. The team could not have been possible, however, without a good deal of flexibility and specific information about both religion and psychiatry on the part of both the doctors and the ministers involved.

At no point in religious phenomena does the ingrained relationship between cultural forms and religious teachings show more clearly than in the interfaith marriage. This is true, manifesting itself pertinently from a psychiatric point of view, in that the issue of interfaith marriages surfaces the tangled network of intimate family relationships for generations past the individual with whom the doctor is working. From the point of view of counseling and psychotherapy as they are practiced by ministers and psychiatrists, respectively, sympathetic listening to the religious problems, as such, reveals much of the constellation of subcognitive issues in the illness of the person. Brush-off techniques seal off a vital channel of communication.

The minister, the psychiatrist, and the social worker need to know specific information about the positions of the Catholic, Jewish, and Protestant groups on the problems of interfaith marriages. There is a most comprehensive study by James A. Pike, entitled *If You Marry Outside Your Faith*.¹²

¹² New York: Harper & Brothers, 1954.

Several valuable pamphlets have been written. Probably the most impartial one is by Algernon D. Black, *If I Marry Outside My Religion*.¹³ Another has been published by the National Council of the Churches of Christ in the U.S.A., entitled *If I Marry a Roman Catholic*, in which is included a statement of the pre-nuptial agreement required by the Roman Catholic Church of all non-Catholics marrying Catholics. In essence, the requirements are (1) that marriage is a marriage of a person to the Church as well as to an individual; (2) that marrying requires, therefore, the agreement of the non-Catholic not to attempt to change the religious loyalty of the Catholic spouse, the agreement of the Catholic to attempt to change the religious loyalty of the Catholic spouse, and the commitment of the non-Catholic to permit the children of the union to be reared according to the Catholic faith; (3) the performance of the ceremony by Catholic and not Protestant representatives.

Such an agreement is highly consistent with the total philosophy of the Roman Catholic Church, which in turn contradicts the almost *laissez-faire* individualism of many Protestant groups. A more extensive and authoritative statement of the Catholic position can be found in the book by John J. Kane, *Marriage and the Family*.¹⁴

Such requirements by the Roman Catholic Church call for the same kind of consistency among Protestant groups, if anything that amounts to a demo-

¹³ Public Affairs Pamphlet 204. Public Affairs Pamphlets, 22 East 38th St., New York 16, N. Y.

¹⁴ New York: The Dryden Press, 1952.

cratic solution of the problem is to ensue. In other words, to "hold their own," Protestants would have to hold a similar definition of marriage. But since this would be inconsistent with Protestantism, Protestants must depend upon educational and therapeutic measures rather than ecclesiastical ones in dealing with the problem. Protestant ministers have discovered that a more flexible counseling approach is indicated in matters which cannot really be settled by church decree. Hence, the clinic becomes all the more vital as a place for clarifying the perplexities created by the impossible solutions of life problems which the churches both unload and are tempted to unload on the heads of struggling people.

Therefore, Protestant ministers need to see to it that counselees who are contemplating a Catholic-Protestant marriage have several resources upon which to draw in their decisions: (1) a "threatless" and noncoercive relationship that is more or less a haven from the unbearably intense pressures that parents and friends place upon them in the time of deciding about marriage—this relationship is conducive to insight-producing conversation; (2) as much information as can be afforded them about the problems involved in interfaith marriages—materials free from propagandistic motives can be given to the person to read; (3) any information as to Protestant teachings which they request, and referral to further reading; (4) an appeal (noncoercively given) for delay of time in which to think through the major issues with them; (5) careful preservation of basic Protestant relationship of the autonomy of the individual

soul before God in making his own decision without domination from the minister. In the long run, this accomplishes more redemptively the needs of the couple than if the minister becomes defensive of a position which has already been established in relation to the Roman Catholic Church and does not need to be re-established by the minister.

If the couple is already married, real problems become the festering point of conflicts which may occasionally complicate forces already at work in the personalities involved. Black says that the more serious questions arise in Protestant-Catholic marriages over issues as to whether to send children to parochial or public schools, which Bible to use in the home, whether the non-Protestant will be permitted to engage in family prayers, the use of money in church contributions, and the choice of Catholic or non-Catholic friends. Unless an already existing mental health prevails with great strength, these issues can be tensions that tax the margin of emotional health unduly.

The problem confronted most often among prospective Protestant-Catholic marriages is that of rebellion of children against parents, it seems. Occasionally the healthier young rebels will say: "I can't tell really whether I am in love with her or whether I am getting a big bang out of pointing out my freedom to my old man." But more often this is an insight that does not appear to the consciousness of either, particularly as they find comfort in each other's embraces from the isolation they experience from those who should provide them with under-

standing. Insight may be so inaccessible as to call for psychiatric help, in that the person may be rendered incapable of decision or constructive activity by his need for security and his need for freedom and integration.

An example of the psychiatric implications of such intermarriage is cited by W. Earl Biddle, a psychiatrist:

Another illustration of unwise handling of a patient is found in the case of a young married woman who was admitted to the mental hospital after an attempt to kill her child. She had been reared in the Catholic religion but married a Protestant man before a justice of the peace, which estranged her from her church. She loved her husband and child but could not return to her religion while married to a man who would not accept the conditions required by the pastor over and above those of the church. The husband would not interfere with her practice of religion, but he could not agree to change his religion or allow the children to be brought up in the Catholic faith. The young woman's family and her pastor constantly berated her for her marriage "outside the church," told her she was "living in sin," and her child was "illegitimate." They begged her to leave her husband and to return to the church. She was in a dilemma. She earnestly wanted to return to her church and make amends for her error, but she could not disown her husband, which were the terms

demanded by the parish priest who evidently wished to break up the marriage. Her predicament preyed upon her mind until she became psychotic and made an attempt to kill the child who she thought was "damned" anyway.

Mixed marriages often cause complications which are most unfortunate. In this case the parish priest erred in demanding that the husband change his religion or that the wife leave him. The woman could not be expected to abandon her family. She realized that she had made a mistake which she wanted to rectify. The matter was eventually solved when the problem was brought to the attention of another priest who understood the psychiatric implications and could find an amicable solution.¹⁵

From the context of the psychiatrist, the conflict between Roman Catholic and Protestant points of view may become psychiatrically relevant when the issue of birth control arises. A private psychiatrist referred one of his patients to the author for religious counsel on this problem. She was the mother of five children and found herself desperately afraid of having more children. She was a Baptist and her husband a Catholic; nevertheless, as is often the case, she actually agreed within herself with the Catholic position as to the sinfulness of birth control. She resented the possibility of having more children, projected the blame for this upon her husband's inability to earn

¹⁵ *Integration of Religion and Psychiatry* (New York: The Macmillan Co., 1955).

a living and upon his religion. The fact of the matter was that he was not a devout Catholic at all and was not committed to the position of Catholics on birth control. Both of them were quite ignorant of birth-control techniques, and her guilt and unhappiness arose from the practice of *coitus interruptus* by her husband whereby her basic need for sexual gratification was stimulated but not satisfied.

Several factors emerged in the interview, therefore: (1) The couple were quite ignorant of the problem with which they were grappling. (2) They were not clearly communicating with each other about their real convictions in the matter. (3) They needed some clear interpretation of the relation of religious loyalty to sexual relationships. (4) The lack of devoutness of the Catholic partner was significant in the outcome. This points to the wisdom of distinguishing between degrees of devoutness in approaching any religious idea in an individual case. Kinsey, for example, makes this distinction regularly in his research as it relates to religion. All of these had combined to push the woman into a mental illness for which she had been hospitalized, treated, and now was on her way back home. The religious importance of sexual relationships as communion and fellowship between man and wife as well as the religious necessity of intercourse as a way of procreation was made clear to the woman. Likewise, gynecological help was arranged for the woman whereby she and her husband were taught more about birth control. Furthermore, the author clarified a particularly distorted interpretation of the story of Onan in

the Old Testament (see Genesis 38:1-11) in which she felt that they would die if they practiced birth control. It was pointed out that Onan was refusing to have children *at all*, whereas she had served God faithfully by bearing five children. Likewise, the medically dangerous aspects of *coitus interruptus* as a means of birth control were interpreted, and it was suggested that God had provided better ways to happiness through science.

The psychiatrist is an expert on nervous and mental diseases, and, as Harry Stack Sullivan has said, "He is expected to show his expertness in the management of his relation with the patient."¹⁶ On the other hand, the psychiatrist who refers his patient to a minister expects something of the same kind of expertness of the minister in the realm of his theological training. The patient referred to above was actually helped, according to her own word, and the psychiatrist's follow-up. The author did not become coercive and authoritarian, nor did he slavishly follow psychiatric and clinical psychological methodology. But such things cannot be accomplished by a minister or a psychiatrist if there is a basic lack of expertness on the part of either, and an overcommitment to persuasion to compensate for deficiencies in information.

The next conflict of religious origin which manifests itself in emotional disturbances is the antithesis between celibate and marital adjustments to life as they relate themselves to the vocational adjustment

¹⁶ *The Psychiatric Interview* (New York: W. W. Norton & Co., 1954), p. 29.

of the patient. This was evident in the religious experience of a Catholic monk whose mental illness converged around his having taken vows of celibacy, although his sexual concern reappeared in the delusional misrepresentation of many of his mystical relationships to the saints, to the contemporary hierarchy, and the Blessed Mother. The extended case description in the preceding chapter also reveals how the woman's role as a wife and a mother conflicted violently with her sense of mission as a religious person.

The cultural components of this religious conflict are quite deep, not only in Roman Catholic culture but also in Protestant fellowship as well. The heavy taboo among some fundamentalist Protestant groups against the activity of women in the life of the church produces much of this conflict. These taboos are biblically based on Paul's teaching about women remaining silent in the church and taking the veiled position in the church (see 1 Corinthians 11:1-16; 1 Corinthians 14:35; 1 Timothy 2:11-12). Among Protestants the problems are much more acute for women than for men, because the cultural interpretation of the necessity of sexual gratification among men is securely accepted among Protestant groups. For instance, in the mission board appointments to foreign mission fields the current of popular opinion is strongly in favor of women going to the field single. In fact, this is so true that when a woman who had hitherto planned to be a missionary gets married, some Christian groups tend to conclude that she has forsaken her calling as a missionary. Likewise, tacit

assumptions are made that the calling to the mission field automatically excludes the girl from marriage. Conversely, however, the same group is equally reluctant to see an unmarried man go to the mission field.

Whereas a careful research study of a group of mission appointees needs to be made as to this problem, enough observations have been made to warrant the guess that the celibacy-marriage conflict reflects a larger cultural problem of masculine and feminine roles than a narrow religious definition permits. Career women in other vocations suffer the same stresses, but they are differently defined. Nurses, for instance, present the triple press of conflict as to whether they are nurses in terms of a profession, a calling, or merely a service situation. They suffer confusion when thrust into marriage if they do not have an opportunity to practice their profession without interference with their role as a wife and mother. Likewise, graduate students in the teaching profession are quite often willing to penalize their whole marital adjustment to the point of breaking in order to keep a graduate program going. They often put hard-luck stories to their professors, asking special favors academically in order to "get the degree" in spite of all.

Underlying these cultural problems with reference to vocation is a matter of conflicting values within the teachings of most churches: (1) The value of Christian perfection conflicts with the mundane demands of sexual passion and the need for children. (2) The value of Christian humility and self-sacri-

fice combines subtly with the more distinctly secular value of "earning a living," "getting ahead," "succeeding," "making a name for oneself," and "being somebody." (3) The value of worship as rest and religion as an unmerited grace without effort conflicts with the "works theology" which calls for "saving the world in one generation" and mass production criteria of value of a distinctly mechanistic culture.

These conflicts become intense during late adolescence and early adulthood, but they do not tend to appear as mental illness until the late thirties and in the involutional period. Then the "closed ends" of life become acutely apparent to the person who made the decision on one side or other of the celibacy-marriage conflict without careful pastoral attention and without the achievement of insight, self-acceptance, and emotional resources in the process. The feeling of the impending end of the world, the development of bizarre and unrealistic vocational planning, and the frantic struggle for a meaningful purpose in life elide then in stresses and strains from within. If these desperate problems of selfhood are aided and abetted from without by precipitating social factors, the patient can present the kind of symptoms with which a psychiatrist must deal.

The minister of religion who takes the teachings of his faith seriously enough to be aware of their clinical effect—apart from his own sense of comfort with them—is pushed into a searching mood when he confronts these problems. He asks himself: "Well, what is all this tension over religion about anyhow? What is going on in these cultural patterns that re-

veals something residual and not merely relative about religion? What *is* the direction and definition toward which all this conflict is moving? What are the abiding elements in human personality and religion at its best?"

These cultural expressions of religion reflect the structural needs of human personality, on the one hand, for communion and compatibility with his fellows. But on the other hand, they demonstrate his need for personal identity and the discovery of his individuality as a person in his own right before God. Stated in the prophetic insights of Jesus, these cultural conflicts represent the tension between institutional and personal religion, and the final answer is always in his words: "The sabbath was made for man, and not man for the sabbath." These cryptic words, set in their context, underline the supreme value of human personality in any cultural context.

A devout Roman Catholic psychiatrist once asked a minister: "You seem to be a flexible minister, but what I would like to ask is where you refuse to bend?" The minister replied that he had found one point of rigidity which he learned from Jesus of Nazareth and had seen demonstrated in good psychiatrists: the infinite and primary value of one person as a person and not as a commodity on somebody's institutional market. This applies to religious living particularly, and more generally to all of life.

Again, another psychiatrist was asked what he felt to be the main criterion for evaluating the worth of a religious pattern for living. Without hesitation he drew the distinction between religion as law and

religion as grace, the religion of blind punishment and the religion of open-eyed love. He differentiated between the prophetic insights of the Old Testament and the Christian witness of the New Testament as over against the molding strictures of the legal religion of the Old Testament, the Judaizers in the New Testament, and the revivification of legalistic approaches to mass religion in the development of the Roman Catholic Church and Protestant fundamentalism. He indicated the need for both ministers and psychiatrists to be more informed about the corrective function going on within religious groups themselves, which often accounts for the breaking off of a small group from the mass of their heritage.

From this point of view, Archie Robertson's book, *That Old-Time Religion*,¹⁷ points out the thread of consistency running through the cultural formation of religious groups which have been mentioned to some extent here. Consistently appearing is the courageous struggle of the souls of men away from the bondage of law and the dull conformities of a dead tradition, toward the freedom of their own individuality and the community of a few like-minded spirits. Unguided and spontaneous excesses have occurred in these formations. Nevertheless, the warm thrust of the human soul toward both individuality and community is the body temperature of vital religion. Occasionally this concern reaches a fever-pitch

¹⁷ Boston: Houghton Mifflin Co., 1950.

stage and the balance is disturbed, as was evident in both the experience and writings of Anton Boisen, and the contemporary culture says in its rejection: "He is beside himself." The basis for this judgment is the subject matter of the next chapter.

FOUR

Some Differences Between Healthy and Unhealthy Religion

A YOUNG MINISTER felt that he was called to have himself committed to prison because of his being Christian. He was admitted to the psychiatric ward of a hospital. The chief psychiatrist later asked the author and a group of his students to meet with his group of resident psychiatrists to discuss the difference between the healthy and unhealthy sense of mission or "call" to religious service. The ideas developed in that seminar form the basis for this chapter. A comparison of the content of the chapter on the religious ideas of the mentally ill with that of the chapter on the cultural manifestations of the same ideas indicates the necessity for criteria for distinguishing healthy religious adjustments from unhealthy ones. This concern has been real to psychologists of religion, particularly since the time of William James, who, in his classical treatise on *The*

Varieties of Religious Experience,¹ has spoken to people of all religious groups and all professions on the "religion of the healthy minded" as compared with the religion of the "sick soul." J. A. Hadfield also speaks on the subject in his book, *Psychology and Morals*.²

The objective here, therefore, is to clarify some differences between healthy and unhealthy religion. The psychiatric referral done by ministers and the psychiatric interview performed by a psychiatrist provide the context for this discussion.

Two introductory concepts are in order as a preface to the delineation of such criteria, however. "Criteria of health or illness," as perceived here, does not mean theological or ecclesiastical attempts at differentiation, such as weighing and measuring the relative merits of liberalism or fundamentalism among Protestants, or Augustinianism and Pelagianism among the historical theologians. Nor will the relative merits of Protestantism or Roman Catholicism in terms of mental health or illness be weighed, as Jung does in his book *Modern Man in Search of a Soul*.³ By criteria, rather, is meant the psychological and therapeutic standards whereby any particular idea or ecclesiastical form of religion may be evaluated, within the context of its meaning, for the particular person who has the idea or participates in the form of religion. Furthermore, in the second place, "criteria of healthy religion" refers to specific

¹ New York: Longmans, Green & Co., 1929.

² New York: Robert McBride & Co., 1928.

³ New York: Harcourt, Brace & Co., 1939.

tactical ways in which a judgment may be arrived at upon clinical principles rather than upon a purely theoretical statement of *all* healthy religion in the abstract. In a sense, therefore, the following criteria for evaluating the health and meaning of the religion of the mentally ill may even have diagnostic value for the psychiatrist and the minister.

In the first place, Dr. Spafford Ackerly, professor of psychiatry at the University of Louisville Medical School, emphasizes the necessity of *examining the pre-psychotic history of the patient before leaping to a surmise concerning his religious ideas*. He raises the questions: Does this religious interest represent a sudden and recent concern, with no "build up" due to past influences and interests? Is the religious interest recent also in the sense that it arose along with the threat to his inner defenses characterized by his illness? Furthermore, in examination of the religious history, the minister and psychiatrist need to ask how the person first was introduced to the ideas he has. Were the relationships whereby he was introduced to religion infected by the distorted motives of persons who used the patient to accomplish their ends?

The religious history will also reveal how much a part of the patient's community culture these ideas constitute, whether or not the ideas give him access to an accepting group, or whether they isolate him from that group whose approval he considers most worth while. Such a careful inquiry into the pre-psychotic background of the religious life of the patient will also reveal his relationship to his family

religion, which in turn reflects his interpersonal situation with his parents and his siblings. The quality and direction of these relationships reciprocally aid the minister and the doctor in understanding both the religion and the psychological make-up of the patient. If a minister observes these matters carefully, a brief factual summary of these data furnished to the psychiatrist to whom a mentally sick person is referred will be helpful in the total evaluation of the patient's life situation. The minister in writing such a referral letter needs to keep the factual information carefully separated from the interpretations which he himself would make of these facts.

From an interpretative point of view, the patient whose illness antedates his religious concern is much more likely to present a distorted pattern of religious thinking. The quaint religious ideas that many patients present, however, are often a part and parcel of the folk-culture of which they are a part, and may be only incidental to their real illness. Likewise, in some instances, particularly in depressive situations where the patient is reacting to a realistic situation with a depressive reaction, the religion may be both a threat of destruction and a promise of redemption to the patient. As such, it may be one of the sustaining forces in his management of the shocks and bereavements that have "thrown" him. Furthermore, in situations where religious concern is concomitantly developed with the illness itself, an almost conscious malingering against therapy or in behalf of certain advantages in the treatment situation may be the activating force of the show of religion. Chap-

lains in particular learn early to watch manipulative uses of religion to attract their favor in a crowded hospital situation.

A second guide to the health of a religious expressiveness among mentally ill patients is *the careful evaluation of the economy of the religious ideas*. The minister and the psychiatrist need to ask: "What are the advantages of the illness, particularly what are the advantages of these ideas to the patient? What function do they serve in his life?" The way in which people are able, both in and out of treatment situations, to communicate their real selves with their religious ideas is a guide to the strength or weakness of their ideas.

Furthermore, when religious ideas are used as concealment devices, the resultant unhealthy religion defensively protects the individual from the demands of participation in a real world. Therefore, the clinician can legitimately ask the question: "Is this a religion of fear or a religion of self-abandon in courageous action and thought?" Mentally ill patients often appreciate such a reassurance: "Wherever you learned your fears, you may be sure you did not learn them from God. 'For God did not give us a spirit of timidity but a spirit of power and love and self-control' " (2 Timothy 1:7).

The fears themselves, though, have a protective function, and the discerning interviewer is concerned with the problems which the religious ideas and attitudes enable the person to solve, if but temporarily and unsatisfactorily. The minister particularly is tempted to talk mentally ill persons out of

“funny” religious attitudes before they have learned what these attitudes accomplish for the patient, and how these needs could be met more adequately and more enduringly. When the latter approach is followed, the ideas tend to be less amusing and more meaningful in the context of the total life situation of the patient. When the larger view is taken and a meaningful community developed wherein the person might be more legitimately secure, the ideas tend to return to a more accurate focus. For usually religious experience as a “security operation” does move into the direction of illness, and the task of therapy from the point of view of the psychiatrist and the work of the fellowship of Christians from the point of view of the minister is to enable persons to develop creative rather than defensive ways of living with themselves and each other. Whether religion and psychiatry do this or not is one way of evaluating the worth of both.

Both the psychiatrist and the minister need the sense of awe that comes from the mystery which is in each of their tasks. The mentally sick person quite often has religious ideas that comment meaningfully upon the sickness of his culture. His own personal grasp of religious reality bursts through the duplicities, the petty compromises, the socially acceptable superficialities and the calloused insensitivity of the culture of which he is often a part. Therefore, the illness itself may have a prophetic element in it, revealing the cracks in the armor of cultural defenses, religious and otherwise. As one of the earlier reformers, who himself was thought to be “just a wee

bit mad," put it: "Maybe even here there is some new breaking through of God's revelation of himself." The best attitudinal orientation in hearing a mental patient's story is that of a student, because the chances are very high that one may learn something from him!

Oriental reverence of the mentally ill as being a bit closer to God at times than other people has just enough truth in it as a superstition to persist in one's own primitive awareness. It should be taken with a grain of salt, yes. But one should always remember that even one grain of salt has not lost its savor for the psychiatrist and the minister who deal reverently with the mentally ill.

A third criterion for evaluating the health or illness of religious behavior and ideation is the "compulsive-volitional continuum." How compulsive or how voluntary are these expressions of religion? Self-determination is not only a psychiatric value, but has been underlined often in the best of religious wisdom. An example of this is evident in Jesus' teachings found in Matthew 19:10-12:

The disciples said to him, "If such is the case of a man with his wife, it is not expedient to marry." But he said to them, "Not all men can receive this precept, but only those to whom it is given. For there are eunuchs who have been so from birth, and there are eunuchs who have made themselves eunuchs for the sake of the kingdom of heaven. He who is able to receive this, let him receive it."

This is a commentary of Jesus not only on compulsiveness and voluntariness, but also on the problem of celibacy discussed in the last chapter. Obviously he appeals to the deeper motivation of the persons who live as eunuchs, that is, persons who are celibate. He points out that three motives prompt their behavior: (1) Some are congenitally incapacitated for effective marital living. (2) Some are made incapable for marriage because of the influence and treatment of other people. (3) Some of them voluntarily "of themselves" choose to do so. They are self-determined.

This may easily be observed in the training of theological students when they begin to examine their motivation for being ministers. Quite often theological faculties have had to enable men and women suffering from gross bodily infirmities to do the best they could as ministers and religious workers. These infirmities seemed to give them a compulsive drive to compensate for their inadequacies through their religious sense of mission. Other persons felt compelled by their relationships to their relatives and friends to carry through with the ministry so as not "to let anybody down." Others, the most adequate ones, voluntarily chose the Christian ministry from among a multiplicity of other possible things they could have done.

Psychiatrists have taught ministers the difference between compulsiveness and voluntariness in the evaluation of the meaning of alcohol to drinkers. They differentiate between the drinker who has been conditioned by his culture, the one who has no con-

control over his drinking, and the person who does not necessarily have to have alcohol to survive. They distinguish between the voluntary and the compulsive drinker. Many ministers may take exception to this distinction, but the advice that such a minister usually gives to the alcoholic is to exert "his will power." He assumes that all behavior is voluntary, but such a view is out of keeping with biblical concepts of the demonic, that is, Paul's concept of his being incapable of doing "what he would do," and James's view of the instability of the "double-minded man." The psychiatrist's less optimistic view of involuntary behavior is more in keeping with the biblical view than that of the complete voluntarism of the minister who feels that by exhortation he can cure the alcoholic. However, neither can one swerve with the psychiatrist on the other hand who interprets all behavior as instinctively determined, with no voluntary self-determination. The latter leads to a fatalism of automatic causation; the former leads to a deification of the human will. Both attitudes pave the way for the patient to project all responsibility upon others.

Nevertheless, the religious conviction of many persons as to abstention from a variety of practices, of which the use of alcohol is only one, can be understood as compulsive in some instances. One psychiatrist has pointed out the compulsive element in the religious zeal with which extreme prohibitionists hold their views. He calls them "dry alcoholics" who are apparently moved by the same inner dynamics as the alcoholic, but in the direction of abstention

rather than inebriation. Friedrich Nietzsche pointed this out in his brilliant commentary on the Pharisees. Jesus had said of them: "Woe to you, scribes and Pharisees, hypocrites! for you traverse sea and land to make a single proselyte, and when he becomes a proselyte, you make him twice as much a child of hell as yourselves" (Matthew 23:15). Nietzsche said of them, "Their only choice is between lusts and self-lacerations, and their lusts are self-lacerations and their self-lacerations lusts!"

A fourth criterion of the health and disorder of a religious experience is the extent of clarity or confusion which combines or completely dissociates symbol and reality in the thinking of the patient. For instance, religious folk speak in a symbol when they say in common religious parlance, "Lord, speak to me," in the words of a good hymn. The mentally well person knows what he means by this: that God does not speak in an audible voice, but reveals his Providence in the normal processes of understanding whereby men arrive at a settled conviction that what they know and do is in keeping with the character of God. But the mentally sick person may say: "The Lord spoke to me," and be referring to having heard audible voices. Boisen explains these voices as the darting of foreign and unacceptable thoughts into awareness with such force and strangeness that they sound apart from the person. At any rate, the symbolism and the reality are confused beyond recognition of the difference between them. The mental patient "overconcretizes" his experience, and his religious perceptions are no exception to this process.

In dealing with congregations in state hospitals formed of patients gathered for worship, the selection of hymns, Scripture, sermon subjects, and illustrations must be done carefully. (See *Hymns of Hope and Courage*, edited by Anton Boisen.) Otherwise, understood religious symbols become distorted through the anthropomorphic and anthropopathic identification of the symbol with reality in the minds of sick people.

In other words, the mentally healthy person has enough poetic imagination to be free from literalistic interpretations of religious symbols. But the sicker a person becomes, the more literally and legalistically he tends to interpret religious symbolism. On one occasion the author startled his students a bit with the statement that he saw a man who said that he saw God in the form of a bird. When asked what they thought of a "character" who would say such a thing as that, one student said: "He must be mentally sick." Then, to frustrate them a bit, the author said: "No. He is a good neighbor, he cares for his own family well, is respected and trusted by his community, and minds his own business." Then, a student asked: "What kind of bird was it he saw?" The author responded to her by saying: "I don't see that it makes any difference what kind of bird it was, as long as it was a bird." She in turn retorted: "Well, I think it makes a very great difference as to whether he saw God as a hoot owl or as 'descending in the form of a dove,' which is the symbol of peace and love."

Then the group began to get the point that sym-

bols *do* make a difference if they are not interpreted literally. Symbols are stimulants to accurate association in the well mind, but in the sick personality they further stimulate dissociation and distortion of perception. The way in which a person manages the problem of symbolic relationships to reality indicates something of his mental health in all areas, but especially is this true in the grasping of religious truth. An extensive analysis of this criterion of mental health in religion has been given by Carroll A. Wise. He says:

For the group as well as for the individual, symbols became overdeveloped, crystallized and dead. . . . In this case, religious symbols, far from promoting growth through an expanding comprehension of reality, serve to promote neurotic and psychotic trends both in the individual and the culture.⁴

Closely related to the capacity of the person to discern this paradoxical relationship between symbol and reality is the degree to which the individual gives completely private interpretations to religious truths. As Gardner Murphy has pointed out, the autistic responses of the individual clothe objective events, things, and ideas with the inner overlay of the individual's personal needs. In other words, in a more religiously meaningful way, the mentally healthy person tests his own religious awareness with the witness of his fellow religious pilgrims. He is

⁴ *Religion in Illness and Health* (New York: Harper & Brothers, 1942), p. 179.

always comparing his road map of directions with theirs in such a way as to help and be helped. He has a native need for collaboration, correction, and clarification of his insights with those of his conferees. He also draws upon the tested experience of the church in history and the biblical account of religion at its best and worst. These become the grounds of reality upon which he stands as he reaches toward the Infinite.

But the mentally sick person is much less likely to have this intention or need in his thinking and acting. He is more likely to "spin" an esoteric pattern of private thinking which is meaningful to him alone and by which he judges all others, breaking relationship with them when they do not get in line with him. As one patient said as she visited her pastor's office to enlist him in a crusade to which she had been called, "You don't understand me. Of all people I expected to agree with me, I expected most of you. You, a minister of the gospel; I am ashamed of you." With this, she bolted out of the door in a rage. It sounds as if the pastor had been in tremendous argument with her, but actually he had simply said to her that he was having trouble knowing best how to be of service to her. She was hospitalized in a few days through the co-operation of her church, her family, and the doctors. Through quick detection of her earliest symptoms, her pastor enabled her to get early psychiatric treatment, and in two months she was back in her home and at her work.

On the other hand, the mentally well person can

be recognized by his capacity to relate his more abstract ideas to symbol, not allowing his abstractions to go higher and higher through finer and finer definition until he loses touch with all symbols of communication. The mentally sick person occasionally presents the foggiest of generalizations, which are so ethereal as "to be out of this world." This movement toward unlimited abstraction tends to appear more often as the illness progressively becomes more chronic, it seems.

In both instances, first of overidentification of symbol with reality and then of complete detachment of abstractions from symbol, the mentally sick person develops set stereotypes of religious thinking. He repeats his ideas with a monotonous sameness, stereotyped in the same words, tones, and gestures. He lacks the capacity to diversify his thinking with additional insight, information, and relationships. Fixed ideas become substitutes for a vital faith which asks for help in its lack of belief. These fixed ideas inhibit the person's relationship to other people and muffle, distort, and seal off communication with them.

This discussion of symbols, abstractions, and stereotypes draws its validation from some of the research of the semanticists, notable among whom is Wendell Johnson, who has written meaningfully on the semantics of maladjustment in his book, *People in Quandaries*.⁵ However, the discussion leads into a description of the biblical teachings wherein

⁵ New York: Harper & Brothers, 1946.

healthy and unhealthy religious experiences are differentiated from each other.

The prophets in the Old Testament and the teachings of Jesus and the apostles in the New Testament reveal at least two lines along which they developed criteria for separating reality from unreality in religious living. They were always concerned with the difference between idolatry and the worship of the Eternal; and, in the second place, they were concerned with the difference between a false prophet and a true one. Usually they related the false prophet to some form of idolatry-teaching.

Technically defined, idolatry is the worship of any finite loyalty as if it were infinite, eternal, and unchangeable. The Apostle Paul calls it exchanging "the truth about God for a lie" and worshiping and serving "the creature rather than the Creator" (Romans 1:25). The writer of First John urges the early Christians: "Keep yourselves from idols" (1 John 5:21). Paul speaks again of the "bondage to beings that by nature are no gods" (Galatians 4:8). The Old Testament prophets looked upon idolatry as the worship not only of objects of stone and wood but of the elemental passions of human nature which these objects symbolized. Here in their prophetic utterances was their perception of the overidentification of reality with the symbol, the substitution of that which is finite for that which is eternal. On the other hand, Paul was aware of the opposite tendency of the philosophical abstractionists who had a "morbid craving for controversy and for disputes about words, which produced envy, dissension, slander, base

suspensions, and wrangling among men who are deprived in mind and bereft of the truth, imagining that godliness is a means of gain" (1 Timothy 6:4-5). These persons in turn had lost themselves in the worship of their own abstractions and had become so fixed in their ideas that conflict became morbid.

The biblical concept of demonology cannot be appreciated apart from the psychological effects of idolatry which it symbolizes. In the worship of a multiplicity of gods, the worshiper became a fragmented person, adulterated in the contradiction of loyalties, and each loyalty took on a separate organization of personality within the personality. The demonology of the biblical stories reveals the pre-scientific management and definition of the unintegrated person, possessed and driven by unmanageable and blind impulses. Even within the biblical account, especially under the insightful teaching of Jesus and Paul, the concept of demonology refines itself into a concept of spirits, such as the spirit of fear, the spirit of bondage. Polytheistic cultures, it seems, tend also to present demonological phenomena. Rev. Melvin Bradshaw, now a missionary in Japan, confirms this by his closer observation of demonism in the Orient. Polytheism stands over against the monotheism of the Judaistic and Christian traditions in which, as the Old Testament puts it: "Hear, O Israel: The Lord our God is one Lord; and you shall love the Lord your God with all your heart, and with all your soul, and with all your might" (Deuteronomy 6:4-5). Driving a straight line of spiritual balance, "the Old Testament is full of

testimony of the fact that the people of Yahweh . . . was open to the allurements offered either by the indulgence or the ritualistic abstinence fostered by the native cults.”⁶ In other words, neither the orgiastic nor the ascetic cults find comfort from the Hebrew view of religion. The unity of God was the foundation for the unity of personality, and the criterion of his oneness was set over against those “whose god was their belly” (see Philippians 3:19), as well as those who flagellated themselves and “cut themselves after their custom with swords and lances, until the blood gushed out upon them” (1 Kings 18:28). An interesting connection between idolatry and demonic fragmentation of personality is shown by Spencer L. Rogers:

The peoples of southern India recognized two classes of potentially possessing spirits which may cause insanity. One type of demon is the spirit of an ancestor who has been slighted through failure to show him the proper ceremonial respect. The other type of demon takes in a large class of local supernatural beings. A competent exorcist is able to drive out either type and thus cure madness.⁷

The prophets of false gods were false prophets, and the biblical writers were concerned with demarcating true prophets from false ones. One New Testament writer enjoins a wholesome skepticism upon Chris-

⁶ P. Kleinert, “Idolatry,” *The New Schaff-Herzog Encyclopedia of Religious Knowledge*, Vol. V, pp. 443-444.

⁷ *Ciba Symposia*, Vol. 9, Nos. 1-2, April-May, 1947, p. 605.

tians: "Beloved, do not believe every spirit, but test the spirits to see whether they are of God; for many false prophets have gone out into the world" (1 John 4:1).

This process of discernment of spirits was not unrelated to the insights of the modern psychotherapist as he evaluates kinds of insights, the health and sickness of the spirits of men. Likewise, it took a similar courage. Several rather "homespun" standards are set forth in the Bible which may be of worth in the evaluation of the health or illness in a religiously inclined patient's expressions.

First, the Bible sets forth the criterion of sincerity. For instance, Jeremiah chides the false prophet for his deceptive manipulation of people by "pleasing the crowd" (see 5:31). Likewise in the *Didache*, a poet-biblical writing of the early church, Christians are told to give a stranger a prophet's welcome. If he stayed longer than three days—presumably eating free meals—he was a false prophet. The psychopathic personality who "uses" religion to say "smooth things" to "tickle the ears" of the populace as a "paid optimist" was no more of a newcomer to the biblical writers than he is to the chiding criticisms of psychiatrists today.

Second, the Bible uses the criterion of community and communication. The Apostle Paul confronted persons also who became so ecstatic that they spoke in the "jabbering" unknown tongues. But Paul was concerned with the power of the prophet to "build up" the church through understanding. He says: "Nevertheless, in church I would rather speak five

words with my mind, in order to instruct others, than ten thousand words in a tongue" (1 Corinthians 14:19). This is the basis of the modern Quaker practice of testing a religious insight by "the meeting" of the community of believers, in order that the clarity of the insight might be established, corrected, and understood by others.

The criterion of maturity is also set forth in the context of Christian love in the thirteenth chapter of First Corinthians. False prophets, specious religion, and immaturity are shown up in the criteria of spiritual health of this poem of the Christian way of life. The religion of much speaking, of esoteric abstraction, exhibitionistic demonstrations of faith, and compulsive activity as "do gooder" are measured by the plumbline of mature love as the supreme criterion of healthy religion, apart from which all else is as nothing.

If I speak in the tongues of men and of angels, but have not love, I am a noisy gong or a clanging cymbal. And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have all faith, so as to remove mountains, but have not love, I am nothing. If I give away all I have, and if I deliver my body to be burned, but have not love, I gain nothing.

Love is patient and kind; love is not jealous or boastful; it is not arrogant or rude. Love does not insist on its own way; it is not irritable or resentful; it does not rejoice at wrong, but rejoices in the right. Love bears all things, be-

believes all things, hopes all things, endures all things.

Love never ends; as for prophecy, it will pass away; as for tongues, they will cease; as for knowledge, it will pass away. For our knowledge is imperfect and our prophecy is imperfect; but when the perfect comes, the imperfect will pass away. When I was a child, I spoke like a child, I thought like a child, I reasoned like a child; when I became a man, I gave up childish ways. For now we see in a mirror dimly, but then face to face. Now I know in part; then I shall understand fully, even as I have been fully understood. So faith, hope, love abide, these three; but the greatest of these is love. (1 Corinthians 13)

In essence, then, healthy religion binds people together in such a way that their individuality is enabled both to be realized and to be consecrated to the total community of relationships to which they belong. This is a religion of mature and responsible relatedness, which does not interpret disdain for people as the call of God to withdraw from or attack other people. Rather, as an old woman in Kentucky said in a prayer meeting in her home, "Religion is aimed to pull people together and not to wedge 'em apart."

FIVE

Interpersonal Relatedness and Religious Experience

PERSONAL RELIGION at its best, then, is an individual's discovery of eternal and satisfying relatedness in his universal field of interpersonal relationships, whereby he lives with courage and sensitivity, and without morbid defensiveness and loss of feeling. As Gordon W. Allport puts it, "A man's religion is the audacious bid he makes to bind himself to creation and to the Creator. It is his ultimate attempt to enlarge and to complete his own personality by finding the supreme context in which he rightly belongs."¹ In Christian communions, this "supreme context" is the kingdom of God, the "audacious bid" is faith in Christ, and the "binding power" is the obligating demands of Christian discipleship.

Therefore, different kinds of religious experiences should be classified in terms of the direction, quality,

¹ *The Individual and His Religion* (New York: The Macmillan Co., 1950), p. 142.

and ways in which persons relate themselves to their community of fellow human beings. Whereas detachment has its real place in the healthy religious life, even detachment from people itself has no real meaning apart from the community. As T. S. Eliot has said, even the anchorite praying alone in the desert does so in terms of the church, the community of faith. This thought of religion is akin in some ways to the more recent orientations in the field of psychiatry, particularly the conceptual formulations of Harry Stack Sullivan in his books, *Conceptions of Modern Psychiatry*,² *The Interpersonal Theory of Psychiatry*,³ and *The Psychiatric Interview*.⁴ He emphasizes "participant observation," recognizing and evaluating the doctor's personal involvement in the whole treatment situation, and calling attention to the dynamic processes of interaction going on between people in the relatedness or unrelatedness. He defines psychiatry as an expanding science concerned with the kinds of events or processes in which the psychiatrist participates while being an observant psychiatrist.⁵ This concept comes more nearly than many psychiatric concepts to describing accurately "the social matrix of psychiatry," to use Ruesch and Bateson's phrase.

Although Sullivan was not a professing religionist, he nevertheless showed the marks of reverence for religious truth which was truth. He drew an em-

² Washington: Washington School of Psychiatry, 1948.

³ New York: W. W. Norton & Co., 1953.

⁴ New York: W. W. Norton & Co., 1954.

⁵ *The Interpersonal Theory of Psychiatry*, p. 13.

pirical concept of interpersonal relationships through observation of the processes of mental illness which may, with careful imagination, be correlated with the concept of *the covenant relationship* in the Hebrew-Christian view of personality in society and under God. This concept "is common Christian property." All historically rooted groups of Christians tend to take the idea seriously of a covenant relationship between themselves and God. The idea is "an inheritance of Christianity from the Old Testament, which frequently describes the relation between Jehovah and his people in terms of a covenant, entered into either with individual Israelites or with the nation as a whole."⁶ This covenant in most instances is the ground of assurance of God's love and favor, the standard of Christian behavior, and the key to Christians' understanding of their purpose in history. The Christian's relationship to himself and to his group, his concept of right and wrong, his relationship to God, and his interpretation of God's purpose for his life—all these draw meaning from the character of the covenant that is drawn, accepted, and understood as being the ground of the divine-human relationships.

The history of the Hebrew-Christian religions indicates a process of tension between legalistic and more distinctly interpersonal and spiritual interpretations of the nature of the covenant, or the "tie that binds" Christians together. The prophetic revolution in Judaism shattered the cultic and folkway

⁶ W. Adams Brown, "Covenant Theology," *Encyclopedia of Religion and Ethics*, Vol. 4, 1912, pp. 216 ff.

“calcifications” of the meaning of the relationship between man and man, as it is grounded in the community relationship to God. The prophet Jeremiah boldly puts the externalism and ritualism of his contemporaries into bold contrast with the inner insight, acceptance, and self-determination of the covenant as he saw it:

Behold, the days are coming, says the Lord, when I will make a new covenant with the house of Israel and the house of Judah, not like the covenant which I made with their fathers when I took them by the hand to bring them out of the land of Egypt, my covenant which they broke, though I was their husband, says the Lord. (Jeremiah 31:31-32)

The New Testament re-interprets the nature of the covenant, criticizing cultic and legalistic externalism altogether, and depicts the relationship of persons in the kingdom of God as being a New Covenant in the bond of self-emptying love effected by Jesus Christ on the cross. Sigmund Freud, although in a negative context, says:

Every Christian loves Christ as his ideal and feels himself united with all other Christians by the tie of identification. But the church requires more of him. He has also to identify himself with Christ and love all other Christians as Christ loved them.⁷

⁷ *Group Psychology and the Analysis of the Ego*, pp. 42 f.

The Apostle Paul speaks clearly of the Christian covenant:

Remember that you were at that time separated from Christ, alienated from the commonwealth of Israel, and strangers to the covenants of promise, having no hope and without God in the world.

And he came and preached peace to you who were far off and peace to those who were near; for through him we both have access in one Spirit to the Father. So then you are no longer strangers and sojourners, but you are fellow citizens with the saints and members of the household of God, built upon the foundation of the apostles and prophets, Christ Jesus himself being the chief cornerstone, in whom the whole structure is joined together and grows into a holy temple in the Lord; in whom you also are built into it for a dwelling place of God in the Spirit. (Ephesians 2:12, 17-22)

Likewise, he describes the results of this relationship in terms of spiritual stability, productive love, and spiritual maturity. The distance of unrelatedness has been overcome:

Until we all attain to the unity of the faith and of the knowledge of the Son of God, to mature manhood, to the measure of the stature of the fullness of Christ; so that we may no longer be children, tossed to and fro and carried about with every wind of doctrine, by the cun-

ning of men, by their craftiness in deceitful wiles. Rather, speaking the truth in love, we are to grow up in every way into him who is the head, into Christ, from whom the whole body, joined and knit together by every joint with which it is supplied, when each part is working properly, makes bodily growth and upbuilds itself in love. (Ephesians 4:13-16)

Thus the kingdom of God exists among men and is manifested in a deepened sense of community or *koinonia*, as it is known in the New Testament. Likewise, the inner community manifests itself in the individual in his experience of being acceptable to the community, even though he is weak, finite, sinful, and imperfect.

The correlation of the concept of interpersonal relationships with the concept of the covenant of the religious community lays the groundwork for developing a classification of psychosocial types of religious experience. Different kinds of religious experience are distinguishable from each other in terms of the ways in which the individual breaks, is broken by, is bound to or bound by the covenant relationship of which he is a part. In other words, the individual lives and moves and has his being in terms of his relatedness to the covenant of his faith. He is either related or unrelated; he is either reconciled or unreconciled; he is either at peace or he is in conflict in terms of his movement of his spirit in relation to his covenant community.

Whatever his condition may be, psychiatrically

speaking, the religious aspects of his problem may best be understood in terms of his type of relatedness or unrelatedness, as the case may be. In fact, the function of religion in his struggle for existence and his threat of destruction may be understood in terms of this relatedness. In a real sense, his community (in the event that his religion is devout with him) may make the difference between his redemption or health, and his destruction or disease.

With this foundational principle of a covenant of interpersonal relationships in mind, functional types of religious experience evident in clinical observation may be described now, particularly among the mentally ill.

The Religion of Hostility

This kind of religious experience is what Horney has defined as "moving against" people. Although one does not take her system *in toto*, her patterns of the movement of neurotic spirits of people are particularly applicable to the patterns of religious relatedness.⁸ The Christian faith has a place for this kind of relatedness, inasmuch as the Christian tradition in its inception did not *taboo* aggressiveness and hostility, as more recent and more sentimental distortions of the virility of early Christianity negate this kind of relatedness. For instance, the expression of anger is not condemned in the biblical account except as it is done apart from the covenant of forgiveness and reconciliation. Jesus recognized that

⁸ Karen Horney, *Our Inner Conflicts* (New York: W. W. Norton & Co., 1946).

anger was inevitable, but that quick reconciliation was necessary to vital religious living. However, he was not a sentimentalist in the sense that he assumed that anger could happen without a process of human alienation, judgment, and condemnation going on. He said:

You have heard that it was said to the men of old, "You shall not kill; and whoever kills shall be liable to judgment." But I say to you that every one who is angry with his brother shall be liable to judgment; whoever insults his brother shall be liable to the council, and whoever says "You fool!" shall be liable to the hell of fire. So if you are offering your gift at the altar, and there remember that your brother has something against you, leave your gift there before the altar and go; first be reconciled to your brother, and then come and offer your gift. Make friends quickly with your accuser, while you are going with him to court, lest your accuser hand you over to the judge, and the judge to the guard, and you be put in prison; truly, I say to you, you will never get out till you have paid the last penny. (Matthew 5:21-26)

Furthermore, this normal way of handling hostility in the covenant of love was also coupled with the experience of tenderheartedness and forgiveness. Jesus said:

Be angry but do not sin; do not let the sun go down on your anger.

Let all bitterness and wrath and anger and clamor and slander be put away from you, with all malice, and be kind to one another, tenderhearted, forgiving one another, as God in Christ forgave you. (Ephesians 4:26, 31-32)

The achievement of this balance between open frankness of expression of hostility and quick reconciliation of differences is rarely achieved in our society today, particularly in religious groups. Rather, hostile-aggressiveness becomes a pattern of religious experience apart from its polar tension with tenderness and eagerness toward reconciliation. The elements of hatred, which are the settled aversions of hostility as a way of life rather than a temporary solution of problems of communication and frustrated needs, become insidious when insight and the will to relate in love are snuffed out. Then the religious group tightens its lines and becomes a defensive in-group rather than a witnessing fellowship. The pattern of its behavior becomes legalistic and external rather than teachable and winsome. The objective of its existence becomes to attack and to hurt rather than to persuade and to heal.

Such a pattern may also develop within an individual. The pathology of religious experience begins as the springs of insight and the sources of control are shut off from within the individual. He no longer wills to relate, but chooses to attack. He no longer desires reconciliation, but chooses to defend himself. His aggression becomes irresponsibility, and he "splurges" his hostility under a thin coating of reli-

gious symbols. Anton Boisen describes this kind of religious experience in a patient whom he knew at Worcester State Hospital and chose to name "Jonah." The patient felt that God had sent him to Worcester to preach the gospel and to call the people out of the wickedness of their ways. But one of the ways he felt that God had called him to do this was to "knock people's brains out with flower pots when they crossed him." Boisen makes the point that self-expression is a valuable thing only when it is in keeping with the larger good of the community as a whole, and that this patient was an excellent illustration of hostility gone pathological at the point of religious justification of compulsive hostility. Andras Angyal indicates that not all expressions are therapeutic, but only those which are expressions of real courage—and not those which are the helpless fretfulness of one's frustrations.

Another example of hostile-aggressive patterns of relatedness in religious experience is cited by a state hospital chaplain:

A thirty-seven-year-old, white, married, male patient was brought before the diagnostic staff. Upon entering he requested of the staff that he be permitted to pray before he was interviewed. The clinical director paused for a moment and replied, "Mr. G., we are not here today for the purpose of prayer. Will you please be seated, so that we may talk with you."

The patient became very resistive and vehemently retorted, "You men are not believers.

You are children of your father, the devil."

When questioned about his religious experience, the patient evaded questions by saying, "You are not a religious man, so you would not understand."

The religious delusions of many mental patients are saturated with unalloyed hostility as a way of religious relatedness. The persecutory feelings of many patients structuralized in religious symbolism are probably the most common manifestations of hostile religion. This was obvious in the patient who told the author that every time she thought of God, the cursing thought of calling him an "s.o.b." came into her mind. She also had this thought every time she thought of her husband, her doctor, and the chaplain. She smiled coyly as she expressed these thoughts.

The dividing wall of hostility of which Paul speaks in the quotations previously given in this chapter is the wall against which the hostilely related patient is constantly thrusting his energies, and becomes such when this kind of relatedness becomes the stereotyped monotone of his spiritual life.

Dependent Religious Relatedness

Another pattern of religious relatedness seen in the psychiatric clinic is the emotional parasitic or dependent person. An example is the patient who, with the complaint that she was not saved, sought to develop dependency relationships which made her as a leech to those to whom she related. She would call her minister three and four times a day, asking

him to reassure her that she was saved. She constantly drew her security from the "smooth sayings" of comfort that some minister had written, said, or by his actions caused her to believe. These were more like an aspirin for her "migraine headache of the spirit." She became quite addicted to religious reassurance.

Another example of this kind of relatedness and religious experience is that of a large, obese man. He smoked one cigar after another all day long. His bed was a center for the obeisance of his family as they nursed one recurring set of symptoms after another. He spoke long and often, in a "word-salad" of religious symbols of his dependence upon God, as to how God was solving all his problems for him. He spoke in almost a baby talk of how other people might drink, run around with women, and play cards, but "*God* was his pacifier!" This person was in a private hospital for psychosomatic treatment at the time, and was something of a complete financial drain on his most distant relatives as well as his closest ones.

Of course, one theologian, Schleiermacher, interpreted religion in terms of dependence. The feeling of dependence was the basic religious sentiment in his theology. However, in his theology also, this dependence was set forth in terms of the consciousness of kind and the values of the reciprocal experience of dependence.

The Apostle Paul epitomizes the legitimate interpretation of the role of dependence in the interpersonal relatedness of healthy religion. He spoke of the law of Christ being fulfilled as Christians "bear one

another's burdens." But on the other hand, in the same context, he also speaks of the paradoxical element of reciprocity in this dependence. He says, "Each man shall bear his own burden of responsibility." Here one finds neither the kind of independence of Henley who could say, "I thank whatever gods there may be for my unconquerable soul," independent in all its self-sufficiency, nor the compliant parasitism of the sick persons described here. Religion becomes sick with the rest of the personality of the individual in such imbalances of the spirit. The clinically minded minister and the psychiatrist can both interpret the illness and the religious experience in terms of the way in which the patient tends characteristically to relate himself to his God.

Certain superficial uses of psychiatric, psychological, and psychoanalytic information by popular preachers in this country today reveal a rather extensive trend toward the wholesaling of opiate dependency as a way of religious relatedness to life. Religious barbiturates make of God a "purveyor to man's appetites" for success, peace without discipline, and healing without insight and self-confrontation. For instance, Norman Vincent Peale says, "If an unhappiness thought should enter your mind, immediately stop, eject it, and substitute a happiness thought."⁹ One counselee read this book. Her pastor asked her what it meant to her. She said:

⁹ *The Power of Positive Thinking* (New York: Prentice-Hall, Inc., 1952), p. 75.

It was the only thing I could find to read that was aimed at my troubles. I got some help from it, but because it would help me to sleep. But then, it did not last, even though I tried it again. It wore off, and then I felt really awful because I had not only my awful thoughts, but also I was worried over not having positive thoughts.

The Despairing Religious Relatedness

The reason that the above girl could not be helped by easy reassurance and relaxation rituals was that she rejected the dependency-parasitic way of life. She was depressed because she could not find a way of self-autonomy. She was a profoundly depressed person who was made to feel all the more depressed by the empty optimism she read. Her main concerns centered around her recent bereavement of her father, her having finished college and having been separated from her "chums" and eligible male friends, and her having been for the first time in her life pushed out on her own in a large city apart from her mother and siblings. She had a long history of emotional deprivation, particularly in terms of her religious community, which otherwise should have had a nourishing effect on her spiritual life. The accumulation of these stresses and strains brought her to her pastor for help. In turn the pastor sought medical and psychiatric help for her in the midst of her profound despair.

Her feeling was that she was not worthy of God's favor, that none of his grace could have been meant

for her, because she did not really matter to anyone. She knew him to be a kind and providential God, but could not feel that God could possibly feel that way toward her. The sincerity with which she said these things did not indicate the whining of a "poor little me" sort of person. They were the deepest of desperation feelings in which emptiness, meaninglessness, and pointlessness of existence made her feel most of the time that she could not go on even one step further.

Condemning feelings of unworthiness overwhelmed this person. She was desperately in need not only of psychiatric care but also of the reconstructed family community of a church who "visited the fatherless" in their affliction. Although the covenant relationship of the church was unreal to her, and although she felt herself "afar off," the skillfully developed friendships of the church made it believable to her. The development of a therapy program, an adequate work adjustment, and an undergirding family of fellow Christians about her enabled the very depressed person to find her way gradually back into an adequate meaning of life. Her doctors feared several times that she would have to be hospitalized, but they were able to avoid this necessity through a long process of sustained psychotherapy implemented by the group life of the church of which she was enabled to become a part.

In the despairing kind of religious relatedness, the movement of the spirit seems to be against the self, either for feelings of extreme guilt in the case of the reactive kind of depression or for feelings of "not

matter” to any one in the case of emotional deprivation. The cult of reassurance which hands a few religious pills of platitude to such a person subtly rejects the reality of his suffering and deserves the retort of Job to his comforters: “As for you, you whitewash with lies; worthless physicians are you all. Oh that you would keep silent, and it would be your wisdom!” (Job 13:4-5).

Extractive Religious Relatedness

Another type of religious experience is what Chaplain Joseph Knowles has chosen to call the “extractive” relationship. The individual here is related to the rest of his covenanted community of concern as a manipulator, “getting out of them everything he can.” He “plays all the angles,” gets every advantage, exercises the cunning of the serpents, and has a remarkable ruthlessness about him. The hallmark of this kind of religious experience is its power to exploit. As Paul puts it, these persons use “godliness as a means of base gain.” The psychiatrist does not confront these persons on the ward of his psychotic patients as often as he confronts them on a prison-compound, handing him a “line of religious chatter.” He may confront such persons in the induction line, claiming certain favors because of religion. Likewise, he may confront psychotic patients whose sufferings have been exploited by professional religionists who relate themselves to people extractively, regardless of the people’s needs. Occasionally he will find an itinerant evangelist who has played his whole town for a “sucker,” on his wild promises of faith healing,

quick and easy salvation, and great success in business. The monetary factor plays a large element in this kind of religious phenomenon.

On the other hand, religion may be a means toward extracting covert erotic gratifications for the neurotic and/or psychotic person in some instances, and for the psychopathic personality in others. The chaplain in a mental hospital is often aware, as is the doctor, of the high degree of erotic gratification the patient seeks in the interview situation. Religious relatedness may take an erotic bend of intention also and thinly veneer the extractive relatedness of the patient.

In many instances, the patient may be consciously using the advantages the show of religious concern gains for him. Here he becomes quite a "smooth operator." A candidate for entrance to a certain school was asked to confer with the admissions committee. He told a very convincing, carefully phrased, and smoothly turned story of how he had been released from prison, converted, and called to the ministry, all within a few weeks of each other. God had definitely sent him to the school to begin his education, he said. The school could not accept him because of his short-term connection with the church. Later it was found that he was retreating to the school as a hideaway from the Federal Bureau of Investigation, because of a long series of offenses for which he was wanted.

This illustrates the wisdom of a certain New Testament criterion for measuring the sincerity of the

religious profession of persons wanting to enter the work of a religious leader: "He must not be a recent convert" (1 Timothy 3:6). Theological schools do well to expect a man to have been an active member of a church for at least a year before he is allowed to enter the seminary to prepare for the ministry. Such a rule has in some instances produced remarkably effective results in screening men who were not sincere in their professions but were extractively relating themselves to the school, seeking to use it for some ulterior motive.

Withdrawal and Religious Experience

Karen Horney, once again, calls withdrawal as a way of relatedness, "moving away from" people. Detachment can become a way of life. When religion becomes the moving force of such a way of life, then religious experience may be said to be a *withdrawn* type of religious experience. Certain aspects of religious withdrawal from life have already been discussed in the consideration of asceticism. However, the monastic adjustment to life is the institutionalized and culturally sanctioned form of this way of living. In certain religious cultures, this way of life and religious relatedness is considered the *summum bonum* of the types of religious experience; to such an extent is this idealized that other forms of life may even be considered substandard.

From a more distinctly clinical point of view, however, the withdrawal of a person from reality is a psychiatrically serious matter quite differently

motivated from much that would normally appear under the name of monasticism. Such withdrawal becomes apparent among persons even in the early stages of an illness. They begin to develop marked feelings of separation, isolation, and distance from persons to whom they had felt rather close. They might complain of exceeding difficulty in their prayers if they are religious people, and develop strange explanations for the difference they feel exists between them and God. The Christian minister notices this withdrawal in abrupt isolation moving between the individual and the church. The person may without any visible provocation cease to attend church after having been a regular attendant for years. On the other hand, "dyed-in-the-wool" shirkers of church attendance may show a sudden burst of interest and activity without any apparent reason for doing so. These persons in turn may have begun to suffer isolation and withdrawal from some other group which was meaningful to them, or to become intensely aware of their loneliness. Anton Boisen gives a thumbnail sketch of such a patient in his study of mystical identification:

Typical of this group is a serious-minded boy, brought up in the Roman Catholic Church, who had accepted its teachings and those of his parents but had been unable to handle his troublesome sex urge in accordance with the standards thus determined. Prominent in his mind were ideas of death and world disaster, but there was much recessive phantasy formation and

there was no fighting spirit, no determined attempt at reorganization.¹⁰

Joseph W. Knowles, another mental hospital chaplain, cites similar examples of withdrawal:

. . . one patient "feared she would say the wrong thing or be misunderstood." Another woman feared that in talking, "other people will be obligated to me." A male patient verbalized his experience as follows: "When I talk to others, I get hurt." Later, he said, "What you say has the ability to turn me upside down inside."¹¹

A vivid example of the frantic attempts of a person to "stay in touch" with reality through a religious community, although she was becoming more and more detached, is a twenty-seven-year-old girl. She had quit her job, changed her boarding place from her "worldly sister's" home, and moved to a strange and large city. She announced to some of her acquaintances that she was being called away for a strange religious mission, the exact nature of which she could not tell them.

These were the initial phases in a complete break with reality and withdrawal into a confused, abstract stumbling of religious inwardness in which she felt that God was "in her and she did not know what

¹⁰ "The Genesis and Significance of Mystical Identification in Cases of Mental Disorder," *Psychiatry*, Vol. 15, No. 3, August, 1952, p. 291.

¹¹ *The Mental Hospital Chaplain as a Counselor with Schizophrenic Persons*. Unpublished doctoral dissertation, Southern Baptist Theological Seminary, 1954, p. 294.

to do to get him out to others." She was extremely upset that her minister could not grasp what she was trying to get across to him; he in turn was somewhat frantic to reach across the chasm of communication to understand her. He sought psychiatric help for the girl through the co-operation of her family, and the therapies which they administered brought her relaxation and renewal of body. Sleep and proper diet caught up "the ravelling sleeve of care" in this girl's life, and within three or four weeks she was lucid enough to begin to talk with focus about her ideas. The understanding and tenderness of a whole church made a great difference in the girl's being protected from embarrassment. She could have been further confused by "pushy" attempts at arguing with her about her religious concern, but she was wisely protected from this as well as from the exploitation that could have come her way as a lone girl wandering in the streets of a large city.

The classification of religious experience as a withdrawn kind of relatedness seems to be a contradiction of terms—"withdrawn" being used with "relatedness." But this contradiction itself accents the real problem, as the religious experience draws its definition from the reciprocal interaction or lack of interaction between the covenant community and the individual. In schizophrenic withdrawal reactions, probably more than in others, one sees the making and breaking power of "the crowd." Karen Horney describes the separation, alienation, and isolation of withdrawn persons with the words of a character in an unpublished novel of Maria Armi:

I dreamed at the time of living alone, of never marrying, of becoming strong and peaceful without talking much, without asking for help. I wanted to work on myself to be freer and freer, to give up dreams in order to see and live clearly. . . . The great question was not to look for sympathy or expect help. Souls seemed to me temples that had to be guarded, and inside them were always strange ceremonies going on, known only to their priests, their custodians.¹²

Such is a description of what Harry Stack Sullivan calls "distance machinery" in a sick person.

Jean Paul Sartre, in his play, *No Exit*, dramatically depicts the hellishness of the unrelated life by describing hell as a situation in which three persons without the capacity to relate to a responsible community are consigned to live in the same room together for time without end, a room which had no exits. This is, religiously perceived, what Søren Kierkegaard called "inwardness with a jammed lock."

Blighted Religious Experience

The religious experience of persons may reach a point of sterility and nonproductiveness. Yet all the while the other processes of the individual's life go on because of external necessity. Such religious phenomena, however, almost defy description.

The medieval moralists help to identify the blighted type of religious experience with their con-

¹² Karen Horney, *Our Inner Conflicts*, p. 82.

cept of *acedia*. They defined this as a disease. "A melancholy leading to desperation, and known to the theologians under the name of 'acedia,' was not uncommon in the monasteries."¹⁸ *The New Century Dictionary and Cyclopaedia* defines it as "an abnormal mental condition characterized by carelessness, listlessness, fatigue and want of interest in affairs." The obscure English word *jejune* catches up some of the meaning of "void of interest, satisfaction; barren, meager, dry, and insipid." A derivative of the Latin word *acidus*, i.e., *acidulate*, meaning "to become sour-tempered, sour, embittered, cross, and captious" as a chronic way of life, gets the feeling tone of the blighted religious life, also. The Greek word *akedia*, meaning the loss of enthusiasm and the onset of tedium, helps to clarify the religious way of relatedness of which Paul speaks when he warns the Galatians: "And let us not grow weary in well-doing, for in due season we shall reap, if we do not lose heart" (Galatians 6:9).

This type of religious experience differs from the depressive, despairing kind of relatedness. It is a sort of chronic "gripe-gutted" attitude toward life, encased in the complaining tones of religious symbols. Apathy within manifests itself as a hypercritical attitude toward everything, in that nothing anybody can do pleases. The loss of luster, the loss of radiance and vitality, the "dying out" of life, becomes apparent in religious cynicism and barbedness of feeling about anyone else's enthusiasm.

¹⁸ W. E. H. Lecky, *History of European Morals*, 3rd edition revised (New York: D. Appleton & Co., 1906), Vol. II, p. 52.

Several manifestations of this kind of religious relatedness appear in pastoral work as well as medical practice. First, early signs of this blighting appear in the religious living of late teen-agers, due to the military drafting of young men. They cannot plan their lives; their vocational and marital decisions are prejudiced. They cannot get a job, because no one wants to invest a year's training of an inexperienced person only to have him drafted. They cannot participate meaningfully in any long-range intentions for living. Therefore, they develop an apathy, a religious unconcern and lack of feeling. So much is this true that a "who cares" attitude is subtly rooted rather early. The religious implication is that God does not care, and fate has taken over in his stead.

Second, religious blighting takes place in severe bereavement situations. Apart from the normal initial stage of numbness and apathy due to the shock of grief, the person referred to here is the person whose basic emotional resources, particularly in terms of his religious values, were tied up in the life of the deceased person. For instance, one such person had a twenty-three-year-old daughter who had just recently given herself to a religious mission in life. The girl suddenly died. He refused to accept the reality of his daughter's death, thrust the whole responsibility upon God, and now lives a sour and distasteful existence. His work and his political ambitions enable him to carry on with a marginal adjustment to life. However, the emotional tone of this man's life is like that of lead; to change the figure, the texture of his spiritual life has become brittle.

By desensitizing large areas of his life, he protects himself against the real fact that death, like God, is no respecter of persons.

The third, and probably the most common, manifestation of the brittle blightedness of religious experience may be observed in counseling with practicing ministers. The handling of religious affairs daily may deaden the spiritual spontaneity of ministers, it seems. Chaplains of a denominational hospital visit many ministers who come as patients to the hospital. Some of these ministers have encountered severe disillusionment in their pastoral work. Many of them have begun to experience the tediousness and tastelessness of their work. Instead of being an adventure, it has become a chore. Yet, they confront the necessity of carrying on the responsibilities of sustaining others, stimulating religious energy for others long after their own had reached a low ebb, and "putting on an act" of enthusiasm when their own feelings were poles apart from the requisites of their task. As actors say, "The show must go on."

Closely associated with this is the religious experience of some few persons in many types of professional schools. Ministers whose religious experience is blighted tend to turn to their seminaries, for instance, to reactivate their spiritual resources, as well as to "re-tread" their sense of adequacy and loss of meaning with further academic degrees. The restoration of spiritual-feeling tone and the development of an undernourished spiritual existence become their most acute necessity.

A fourth clinical manifestation of "religious blight,"

or a "soured" religious experience, may be observed in educational institutions where people who have been in schools all their lives plainly get bored with it. In fact, this religious sourness is a real occupational hazard for theological professors, in particular. Whereas prisoners in penal institutions get "stir crazy," the institutional maladjustment of theological professors is to get "sour on the world." Nothing "will come right," and students tend to "catch" their cynicism.

Pastors, theological professors, and lay religious leaders can move so far in the direction of this kind of maladjustment as to organize their lives around some demonic disillusionment, which gets bigger and bigger as they chew on it in their minds. Almost always, if not always, professional religious workers who need psychiatric referral have elaborated their illness around an occupational conflict, and the two—the conflict and the illness—are inextricably interwoven. For this reason, the psychiatric therapy of religious workers involves a great deal of vocational insight on the part of the psychiatrist as to the relation of the illness to reality-based vocational problems. Likewise, the clinically trained pastor can be of inestimable aid to the psychiatrist in providing a picture of the social context of the suffering minister. These observations tend to be true of any professional person, but are more true of ministers and psychiatrists when they themselves encounter emotional disorders. In fact, what is said here about religious blighting could be very easily taken out of the con-

text of religious values altogether and applied to other professions as well.

Another evidence of religious blighting appears in the religious experience of wives and mothers who have deep religious impulses but are "tied down" at home by religiously irresponsible and noncommunicative husbands. These women do not have an opportunity to express their deepest religious intentions. They may get quite desperate when this religious blighting is coupled with the "monotony of monogamy" which characterizes too many marriages. The children take so much of the mother's time in caring for them and the father's time in providing for them, that either the man or the woman may mistake needs for a deeper nourishment of the spiritual life for the need for sexual variety and experimentation. They may, under the pressures of this kind of blighting of their lives, slip into extramarital sexual escapades or into some kind of illness.

Finally, another clinical manifestation of blighted religious experience is in the stunted religious growth of persons brought up in legalistic religious environments. Both the stunting and the legalism are manifestations of religious blight. Legalistic codes, developed by a basically suspicious adult religious leadership in both the church and the home, represent the loss of creative vitality and the development of a religion of fearful defense. Children reared in this kind of setting tend to reach a certain point in their religious growth and then to stop. As they grow older, the archaic experience remains unassimilated into their adult life. These "vestigial remainders"

affect the spiritual attitude of the adult with such symptoms as sourness, bitterness, and a chronic complaining about the burden of the religious infantilism which the person had "unloaded on him when he was a child." He is too old to be drinking the "milk of a child's religion," yet he has not found the "strong meat of an adult's religion." He lives in the state of constant religious shrinking and undernourishment as a result. Therefore, the cynical, "snide," and sour religious attitude embitters every contact with religion or religious people.

This particular manifestation of religious experience may be apparent in some psychiatrists. They react sourly to the religious problems they confront as adults. Whether they mean it so or not, their patients detect their cynicism just as the students of a religiously blighted theological professor detect his sourness and cynicism. Such a doctor and such a professor both need the utmost of understanding, because one sour attitude is not cured by another. Neither is a sour attitude cured simply by mixing sweetness with it. Hence, one can be frank about these attitudes with no need to overcompensate with "oversweet" words about either ministers or psychiatrists.

Adult professional persons can handle their own disillusionments in at least two different sets of choices: They can let the experience of disillusionment soften them, harden them, or mellow them; or, they can let the experience sour them, sweeten them, or season them. The ideal person is a seasoned, mellow person. The exhortations of the Epistle to the

Hebrews are relevant at this point: "See to it that no one fail to obtain the grace of God; that no 'root of bitterness' spring up and cause trouble, and by it the many become defiled" (Hebrews 12:15).

Religious blighting comes more nearly to being a "widespread," "garden variety" kind of religious ill-health. In it, as in the other types of interpersonal relatedness in religious experience, the community reference stands as determinative. For instance, the Epistle to the Hebrews relates bitterness to the defiling of "the many." The context of interpersonal relationships—that is, the pattern of the covenant that binds religious people together—gives the minister and the doctor a way of knowing what religion actually means in the attitudes and behavior of both sick and well people, and "society itself becomes the patient," to use L. K. Frank's phrase.

The vitality of an interpersonal approach to understanding types of religious experience in the mentally ill as well as the mentally healthy is felt keenly as one reads the two novels by Alan Paton concerning South Africa. The first one, *Cry the Beloved Country*, is the wistfully told story of the shattering of the solidarity of the South African community by the forces of industrialization. The story is about the confusion of an African minister whose own son is executed for having committed most of the crimes against society. The "broken" community exacted its toll on the family. In one place, the consternation of the people of South Africa is poignantly set forth when Paton says: "The counselors of the broken tribes have a counsel for everything except the mat-

ter of a broken tribe." Likewise, in America, religious counselors tend to have counsel for everything except the matter of the shattered state of the relationships of religious people to each other.

The ineffectuality of the broken community to meet its people's personal needs for counseling and therapy is set forth in Paton's second novel, *Too Late the Phalarope*. A young man, pushed from within by a noisome compulsion he could neither understand, control, nor communicate to some member of the community, chose to withdraw more and more from those whom he most loved and feared at the same time. Finally the fact that he had broken one of the most serious laws became known, and the writer says: "Because he could not tell one of us, all were destroyed." Thereby Paton comments both upon the shattered, sinful, and legalistic nature of the community, and upon the powerlessness of the man in question to relate himself and his need even to the representatives of the church or of medicine.

The task of healing a broken community and the wounded and harassed horde of unrelated and isolated people involves both the minister and the psychiatrist. A revitalized understanding of religious experience in terms of interpersonal relationships adds inestimably to the meaningfulness of both their task and their relationships to each other. Through such a renewed meaning, the otherwise pointless and confused religious ideas of the mentally ill begin to have some "rhyme and reason."

On the other hand, as one looks back on the kinds of religious experience discussed here, he is likely to

lose perspective if he does not draw some lines of relatedness that characterize the wholesomely religious person at his best. Otherwise, even dealing with the religion of the mentally ill person becomes a sort of "wandering" in itself.

The thoughtful person senses, upon considering the hostile, the dependent, the despairing, the extractive, the withdrawing, and the blighted types of religious experience, that these are negative statements of some essential aspects of the religion of love which finds its supreme expression in the Christian gospel. They are broken fragments of the bread of life. For instance, one could without much contradiction from his fellows say of hostility as a type of religious relatedness that the person who does not have some initiative and aggressiveness in the convictions for which he stands is not "worth his salt." He could observe that the person who has not learned to depend wisely upon others has not found the elementary trust that Christians place in one another. Also, the person's life is superficial who has not felt the despair of his real sins. Also, even the Master enjoined upon his disciples to "be as wise as serpents and harmless as doves" in dealing with the exploitative kind of people to whom he was sending them. And more than that, the Christian is urged to withdraw from the press of the crowd for contemplation and prayer, even as Jesus withdrew from the crowd to pray. Wherein is the way of health in this paradoxical set of truths? What distinguishes the healthy expression of these kinds of relatedness from the expressions

which are encountered in the religion of the mentally ill?

Several things may be said at this point. First, the spiritually sound person is characterized by the flexible capacity to move from one to the other of these "manners of relatedness" *as fits the occasion*. He is not fixed, stereotyped, patternized, and enslaved by any one kind of relatedness. He can be aggressive when the time and place calls for it, but he is not aggressive in *all* relationships regardless of time, circumstance, or place. So it is with the other kinds of relationships described here. The spiritually mature person is one who can take the prerequisites of given situations and fulfill the relationships he ought to fulfill. The psychiatric concept of appropriate behavior is akin to that of the classical Greek writers who spoke of righteousness in terms of appropriateness in social customs, usages, and so on. These writers, however, had another kind of conformity, which implied harmony with the gods, and with the eternal logos. *But in the New Testament writings, these two kinds of appropriateness—social and religious—were not separated.* They were expressed most vividly in the hunger and thirst of the individual after righteousness, his search for the truth, and his desire "to be made conformable to the image of God in Christ." However, in much psychiatric and mental-hygiene thinking, the concept of appropriateness of behavior is more akin to the Roman and classical Greek concept of the purely human and social aspects of that behavior than to the New Testament concept of the righteousness of God.

The spiritual value of beauty is also relevant to this discussion of spiritually appropriate interpersonal relationships in the mature religious person. The writer of Ecclesiastes gathers up this in his statement: "I have seen the travail, which God hath given to the sons of men to be exercised therewith. He hath made everything beautiful in its time; also he hath set eternity in their hearts." This passage comes as a sequel to the wise man's saying about the fact that "for everything there is a season, a time for every purpose under heaven" (Ecclesiastes 3:1 ff.). The awareness of timing in relationships fits the eternal to the temporary, and brings the beauty of the Lord upon the works of one's hands as he relates himself in a mature way to the total sphere of his world. The exhortation of the Apostle Paul reflects a bit of this when he says: "Look therefore carefully how you walk; not as unwise, but as wise, redeeming the time, because the days are evil."

Furthermore, a second differentiation may be drawn between the relatedness of the spiritually mature and the mentally ill: each one of the kinds of relatedness mentioned heretofore is negative because of *the absence of the relatedness of love*. The hostile person is aggressive in order to defend himself, not in order lovingly to represent reality to those toward whom he is hostile. The dependent person "uses" others *in order* to avoid responsibility himself; they are means to his ends rather than persons in their own right. His dependence is not one of trust and respect but of repressed disdain. The extractive person makes tools of the persons from whom he draws

out what he wants, only to be done with them—break the relationship—when he no longer has any use for them. So it could be listed in the whole catalogue of relationships which manifest themselves in the defective religious attitudes of mentally ill persons.

Martin Buber, in his poetic-philosophical treatise, *I and Thou*,¹⁴ draws the distinction between the relationship in which persons are *used* as an *it*, a thing, a tool, a means, and the one in which persons are involved together in a spiritual communion of an I-Thou relationship. In this latter communion, the fellowship is based upon loving and caring, personalizing and understanding. In the former, persons are objectified, and the element of communion and interpersonal love is replaced by detachment and distrust. Middle walls of partition occur in this latter instance along the lines of the defective kinds of religious attitudes mentioned in this chapter.

Once again, this pattern of the relatedness of love leads to the supremely worthwhile kind of religious experience of which the Apostle Paul speaks when he says that the objectified rituals of life avail nothing, "but faith working through love" accomplishes all things. Bringing life into conformity to this kind of love and faith makes the life an "appropriate one," integrated in faith and knowledge of the "Son of God, unto a full-grown man, unto the measure of the stature of the fullness of Christ."

¹⁴ London: T. and T. Clark, 1937.

SIX

The Positive Work of Religion in the Therapy of Mental Illness

MINISTERS IN GENERAL and a few psychiatrists in particular have held to the conviction that healthy religious experience has something to offer in the changing of mentally sick persons into healthy people. Discussions of these convictions, however, tend to "bog down" at several points: (1) Ministers and psychiatrists tend to stop at the door of the problem to "divide up" their work so their social roles will not conflict in action. (2) Ministers and psychiatrists tend to try to settle their philosophical differences apart from an actual clinical situation of treatment. (3) Ministers and psychiatrists may get into totalitarian, "either-or" conflicts, saying that *all* psychiatry is of the devil, *all* religion is bad; and that either a person must depend exclusively on the one or he is to be led astray. (4) Ministers and psychiatrists feel uneasy in each other's presence and unfamiliar with each other's terminology, almost needing interpreters

to translate their language back and forth. (5) They also tend to wind up these discussions by merely saying nice things about each other; they still have not nailed down any particulars as to the specific ways in which religion may actually help in the therapy of mentally ill persons.

The purpose of this chapter, therefore, is to get at the particular ways in which healthy religious experiences may become a vital part of the healing of the mentally sick person.

Religion at the Point of Diagnosis

The first way healthy religious experience participates in the healing of mentally sick persons is through its sincere regard for factual diagnosis of *what* actually is the matter with the patient. This is the point at which many historic appearances of faith healing have broken down: they do not manifest a religious reverence for an accurate diagnosis of the disease that faith is reported to have healed. The medical doctor is trained "from the ground up" in differential diagnosis. When he becomes careless at this point, he has ceased to be a doctor worthy of respect as a doctor. When a religious worker, likewise, begins to make claims as a healer, his religion has "lost its savor" if he does not first seek reverently to discover *what* he is supposed to be healing. This, to say the least, is a vital part of religious experience in the healing processes.

For instance, the patient himself usually presents his own diagnosis of his trouble. This is true even of stomach symptoms and other bodily aches and

pains, to say nothing of psychiatrically classifiable symptoms. Even a medical doctor, especially one who is in too great a hurry to get to the next patient, may take the patient's diagnosis of his illness at face value, and proceed in a therapy aimed at such a diagnosis. If this *can* be true of a doctor, it is doubly possible for a minister or religious counselor.

Again, the community as a whole gives its own diagnosis, or, more often, many diagnoses of the illness. Community superstition, homemade diagnoses, and "family remedies" move into the decisions with reference to a patient's trouble. This is particularly true in the case of mental illnesses. "She just comes from 'poor family stock' and has been weak-minded all her born days." "He got thrown by a horse when he was young and ain't been right since." "He just lacks confidence." "He comes from a broken home." "He's an only child." "Her time of life has been workin' on her, you know. Some women are mean as scratch when the change of life is on." "She's just got the devil in her." "He resisted the call to preach when he was a boy and it has preyed on his mind ever since." These are community diagnoses quite commonly heard by religious workers. The grain of truth in them makes them all the more deceptive, tempting the religious worker to "begin treatment" on a *community* diagnosis.

Furthermore, much frankness is in order as to the "ministerial diagnoses" of mental illness, also. "He just lacks faith, and needs to pray this thing through at the altar." "A large part of our modern personality problems, divorce, child delinquency, and the enor-

mous increase of nervous breakdowns and mental disturbances are by-products of the apostasy from religion to psychology." "Worry is sin." "Anybody that would go to a psychiatrist needs to have his head examined." The community actually does a good deal of "diagnostic" work simply by deciding how much eccentricity it can safely permit an individual to have and to how much trouble it will go in caring for a patient before a doctor is called. But this is qualitatively not the same as differential diagnosis of disease. Therefore, a religious worker needs to be careful how he takes the word of the community at face value as to what is wrong with a patient.

More serious are the attempts at diagnosis by pastors and religious workers who may have had clinical training, even a "full year of clinical internship," who are tempted to make diagnoses of counselees' troubles without the complete examination of the person by a competent physician. The fact remains that external symptoms of a broken-hearted lover and a progressive mental disorder may be confusingly alike. It is a very different matter to deal with the latter symptoms *inside* a hospital where medical diagnosis has already located them, as compared with dealing with the same symptoms *outside* a hospital where the diagnosis is yet to be made.

Sperry is right, in his book, *The Ethical Basis of Medical Practice*,¹ when he says that the church will not have a completely solid groundwork for the integration of pastoral theology with medical therapy of

¹ Willard L. Sperry, *The Ethical Basis of Medical Practice* (New York: Harper & Brothers, 1950).

patients until the theologians have thorough medical training. However, the problems of differences in social roles and grounds of communication with the needy person will be even more complex when this comes to pass than they are now.

Finally, Christian candor requires discussion of the religious character of the need for more careful diagnoses by medical doctors themselves. Psychiatry itself is quite new in medical education, and considerable numbers of doctors apparently have had little or no psychiatric training. The way this appears outside the medical classroom is quite frustrating to the religious worker who is not supposed to diagnose illnesses. For instance, the prejudices of internal medicine doctors and surgeons against psychiatry may prevent openly psychotic persons from getting help. These doctors may refer their patients to ministers for religious counsel when these patients are actively hallucinating, threatening other persons' safety, and are inaccessible to reasonable conversation.

Likewise, general practitioners may fall back upon proverbial folklore for advice to psychotic patients who seek their aid. A mentally sick minister suffered from severe delusions of persecution. He felt that the F.B.I. was checking his every move. Finally he went to his doctor. The doctor upbraided him for a lack of faith in God, and told him he could not find anything wrong with him. Another man under severe anxiety was told by his physician that the thing wrong with him was that he was unmarried. He was advised that marriage could relax him. The fiancée of the

man asked: "What does this make of me, a dose of phenobarbital?"

The major issue of this discussion of religion at the point of diagnosis is this: the matter of "taking pains" to get a clear diagnosis is a manifestation of a reverence for truth and personality. This, in a religious context, is an act of religious devotion. As F. H. Giddings has said, "I want to know if a thing is so, but then again, *is it really so*; or, is it just that everyone is saying *so*?" The religious quality of such an attitude is reflected in the following thoughts of the late Charles F. Read, M.D., for many years the superintendent of Elgin (Illinois) State Hospital:

Psychiatry, despite all the scientific devices it employs, remains a very human art. Even as Fra Angelico painted Madonnas and angels while upon his knees, so should the practitioner of mental medicine go humbly about his business of diagnosing and treating mental disorder. Out of a thorough knowledge of the extent of his ignorance, he may well say, along with all other good physicians, "If possible, I shall assist Nature to cure my patient, but in any event, I shall take good care to do him no harm."

Religion at the Point of Referral

Patients and their families often seek the advice of their ministers in the approaching necessity of seeking psychiatric treatment for nervous and mental diseases. With a monotonous repetition, they ask

about the religious attitudes and convictions of the psychiatrist. This is most important from the patient's point of view. Naturally, the question may reflect religious insecurity, but the patient who is sick enough to need psychiatric help cannot be expected to be so secure religiously as to warrant complete rejection of the validity of his question.

The patient has no right, however, to expect his psychiatrist to be a trained theologian any more than he has to think of his pastor as a diagnostician of nervous and mental diseases. If the patient can be reassured that his doctor will take a clinically reverent attitude toward his religion as having reality and meaning to the patient himself, then he has the security he needs. Such an attitude as that expressed by Dr. Charles Read, regardless of the formal religious connections of the psychiatrist, lays the groundwork for a relationship of a trusted motive between the psychiatrist and the patient as far as his religion is concerned.

The minister who refers a patient to a psychiatrist with an attitude like this can effectively interpret the step about to be taken by the patient as an essentially religious quest for the truth about himself, and for the ways and means of becoming a more effective person in the Christian community. The co-operation of a psychiatrist who accepts the patient as a religious person makes such a referral possible.

Another religiously relevant problem in the care of the mentally ill at the point of referral is that of deceiving the patient about the nature of his illness and the kind of doctor to whom he is being referred.

The psychiatrist's work, it seems, is severely impeded by referral of patients to him under the assumption that he is a "nerve doctor," or "just an understanding doctor," or any of a number of euphemistic ways of sugar-coating the fact of the need for psychiatric help. More deceptive than these, however, is the referral of the patient to the psychiatrist with the "built-up hope" that the therapy will be conducted in such a way that the psychiatrist will be expected to give pastoral care, religious instruction, and theological judgments to the patient. This subtle kind of deception of the patient *can* actually prevent him from getting the real therapy the doctor has to offer.

Furthermore, the presuppositions of the question "Is the psychiatrist a Christian?" often imply this kind of expectation of the doctor on the part of the referring minister and the patient and his family. But more subtly than this, such a referral reflects a "passing of the buck" for the pastoral care, religious instruction, and theological guidance of the patient from the minister to the psychiatrist.

Therefore, at the point of psychiatric referral, an essentially religious issue at stake is this: Is this a subtle abandonment of the patient to psychiatry, referring him *away from* the church? To the contrary, it should be the church calling in specialized help in its ministry to the person as a whole. It naturally follows that in the process of therapy, therefore, the role of religion as a positive force becomes intensely relevant as the minister and the church take their place in vital relation to the psychiatrist and the hospital, respectively.

Too often the inscription "Abandon hope all who enter here" has been overtly or tacitly written into psychiatric referrals. The definitive symposium edited by Paul Maves, *The Church and Mental Health*,² deals extensively with this problem in the relationship of the church to the process of therapy of the mentally ill. The book merits careful study of psychiatrists, ministers, and lay persons. Howard Schade, writing in this symposium, accurately observes:

Competent referral ability is a most important ministerial asset. At the same time, while referring a parishioner to another person for more specialized treatment, the parish minister does not wash his hands of the parishioner, but maintains a continuing ministry to him.

Religion in the Process of Treatment of Mental Disturbances

Several important prefacing remarks need to be made concerning the role of religion in the process of treatment.

First, the referral of a mentally sick person is no easy matter. Many such persons refuse to go for psychiatric help. Some patients are willing to go but are forbidden to do so by parents, spouses, and other dominating relatives. Even when these factors are equalized, the accessibility of psychiatric help may be impossible, due to scarcity of psychiatrists, overcrowded schedules of available psychiatrists, costs for psychiatric care, or a number of other factors.

² New York: Charles Scribner's Sons, 1953.

Furthermore, psychiatrists naturally take patients in the order of the acuteness of their needs. The referral of a person to them, therefore, for serious marriage-counseling needs, for insight-release therapy of consistently continuous and frequent interviews, and for the management of a severe pre-marital, pre-parental, post-bereavement, or post-divorce kind of stress often meets with thin results. The reason is obvious—the psychiatrist feels obligated to spend his time with persons who need him most.

Again, chronic mental illnesses often stalemate at a point *just before* the need for immediate psychiatric attention and *just after* the person has worn threadbare the patience and resources of those about him. These patients tend to fall back upon the resources of religious institutions—local churches, missions, schools, colleges; and these institutions are imagined to be able to do *something*—just what is not clear—for them.

Therefore, a discussion of the role of religion in the therapy of mentally ill persons must take these factors into consideration. Additional research needs to be done here, although some has already been done by a few people.³ Such research should reveal the basic identity of religious counseling as such, as differentiated from psychiatric therapy as such. Likewise, the research should reveal a more serious and empirical study of the psychology of religion than has yet been done. And such a study should do much to relieve whatever need the minister has to emulate

³ See Anton Boisen, *Problems in Religion and Life* (Nashville, Tenn.: Abingdon-Cokesbury Press, 1946).

other professions, by enabling him to grasp the unique identities of his own calling as a counselor.

A step or two can be taken in these directions here in the attempt to clarify the positive role of religion in the therapy of mental illness. The minister often cannot theorize about his task at the above-mentioned points. Whether he likes it or not, these patients' care falls back into his hands when psychiatric resources are not available. Rural pastors face this most often in the open community. Likewise, chaplains in state hospitals which do not have even one authorized psychiatrist on their staff must hear the stories of the patients, doing what they can to be helpful, and utilizing religious resources to the best possible advantage in the task.⁴

Clinical experience at these points of desperation reveals the ways in which religious experience has done more than simply soothe people's nerves with a supportive ministry, however important that may be. More than this, some scientific evidence is beginning to appear as to definite changes being effected through religious experience in the process of therapy of the mentally sick. The best approach at this point is to turn to the psychiatrists themselves who have written on this subject.

The most complete description of a person for whom religion participated in both his illness and his recovery which the author has been able to find has been published by Paul Bergman of the Men-

⁴ See Joseph W. Knowles, *The Mental Hospital Chaplain as a Counselor with Schizophrenic Persons* (unpublished doctoral dissertation).

ninger Foundation at Topeka, Kansas.⁵ He says that the electrical recordings of the interviews give the impression that "God became the first object of concern for" the patient. "The therapist occupied first place among human beings. To him Joe reacted most sensitively. To explore his mind, to know what the therapist approved or disapproved, what he thought of religion, whether interpretations coincided or differed with God's as interpreted by Catholic authority, became to Joe matters of anxious preoccupation."

The patient then underwent a sudden conviction that he owed something to God and must act upon his obligation. Bergman records the following changes of personality after this: (1) The requirements of his Catholic faith no longer seemed fearful to him, but became matters of positive desire. (2) He stirred up the memory of the positive love and affection given him by his grandmother as a child; particularly did he remember her unperturbed faith in God. (3) He found it hard to talk about his new and intimate feelings and to keep therapy and religious conversation apart, as having different but related functions. (4) He was no longer panicky upon the visits of his parents, but remained calm and did not take to drink to find forgetfulness. (5) His withdrawal tendencies, in terms of suicidal ideas, showed some change but were not dissipated by any means. (6) He began to relive his disappointments in the Church

⁵ Paul Bergman, "A Religious Conversion in the Course of Psychotherapy," *American Journal of Psychotherapy*, Vol. VII, No. 1, January, 1953, pp. 41-58.

and in people, more generally toward a more realistic solution of his interpersonal relationships,

Bergman works at the interpretation by considering the alternatives: (1) This could be seen as a psychosis-like experience in which the patient was substituting religious realities for losses in his life. (2) It might be viewed as "a re-shuffling of his relationship to his father." (3) It might be interpreted as a shift from Protestantism to Catholicism for a more patriarchal religion, although the records indicate nothing of this in treatment references. (4) Religion could mean to him a way of rebellion, an ideology of opposition.

Bergman concludes that the experience enabled the patient to recover his sense of equilibrium between the experiences that enriched him and those that demanded from him, his need to be cared for and his need to accept responsibility. Bergman concludes, with reference to the role of religious phenomena in the clinical context of treatment:

The alternative would be wrongly put if one asked whether one should favor Joe's poor religion or attempt to free him from it. There is ample room for growth within the framework of religion. It is just the elasticity of religion (and other cultural institutions) which makes them, on the one hand such unreliable tools to achieve improvement, and on the other hand such firm containers for whatever human substances they will be replete with.⁶

⁶ *Ibid.*, p. 58.

Harry M. Tiebout lays "particular stress upon the conversion feature" in the phenomena of recovery which go on among alcoholics in Alcoholics Anonymous groups.⁷ He further elaborates these observations in an article entitled "Conversion as a Psychological Phenomenon (in the Treatment of the Alcoholic)."⁸ The main contention of this article is that "religion should release the positive potential which resides in the unconscious." He calls this change the "breaking through" of an almost tangible wall, a shell, a barrier

. . . which vanishes with a conversion experience and in its place the patient begins to feel, perhaps for the first time in his life, a sense of the nearness and reality of other people. . . . The breaking through of the wall by the patient does something more than bring the patient closer to life. It actually makes him freer to meet life. . . . He feels that he is in communion with God, man, and all the creature forces of the universe.
(p. 29)

Tiebout's own sense of revelation appears when he asserts that until now he had completely ignored the creative effect that a positive religious group can have because he had "no first-hand knowledge of how it worked." (p. 33)

Recently bits of news have reached this country from Vienna of the work of Dr. Viktor Frankl. Frankl seems to be developing a concept of personality and

⁷ *The American Journal of Psychiatry*, January, 1944.

⁸ *Pastoral Psychology*, April, 1951.

psychotherapy which opens a wider view of *how* religion operates in the therapy and regeneration of personality. Two characteristics of his concept have been reported: (1) Repression operates to inhibit religious feeling, to prevent its communication when it is consciously felt, and culturally to taboo religion if it is articulated. He feels that sex shyness has been replaced in many instances in more recent culture by religion shyness. (2) The search for power and sexual gratification, the search for the release of hidden hostilities, and the nihilism of ethical restrictions are being superseded in the contemporary person by the hunger for meaning and for a satisfying interpretation of the end and purpose of his predicament and suffering. Frankl interprets this hunger as the need for God.

With these two concepts in mind, Frankl calls this repression of the spiritual "the real pathology of our age." He says that his own therapeutic appeal "is not to the sick portion of a patient's personality . . . but to the healthy portion. No matter how sick a patient is, the healthy elements of his personality can be mustered against the sick." The purpose of therapy from his point of view seems to be to help "people to become capable of suffering . . . there is a suffering which transcends all illness, which forms an integral part of all meaningful existence."⁹ Such a point of view as that expressed by Frankl, although to the psychiatrist it may give some slight evidence

⁹ Viktor Frankl, *Aertzliche Seelsorge* (Vienna, 1946).

See also M. Arthur Kline, M.D., "A Psychiatrist Discovers God: We Are Born to Believe," *Woman's Home Companion*, April, 1954.

of special pleading in behalf of religion, is not unrelated to the thought of C. G. Jung who says: "About one third of my cases are not suffering from any clinically definable neurosis, but from the senselessness and aimlessness of their lives. I should not object if this were called the general neurosis of our age."¹⁰

The search for meaning is vastly more than the search for pleasure and the avoidance of pain, and when pursued with what Horney calls more wholeheartedness, becomes a pilgrimage, a quest, and a hope, which with very great ease becomes a religious experience similar to that of a patient referred to a minister by her psychiatrist. She said she "needed God and nothing less would meet her need."

Paul Tillich, the theologian, has gathered up the resources of psychotherapy into his statements of the character of the Christian faith in a book called *The Courage to Be*. In this book he correlates the search for meaning in the presence of meaninglessness, and emptiness, and destruction with the healing power of the Christian gospel. He says:

We use the term meaninglessness for the absolute threat of nonbeing to spiritual self-affirmation, and the term emptiness for the relative threat to it. They are no more identical than are the threat of death and fate. But in the background of emptiness lies meaninglessness, as

¹⁰ *The Practice of Psychotherapy*, tr. by R. F. C. Hull (New York: Pantheon Books, Inc., 1954), p. 41.

death lies in the background of the vicissitudes of fate.

The anxiety of meaninglessness is anxiety about the loss of an ultimate concern, of a meaning which gives meaning to all meanings. This anxiety is aroused by the loss of a spiritual center, of an answer, however symbolic and indirect, to the question of the meaning of existence.¹¹

Likewise, the psychiatrist will find the quaint symbolism of John Bunyan's *Pilgrim's Progress* provocative as an interpretation of some of the same problems that he treats daily in his patients.

In an article, "Why People Change,"¹² Ian Stevenson, a medical doctor, emphasizes the fact that spontaneous religious experience often appears as constructive personality change in the absence of psychotherapy, changing rather severe personality and behavior problems into more beneficent ways of life. He speaks of this as a constructive element in personality itself which "includes not only the value of increased comfort and pleasure to the individual person, but an increased contribution of that person to others." He attributes these religious changes to the distillation of personality through the constructive discovery of the meaning of suffering, and to the spiritual inspiration of a living person or ideal with which the individual identifies. He cites as an example the spiritual recovery of Anton Boisen,

¹¹ Paul Tillich, *The Courage to Be* (New Haven, Conn.: Yale University Press, 1952), p. 47.

¹² *Harper's Magazine*, December, 1953.

which was effected upon his having discovered the purpose in his suffering to be that of enabling him to understand his fellow patients and to move toward their relief.

Another psychiatrist writes anonymously (he, nevertheless, is said by the editors to be one of "England's most distinguished psychiatrists, the author of standard works in his field, and a man who has won recognition as a teacher") on the subject "Psychiatry and Spiritual Healing."¹³ He calls attention to the spontaneous regenerative role of religious awakening in the lives of members of his own family. He cites also the more radical demonstrations of this healing in the lives of alcoholics, through religious revival techniques which induce a state of shock and self-confrontation, resulting in therapeutic achievements similar to those gained by the use of insulin shock and the leucotomy.

A more careful study of these processes, however, is to be found under the authorship of Leon Salzman, who writes on the "Psychology of Religious Ideological Conversion."¹⁴ He challenges "clerical writers" to describe their experience and observation scientifically instead of in terms of "mystical visitations." He describes religious experience in and out of the course of therapy under two headings: (1) the progressive or maturational type of religious experience, and (2) the regressive or psychopathological type of religious experience. The former type issues in "the

¹³ *Atlantic Monthly*, August, 1954.

¹⁴ *Psychiatry*, Vol. XVI, No. 2, May, 1953.

positive fulfillment of one's powers with self-awareness, concern for others, and oneness with the world." It is a conjunctive experience, lessening anxiety, and integrating the maturing development of the life of the person. The latter or regressive pathological is a "pseudo solution . . . brought about by increasing anxieties, and has a disjunctive effect on the personality." He says, furthermore, that this type of religious experience may "either precipitate or be a part of the psychotic process." At the same time, he says, the experience may ward off a psychosis because of its positive and conjunctive elements and because of its defensive nature.

Salzman further describes the pathological type of religious experience by its aftermath, which includes an exaggerated irrationality and intensity of belief in the new doctrine, which results in back-sliding for a high percentage of converts. The convert is concerned more with the form than the "greater principle" of his new doctrine, and his concern affectively involves contempt, hatred, intolerance, the compulsive need to proselytize, and a need for martyrdom and punishment for his beliefs.

Salzman reverts in his conclusions to the position that when conversion and religious spontaneity occur in adolescence, such may be a stepping up of maturation processes; that through such experiences a person may discover a new life. But in the instances of severely disturbed people, Salzman returns to psychoanalytic doctrines of reducing religious experience to the conflict of an individual with authority figures whom he hates. Salzman thinks that the pa-

tient resolves these tensions to higher levels of omnipotence in religious authoritarianism.

Salzman's words about "clerical descriptions" of religious experience in terms other than those of "mystical visitation" are somewhat challenging. In fact all of these psychiatric contributions to the study of religious experience call for a more detailed description of what happens in the positive function of religious experience in the therapy of sick people.

First, the original concept of interpersonal relationships in a covenant community is foundational to the understanding of this positive function of religion in therapy. The nature of the ultimate loyalty which binds that community together is of supreme importance. The character of a person's god has something to do with the kind of person he becomes; as Ian Stevenson has put it, people change because of having met, participated with, and chosen to be like a living person who is mature. The same thing happens "in reverse" when a person regresses and becomes sick: by positive affection or negative fear, he has bound himself to an immature ideal, a person, or a cause—i.e., a god—that is less than infinite in the capacity for growth, spiritual refreshment, and the renewal of life. In the words of J. B. Phillips, his god is too small. Thus he becomes bound to, enslaved by, and thrown off balance by the worship of that which is temporal. In biblical terms, he has become an idolater. He expects magical—which is what Salzman seems to mean by mystical—solutions from his idol.

The psychiatric clinic, and articles like those by

Salzman, reveal the nature of these idols: a father whom the patient feels bound to hate; a mother whom a patient feels impelled to placate; a deceased loved one whom he is compelled to enshrine and worship; an inheritance which demands his "heart's full adoration"; or, a teacher or an analyst who, he feels, can guide each thought each day, lest he perish.

Likewise, a particular drive or impulse of the individual may be deified upon the illusion that the more complex needs of a given individual *can* be *completely* satisfied, and when satisfied, bring happiness. For instance, the cults of success, sexual satisfaction, agricultural plenitude, and the lust for power have had their representative expressions in almost every age, ranging, as a case in point, from the fertility cults of Ashtaroth to popular perversions of psychoanalytic theory today. Likewise, the cult of absolute freedom from all authority is constantly curling back upon itself in the erecting of some new golden calf of authority. Erich Fromm, in his book, *Psychoanalysis and Religion*,¹⁵ leaves the impression that any authority, or its recognition to the point of trusting it, is the beginning of evil itself. Yet, at the same time, the collection of psychoanalytic concepts themselves tends to become the new authority.

A Christian minister perceives the character of the god before whose shrine the patient worships to be of primary importance in his conversations with a counselee. Weaning the patient from his household

¹⁵ New Haven, Conn.: Yale University Press, 1950.

gods, his confusion of loyalties, his cherished grudges, and his worship at the shrine of his own omnipotence is the religious part of his getting well and staying well. But more than that, doubly important to the healing of the patient is his discovery of a God who "fainteth not and neither is weary," "whose love is broader than man's mind," "who is the fullness of maturity," "who satisfies our desires with good things," "who binds us to himself in order to free us from all lesser and inadequate loyalties," "who has granted that we may become like him in love," "who emptied himself for us that we might become sons of God," "who has called us out of darkness into his marvelous light," "who enables us that our love may grow in all manner of knowledge and inner perception," "who loves us with an everlasting love," and "who forgives us of our sins and enables us to forgive each other and bear one another's burdens."

These focal phrases are the daily bread of the New Testament perceptions of the nature of God. The fact that so many people prefer to hold on to tribal deities, punitive distortions of the character of God, and the fragmenting power of their idolatries is discouraging to the Christian minister in the same sense that the psychiatrist is discouraged when he sees so many of his patients preferring their illness to the adventures of health.

The transformation of personality which comes to pass through ethical religious experience is actually no esoteric, mystical secret. Careful study of the Hebrew-Christian struggle to clarify the character

and nature of God reveals both the "what" and the "how" of these transformations. Here the idolatries of the biblical account are constantly being challenged and overcome by the power of ethical love intrinsic to the character of the Hebrew-Christian conception of God. The person who does not take the time and the discipline to learn of this revelation has only magical or philosophical guesses to fall back upon.

The experience of a thirty-five-year-old woman referred to her minister by her psychiatrist indicates the way in which this discovery of the Eternal takes place. The psychiatrist had moved through a rather extended process of therapy with her. She kept complaining that she wanted to know what God is like, and how he could help her in her struggles. For this kind of guidance she was referred to her minister by her physician. She told of her idolatrous fear of her father, her early marriage to get away from home, her overdemanding ambitions for her husband, and her attempt to force him to do things at parties of which he would not approve. She said that she could not bear to think of God as one who would punish her, but that she needed the safeness that would come within her if she knew he was the kind of God she could trust without fear.

She wondered if she could just be healed of her back pains, her fears of leaving her husband, and her "drawings in the neck" without having to struggle so. She wanted her minister to ask for a miracle for her, so she would not always be like this. He frankly told her that the miracle would come in her facing

and accepting the necessity of the struggle, and sincerely searching for God in the quietness of her own privacy when she was away from all other persons, including the minister himself. He encouraged her to give up the idols named above, after having interpreted them to her as idols. He pointed out that the discovery of God as eternal love in her life would put all lesser affections in their legitimate places. He prayed a brief prayer with her and sent her on her way, to return again after she had made some efforts at prayer on her own. He gave her emotional support all along with such remarks as "There is no way around this suffering, but there is a way through it."

The patient sustained her relationship to her psychiatrist, who carried the work of psychotherapy forward with her, and the minister functioned as a gentle religious interpreter. On the second interview, she asked the question: "How long will I have to be bothered this way?" The minister pointed out that Jesus did not promise people freedom from suffering, but gave them his teachings in order that they might not be alone or afraid. Likewise, Jesus had enabled him, as her minister, to share with her in the search for the meaning of suffering so that she might have a tangible human witness of God's presence in her tribulations. Her pastor interpreted certain facts that could not be changed: the fact that she had made past mistakes which were in the past; the lack of love her father had shown her; the fact that she could not run her husband's life for him without ruining her own. She burst into tears and

said: "All my dreams are smashed; what can I do?"

Her pastor encouraged her to continue her search in prayer for a new meaning in life, a knowledge of the love and presence of God, and a cleared-up mind about her future. Having made another appointment, he encouraged her to go home and lay the whole thing down for a while, asking God how to pick it up again. This she did with courage. In the "act of surrender," as Tiebout calls it, her prayer was answered. She said that she was as if she had been born anew. She came back to her pastor free of her physical symptoms, set loose from her anxiety about leaving her home, and with a new intention to help her husband as an earning partner rather than a complaining critic. She immediately began to reconstruct her life and to talk about the blockages between her and her friends, her church community, and her work associates. She became much less critical of herself and others. She was a student of the processes of overcoming these blocks that "her old self" had put into her way. Furthermore, she became sensitive to the unhappiness of her friends and was able to participate meaningfully and helpfully in their concerns.

The psychiatrist and the minister have followed this person and her husband since 1946, and her integration has moved, with some unevenness, from one level of growth to another. Nevertheless, the jagged growth has never shown any full-scale regressive pattern, the symptoms have not returned, and the community life of the couple has been highly

productive in the fellowship of the church of which she and her husband are members.

Psychiatrists have seen much of the damage done by irrational, unjust, and exploitative authority. One can full well appreciate their skittishness when the authority or sovereignty of God is mentioned. However, such a concept becomes highly therapeutic when viewed from the character of God as a reasonable, just, and self-giving authority, as portrayed in the person and teachings of Jesus. The presence of such a God in the life of a person frees him of the necessity of being enslaved to any creature. Likewise, as parents, teachers, ministers, and physicians, earthly authorities are relieved of the necessity of being infallible, final, and unreasonably demanding in their authority; by becoming related to such a God, they no longer feel any compulsion to "play God" or any necessity to compete with him.

Nor do they feel any necessity to defend God, if indeed their faith in him is relatively mature. They know that he needs no defense in his security. Furthermore, they have no need to feign a complete maturity, in that any maturity reached by any person is yet a state of incompleteness as compared with that maturity which is infinitely in store for Christians at any level of growth in the eternal possibilities for fruition in God.

The next specific factor in the healing of persons through religious experience is in the fellowship of the church. Rightly viewed from a therapeutic point of view, a church is a fellowship of people who know

each other and are bound together in love through their common covenant of gratitude for redemption from the separation of sin, the isolation of self-omnipotence, and the loneliness of being misunderstood and rejected. Such a community has two or three potentials which are too seldom realized in the actual healing of persons who are either potentially or actually mentally ill.

Here, for instance, is a twenty-nine-year-old man. His father had been a minister, but was completely intolerant of his son's questions about God. He had consistently made the son's decisions for him, even to the point of selecting a wife for him. When the father died, the son, who had hitherto had what would apparently be called a very exemplary religious life, developed a severe mental illness, a part of which involved his losing his faith in God. He was hospitalized, and a careful psychiatrist had dealt thoroughly with the medical and psychiatric factors. He was ready to go home, but he was still confused in terms of the meaning of God in his life and in terms of his plans to "have anything more to do with the church." His doctor suggested that he confer with an understanding minister. The minister accepted his doubts and encouraged him to talk about them. This was a surprise, because the man said, "Religion was never a matter for discussion at our house." The minister indicated to him, "God can take your questions about him without being shaken too much by them." The man said, "But my father would never let me question." The minister pointed out, "That is the main difference, I suppose, between your father and

God. You see, God is much more secure than your father was."

The church in turn became a relationship in which this man's particular distortion of the religious life could be accepted, the adhesion between the man's concept of God and his concept of his father severed almost surgically, and a substitute family relationship reconstructed while the bereavement process had its full course. "The visitation of the fatherless in their affliction," James's definition of pure religion and undefiled, is demonstrated here as the religion of the man was purified of its idolatry of a domineering father and the enshrined worship of the dead. Both of these factors, according to the psychiatric estimate—although described in different terms—were participant in the illness itself.

Occasionally the whole "family" of a mentally ill person may be reconstructed, for temporary and purifying purposes, from among constituent members of a church in a quite anonymous fashion. One depressed woman's total family constellation was reconstructed, inasmuch as she was completely alienated from her original family since her marriage to a person of another faith. She constantly received letters of prayers for her salvation from her mother; and with only psychiatric consultation and supervision of the minister in the church, the woman was enabled through a severe time of reactive depression, and has not had a relapse in two and a half years. One member of the church "stood in" as a brother figure, another as a good father, another as a mother, and another as a sister. These new relationships be-

came "good news" to the woman. She began to take root and grow. She "outdistanced" her older family relationships and became free of her despair. A careful five-year-follow-up on this situation reveals no recurrence of medical or psychiatric symptoms.

As has already been indicated, the Christian teachings concerning the priority of the family of God over the binding idolatries of earthly families is in itself the material out of which the therapeutic methodology of the church in relation to the mentally ill can be fashioned. For instance, the surface guidance given by a psychiatrist to a late-adolescent girl struggling to gain autonomy of her parents before she really becomes ill sometimes may leave her in despair, because she can find no reason other than the doctor's word for the decision to move away from home. This same problem can be handled in a religious context with smoother results. One girl was told that leaving home was in keeping with the wisdom of Jesus in his teachings about the claims of the kingdom of God over earthly family loyalties. Yet, at the same time, she was given the encouragement that this was the best thing for her mother if she, the daughter, could do this without becoming vicious and compulsive. This was her mother's only opportunity to be freed of her idolatry of her daughter. She would be restored after the break "a hundred-fold" more mature than she was before. One should not, however, on the basis of a few dramatic experiences, overlook the fact that the majority of acutely mentally ill patients are so far out of contact that the more radical somatic therapies of the hospital psy-

chiatrist are indicated. This is the brunt of the anonymous article by the British psychiatrist in *Atlantic Monthly*.

Here the role of religion in the therapy of the patient is a social one. The scarcity of hospital facilities and the poverty-stricken nature of those facilities for the treatment of psychotic persons in the average community is so great that an ethical imperative is imposed upon the prophetic ministry of the church. The churches of a community should take the initiative to study the needs of the mental hospitals of the community, bring the instruction of the enlightened conscience of the fellowship to bear upon the overcrowded conditions of hospitals and the isolated discouragements which psychiatrists themselves meet. It is not enough that ministers and church people complain about poor facilities or develop "exposé techniques" of social change. Rather, they need distinctly reverent attitudes of encouragement, and of purposive avoidance of public criticism of hospitals and doctors.

Furthermore, the point at which religion becomes most effective in the therapy of mentally ill patients is when the church challenges the respect, enlists the devotion, and gains the wholehearted dedication of the psychiatrist himself to the God it proclaims. The psychiatrist needs a pastor and confidant, because his task is arduous. In a real sense, the pastor needs a comrade and therapeutically sensitive psychiatrist, because his ministry has its toll of emotional "wear-and-tear." The fellowship of the church needs a psychiatrist whose presence in its communion does much

to break down superstition and to make psychiatry an expected part of the redemptive task of the church and the community.

Ian Stevenson has said that the psychiatrist should be moral but not a moralist; it can also be said that he should be religious but not a religionist. The church and the minister are often responsible for the psychiatrist's lack of enthusiasm for its fellowship, in its disregard of the rudimentary principles for human persons, and in its brash, crude, and coarse jokes about psychiatrists and the mentally ill. If the doctors are as sensitive as they must be if they are to understand the bruised and exploited feelings of their patients, much they see when they go to church would be like acid in the eyes of their inner understanding.

Therefore, the church and the pastor should never hesitate to bear its best witness to the psychiatrist, because his task and the task of the Christian fellowship join in their concern for the "weak and heavy-laden," those who are "cumbered with a load of care." And from the vantage point of the psychiatrist, religion is no more a means to the end of health than health can be an end in itself. Otherwise, religion is "used" as a "resource" and not because there is *really* anything to it. Likewise, the psychiatrist can participate more fully in the processes of differentiating religious truth from error if he is a part of the Christian community. He can help the church "test the spirits." Thus he can make his contribution to religion as a "participant observer" rather than as an onlooker, to borrow Harry Stack Sullivan's definition of psychiatry.

SEVEN

The Psychiatrist's Approach to Religious Experience in Mentally Ill Patients

THE PSYCHIATRIST HIMSELF vitally affects the religious experience in the lives of his patients, whether he intends to do so or not. The ways in which this influence comes about deserve some attention in this discussion of the religious living of the mentally ill.

One important thing needs to be said about psychiatrists apart from their religious orientation. Their basic training should be the first way of determining their fitness. The training of a psychiatrist is primarily that of a medical doctor. Any person who practices psychiatry should have an M.D. degree. Beyond this he should have his residency in the psychiatric treatment of psychotic patients in hospitals. A list of the hospitals approved by the American Psychiatric Association is published in the book *The Psychiatrist: His Training and Development*. This is a report of the 1952 Conference on Psychiatric Education. It can be ordered from the American Psy-

chiatric Association in Washington. By reading this book, ministers and laymen can discern the professional standards which psychiatrists hold for themselves. A doctor should have passed the board examinations before he practices psychiatry, particularly apart from supervision in hospitals by psychiatrists who *have* passed these examinations. This is a prerequisite criterion to all the discussion that follows.

The psychiatrist's personal religious orientation exercises a selective effect upon *which* patients come to him. For instance, in the New York City area recently a suburban minister met difficulty in making psychiatric referrals because some of his parishioners perceived psychiatry as being primarily a Jewish concern, inasmuch as many of the local psychiatrists are Jews. Race prejudice colluded with religious prejudice and superstition about psychiatry to hinder patients from getting the help needed. In the author's city, Jewish, Catholic, and Protestant psychiatrists are in practice. Patients occasionally select psychiatrists in relation to their own feeling about their religious affiliation and that of the psychiatrist; or a Baptist patient may refuse to talk to a doctor who "is not a Christian," or he may not want to have his illness known by his fellow Baptist and may therefore choose a Catholic psychiatrist and go to a Catholic hospital. Conversely, the Catholic psychiatrist may find that his Catholic patients prefer a Protestant psychiatrist, or vice versa, in terms of their own feelings about their religion and religious groups.

Various Psychiatric Approaches to Religion in the Treatment of the Mentally Ill

Once the patient has reached the psychiatrist and established a secure interpersonal relationship in the treatment situation, however, the psychiatrist's approach to the religious experience of the patient becomes less formal and much more experiential, much less external and much more personal, much less theoretical and much more practical. But clinical relationships to psychiatrists in treatment situations as well as some attention to their writings indicate that different psychiatrists have different psychiatric orientations, which tend to exert a determinative effect upon the ways in which they manage religious experience as it shows up in therapy.

To say that a doctor is a psychiatrist reveals no more about his attitudes and procedures than to say that a minister is religious. A fairly careful analysis of the different types of psychiatrists and their approaches to religion may be helpful, therefore, both to the psychiatrist and the minister, in developing a better working relationship in the treatment of mentally ill patients. Also, some attention needs to be given to the varieties of attitudes ministers take toward the mentally ill and their doctors. The following outline is admittedly not an airtight and unrelated group of psychiatric approaches to religion; nevertheless, it may at least provoke serious consideration of the problem. All of these different approaches are in terms of the theoretical concepts of

the psychiatrists. Note needs to be made in the beginning that all of them have achieved notable therapeutic results, which in large measure were determined by the devotion, health of relationship, and depth of personal insight of the doctor as he related himself to his patient.

A. THE ORGANICIST'S APPROACHES

Some psychiatrists interpret mental illness as a bodily disease with certain behavioral symptoms. Their therapy is somatic therapy. They concentrate upon the use of a separated environment for the patient (usually a hospital) where the patient can be freed of all pressures from his habitual round of social responsibilities. His religious connections and responsibilities are simply one grouping of these pressures. Furthermore, the somatic therapist depends quite completely upon a combination of rest (through sedation if necessary), vitamin therapies coupled with dietary control, different forms of shock therapy, and the more recent techniques of surgery for the treatment of mental disorders.

Such a psychiatrist's orientation to the religion of his patients may take any of several turns. First, the doctor may be a brash mechanist who reduces all human behavior to conditional reflexes of a mechanical organism. He may say as one doctor said: "No. Religion, the war, psychotherapy—none of these has anything to do with the causation and cure of mental illnesses such as one sees in this hospital. One day we will find a drug or an operation that will

reach these diseases, and we will cure them. Then the mystical and psychological theories will go hay-wire for sure!" The interesting thing about this kind of psychiatrist is that he tends to group religion and psychotherapy together, as having little or no relevance to the process of therapy as such. What he actually does, therefore, is to thrust responsibility for psychotherapy upon the prehospitalization and the convalescent care of the patient, which will be done by members of the family, friends, nonmedical counselors, and particularly the minister of such a patient.

Such a position of the psychiatrist, therefore, necessitates nonmedical counseling with the patient about his search for a meaningful destiny in life. Sometimes overworked psychiatrists are pushed by the number of their patients into such an attitude as has been described above, whether or not they agree philosophically or ideally with it. Therefore, a good measure of understanding is highly indicated on the part of outsiders. It needs to be said, also, that a deep debt of admiration is due these "exact" scientists for their highly significant successes in the use of drugs, electrotonic therapies, and psychosurgery in the dramatic changes at all stages of mental illness.

In the second place, the organicist type of psychiatrist may perceive himself as an exact scientist and have no comment at all about religion. To do so would be a lack of discipline, from his strict view of his science. Therefore, he develops a *laissez-faire* attitude toward religion in the course of the therapy of psychiatric disorders. Or, in the third place, doc-

tors who hold to such procedures in therapy may well consider religion as a compartment in their own lives, unrelated to an interpretation of mental illness. In some instances, their religious virtues manifest themselves in their concern for their patients, just as if the patient were a surgical patient and they a surgeon. Yet, they would disavow any connection at all between the illness and the religious attitude of the patient, either in terms of being disoriented religiously as a part of the causes of his illness or in terms of the effectiveness of an adequate religious experience in his recovery. Such an attitude is reflected by Jacob D. Mulder, M.D., in his book, *Psychiatry for Pastors, Students, and Nurses*.¹ The author of this book frankly espouses a medical organicism with reference to personality and mental illness. In one place, he says two contradictory and irreconcilable things:

My own view is that mental disturbance is due to disease of the body. By body I understand, however, infinitely more than a chaos of atoms. The body is a highly specialized organism and includes what is called life. Mental disease, therefore, in affecting the body may not only attack the physical substance but also the physiological functions.

But man is far more than matter and physiological activities. Man is endowed with spirit and is an image bearer of God. The last, namely man's spirit, is the essence of his personality,

¹ Grand Rapids, Mich.: Wm. B. Eerdmans Publishing Co., 1949.

and gives man intrinsic value far above all creatures, and makes him an individual, responsible and immortal. (p. 136)

The book represents the sincere naïveté of a devout man who has seen psychiatry as an alternative choice between an organicist's position and a Freudian position. These are matters of belief with him. He chose the simpler organicist point of view. The whole explanation of the various psychiatric illnesses is, therefore, from this angle. Of course, this simplifies mental illness to a physicochemical disorder amenable only to that kind of treatment. The relevance of his subtitle, *From a Christian Viewpoint*, therefore, refers to the character of the author as a person and certainly not to the frankly mechanistic, non-Christian view of man implicit in his presuppositions.

The best that can be hoped for in the attitude of an organically oriented psychiatrist toward the religious needs of his patients is that he consider them "a specialty need" for referral. The worst possible fate that the patient could receive would be for the psychiatrist with such a concept of his own task to begin to "unload" his own particular unexamined attitudes toward religion on the patient. An example of this is the doctor who allegedly told a patient, "You need to take about a year's holiday from your religion; the damned stuff never helped anybody anyway." The author realizes that he has only the patient's word for it, and she may have been "baiting" him with this, inasmuch as she needed his ap-

proval. Nevertheless, if this is an accurate report, and it could well have been, since similar attitudes had also been expressed out of the therapeutic situation, then one's response would not be in defense of religion, but in defense of the patient herself. She has a right to more scientific treatment than this. The *laissez-faire* attitude is much more scientific, and at least reflects a reverential attitude toward human personality.

B. THE CONSULTATION APPROACH

The second type of approach to the religious experience by the psychiatrist is the one most familiar to this author. This is the "consultation," or teamwork, approach. By his training, the psychobiologically oriented psychiatrist is, apart from any particular personal idiosyncrasy which may hinder him, likely to consider a predominantly religious experience in his patients a signal for careful referral to and collaboration with a trained minister whom he knows. Usually he works on a consultation basis, and excellent opportunity for collaborative exploration of the nature of religious experience prevails in this situation.

In the care of patients where no pronounced religious problem appears as a complicating factor, the psychiatrist usually does not make a point of such consultation, any more than a pastor seeks psychiatric help for a parishioner when no psychiatrically relevant problems emerge in his care of the person. For the minister to press the point for this is to expect too much of the doctor and to create problems

where enough problems already exist. In every instance, however, the psychiatrist can be materially aided by the work of a trained minister and his church at the following points:

1. In the care of the family in the upsetting crisis of sending their loved one—and sometimes “not-so-loved” one—to a psychiatrist. Intelligent interpretation of the experience to the family may remove therapeutic hindrances from the way of the psychiatrist, who often is stopped by the family's withdrawing the patient from treatment. A minister can help establish the doctor in the confidence of the patient and family, and save him time for the most serious elements of his treatment of the patient. The treatment of acutely disturbed mental patients is sometimes a quite isolated task for the doctor himself. Therefore, he is not nearly as grateful for a pontifical announcement from a minister about the power of religion to heal the mentally sick as he is impressed by the willingness of the minister to meet him at the hospital and stay with the family while he, the psychiatrist, tries to get the patient's personal story clearly enough to make a provisional diagnosis.

2. Occasionally, a psychiatrist treats a patient who needs religious reassurance as to the reasonableness of some of the religious insights he is “coming up with” in therapy. The doctor does not necessarily expect the patient to be told that his ideas are right, as much as he desires that the patient have an understanding minister to serve as an accepting “communicator” with the person. A part of the “lost radiance” of Christianity, it seems, is that the term

communicant has come to mean only a member of a church organization. Possibly a restoration of some of its meaning of having an accepting group with whom one may communicate with the assurance of understanding and acceptance would increase the power of the church to help the mentally ill.

When a pastor can establish this solid acceptance with mentally ill patients, he can occasionally challenge their delusional structures, if he does so under the careful supervision and planning of the psychiatrist. The weakness with many ministers' overdependence upon nondirective procedures at this point is that they may be saying "yes" and "uh-huh" to the whole delusional structure of a psychotic person. On rare occasions doctors have expressed the need for the minister's help at this point. They seemed to feel that as long as the patient had no question as to the correctness of his religious ideas, these ideas were a hindrance to further therapy. For a minister firmly to disagree at certain points seemed to "shake" the deluded person to some anxiety at least. This is an open question involving much theory, but some accurate research could well be concentrated here.

3. The convalescence period is the most important point at which the minister and the psychiatrist can effectively mobilize the religious experience of the patient toward creative living. At this time, the patient is making the transition out of therapy into his regular routine. A well-trained and perceptive pastor, small groups, church visitors, and the "fellowship of suffering" of a church can often effectively make the difference between the conservation and the in-

nervation of the results of the doctor's efforts. The private psychiatrist in particular usually does not have a social service department or agency to complete the team-line of his efforts in behalf of the patient. A psychiatrist can effectively collaborate with his colleagues in psychiatry in the equipment of people of the ministry and allied professions of teaching, law, and job-placement, to help at the point of rehabilitation of patients. One of the real services a pastor can render at this point is in "knowing certain people" in his community who can help patients to get work, to find a place to live, to find a meaningful circle of friends, and to find a church home which will sustain them acceptingly.

C. THE PSYCHIATRIC APPROACH OF INDIRECTION TO THE RELIGIOUS EXPERIENCE OF THE MENTALLY ILL

A third approach a psychiatrist may take to the needs of his patients seems to be implicit in a pattern of procedure followed by Harry Stack Sullivan in his book, *The Psychiatric Interview*. He does not make this suggestion with reference to religion, as such, among patients, but in regard to a case of homosexuality. He says:

Some time ago, I had occasion to see a patient who revealed in the first interview that he had a homosexual problem. The upshot of the reconnaissance was that I told him that I had no psychiatric time available—and I didn't know anybody else who had—for his interest in homo-

sexual problems. If, on the other hand, he wanted to find out why he could never hold any one job for more than six months—despite an initial curiously ascending progress at amazing speed—and was always in ever-increasing, terrific danger of being completely discredited and expelled by the organization he worked for, then I thought I could find him a psychiatrist. Believe it or not, the patient was quite content to go to work on the problem of why, in the space of six months or so, each one of his bosses came into such open collision with him that he left. The curious thing about this story is that in the process of studying his difficulties with bosses, the great homosexual problem sort of caved in. This kind of success story doesn't happen very often; in general, homosexual problems or any other problems don't just cave in. The important part of this story is that, as a result of a brief reconnaissance, I declined entirely to have anything to do with what the patient considered his problem. Instead I indicated a problem that needed very urgent treatment and that I thought psychiatry could help him with. The patient agreed, and we went to work on this second problem—that is, we began the detailed inquiry. (pp. 91–92)

The assumption on which Sullivan is moving here is that the patient's own statement of his problem is often a "security operation" in itself. To shatter this is to cause him to "give up the shadowy vestiges of

security" which "he has been able to maintain." Sullivan feels that this may be "simply disastrous to toss . . . in the patient's face."

This same process of indirection with reference to religious ideas is often followed by the psychiatrists whom the author has observed. They proceed on the assumption that when the patient's distorted perspective is clarified, he can move more securely and satisfyingly in the religious world view he develops in the latter phases of his experience of healing. Such indirection can be interpreted by outsiders, who do not know the psychiatrist, as a type of indifference to religion on his part. Rather, the psychiatrist is taking a much more serious view of religion in that he does not take the patient's distorted religious experience as the pattern for his relationship to the patient. When he takes such an indirect approach, the distorted elements of the religious experience tend both to "cave in" and dissolve. The by-product of the therapy of a careful psychiatrist may be, and often is, a deepened, matured, and enriched religious experience. Whereas, if he set out with this as a conscious objective, it may not have come to pass. Religious experience is a by-product of sound religion, and religion itself is distorted when healing becomes its primary end. Such an approach enables the psychiatrist to stay with the requisites of his own expertise, out of religious controversy with the patient, and in full control of the therapeutic situation. Without these, the psychiatrist's own security would be in jeopardy.

This is glaringly evident in the work of the psy-

chiatrist who attempts to deal with the religious experience by direct, negative attack and derogation. He galvanizes the security operations of the patient in such a way that his own relationship is jeopardized. Psychiatrists have taught ministers about this phenomenon in their approach to alcoholics in religious counseling. Ministers have learned from the psychiatrist that direct attack on the symptom of alcoholic excess tends to increase rather than decrease the symptom itself. Whereas, if the minister concentrates on the more basic and specific difficulties with the wife, the employer, the children, the family inheritance, and the bitter bereavements which the alcoholic is desensitizing and "decoying" with his alcohol, they are much more likely to be meaningfully related to him.

D. THE SUBSTITUTION OF PSYCHOANALYSIS FOR RELIGIOUS EXPERIENCE

In reality, this subtitle indicates only a small part of the total emphasis of psychoanalysis in this country. The approach discussed here would certainly not be representative of all psychoanalysts, because the above approach suggested by Harry Stack Sullivan would be more representative. Not all psychoanalysts or psychobiologically oriented psychiatrists would be quite so democratic as Sullivan's indirect approach would suggest. Rather, they verge upon making psychoanalytic therapy more totalitarian, and developing a substitute form of religion for the theistic interpersonal experience of religion which in-

volves communication with a personal God. Religion is a humanistic formulation of the ideal culture to them, and the values of human personality, as such, become the *summum bonum* of religion.

Such a view is presented rather confusingly in Erich Fromm's book, *Psychoanalysis and Religion*, in which he makes humanists of Jesus and Isaiah. Fromm certainly does not use the philosophical concept of humanism in its usual sense, if he makes humanists of two persons who prayed to a quite personal God, who spoke of distinctly mystical encounters with God, and referred consistently to his sovereignty over nature and the course of human history and personal destinies. Furthermore, the pattern of such a substitute approach to religion in the therapeutic situation does not come to grips with the polarities between authority and dependence, self-dedication and self-autonomy in personality. One can very easily see, from the thought of Fromm, the reasonableness of Boisen's criticism that he does special pleading for the supposed self-sufficiency in personality. In a word, the *equation* of psychoanalytic therapy with the religious process is a confusion of a finite process for an infinite one, the binding of eternal relationships to time, and a type of idolatry of the analyst and his analytic results. At least, such seems to be the end product of Fromm's approach.

Some positive conclusions can be drawn concerning the psychiatrist's own attitudinal orientation toward the religious ideas of his patient. Reference has already been made to the way in which psychiatrists have enabled ministers to be more discerning

and redemptive in their management of alcoholic persons. Ministers have been taught that alcoholism represents profound disorders in the total organism of the individual as he relates to his meaningful community, his enduring goals in life, and his own concept of himself. Ministers have been taught that what they see, on the psychopathic ward and "skid row," of the damage done by alcohol to a personality does not *necessarily* imply that *any* person using alcohol is *inevitably* doomed to become an alcoholic. Ministers have been taught to distinguish between the voluntary and the compulsive drinkers, and that the difference lies in the area of *the meaning* that drinking has to that particular person. The meaning of alcohol to one person may be poles apart from that which it bears to another person, particularly if the two persons come from different cultures. Some ministers have learned to respect their own culture if it has taught them from birth to be abstainers. Being able to drink alcohol does not necessarily mean that one is free of compulsions!

The psychiatrist can effectively follow the same pattern he has taught the minister with reference to alcoholism in his own attitudinal reorientation toward the religion of his patients. For instance, distorted and bizarre religious ideas represent profound disorders in the total relationship of the individual to his meaningful community, his goals in life, and his concept of himself. When a psychiatrist observes these pathological manifestations of religion on his ward, it does not necessarily imply that *any* person with a *similar* idea is inevitably doomed to become

psychotic. Nor does it imply that the clinical manifestations of religion the psychiatrist sees on his ward provide even a scientific basis for the development of a coherent and complete view of religious experience, although without these findings any view would certainly be incomplete. The difference lies in *the meaning* that the idea has to the total personality of the individual in creative rather than destructive ways of suffering, and in productive rather than sterile relationships to his fellow pilgrims in the search for the abiding purpose in life.

Such an attitude, it seems, supplies to the psychiatrist a ground of collaboration with people of all types of religion. At the same time, the psychiatrist approaches religion in keeping with the highest standards of his expertness, which in turn he recommends to others in allied professions. Such an approach calls for an underlying security in the psychiatrist himself, and can be hastened in its development if the psychiatrist has the advantage of knowing some profoundly religious yet emotionally adult persons.

These latter phrases may be considered as a redundant use of terms by some, and as a hopeless contradiction by others. In either event, the reaction would represent the range of experience, the professional security, and the particular religious biography of the person so reacting. Careful study of the historical records of the Hebrew-Christian community found in the Old and New Testaments will reveal to the psychiatrist the unsophisticated story of the lives of both healthy and religious per-

sons. Also he can get a first-hand impression of the Bible, a book which has been more abused in oral reports about it than have some of the research reports of persons like Meyer, Freud, Kinsey, and others.

Spliced in between the biographies of the biblical personalities are priceless proverbs, parables, and poetic utterances that are psychotherapeutically relevant. They carry the power of "lively" sayings, which are able to call back to the minds of patients the interpretations of the psychiatrist that have been clinched with the "saying." A few examples picked at random are: "Let the day's own trouble be sufficient for the day" (Matthew 6:34); "Faith works through love" (Galatians 5:6); "Do not let the sun go down on your anger" (Ephesians 4:26); "Do not refuse one another [sexual intercourse in marriage] except by agreement" (1 Corinthians 7:5); "Let love be genuine" (Romans 12:9). One of the main ways the Bible can be used therapeutically is in the symbolic relation which the patient's understanding of the Bible bears to the real problems he is trying to communicate. In another connection the author calls this "the diagnostic use of the Bible."

Ministers and Their Approach to the Religion of the Mentally Ill

Highly determinative in the implementation of all the suggestions made in this book thus far is the kind of minister whom the psychiatrist meets in the regular round of his care of his patients. Just as psy-

chiatrists should not be "lumped" together in mass judgments, neither should ministers. A minister does not get publicity for the anonymous task of pastoral counseling and confidential care of innumerable types of difficulties among his people—at least he should not get publicity for this. He should not let his "left hand know what his right hand is doing" (see Matthew 6:3). Neither does the psychiatrist receive the emotional support and public appreciation due him for being the recipient of problems with which everyone else in the community has lost patience. But if a psychiatrist gets into trouble, then this "hits" the front page. Or, if one minister starts preaching to the chickens, or if another one gets into a fist fight with his deacons, this becomes headline material. All the while this sensationalism is going on, a subtle stereotype of both ministers and psychiatrists is being formed.

Consequently, both the minister and the psychiatrist need to exercise the primary principles of both their concerns, religion and health, and refuse to become the victim of the stereotypes the culture has developed in order to avoid taking either psychiatry or religion seriously "by laughing them off."

However, the psychiatrist needs to make note, as he could not fail to do, that *some* so-called ministers fit the stereotype; at the same time, he does not generalize on these. Clergymen never do the cause of a living faith in God a service when they rush to the defense of a false prophet. Their failing, to the contrary, is to be too indiscriminate in this criticism

of each other. They could learn much from the caution of the medical profession in sabotaging one of its number.

Nevertheless, the psychiatrist needs to become acquainted with a minister personally before he can work with him. Furthermore, he needs some criteria whereby he may determine the dependability of a minister as a trained person in religion, in handling confidential data, in relating himself effectively to families and individuals, and in his knowledge of his limitations. A few such guiding principles may be helpful:

1. The psychiatrist should make note of the training of the minister. The standard training for a Protestant minister, for instance, is that he have a Bachelor of Divinity degree, which represents a minimum of three years' prescribed course in biblical, theological, historical, ethical, and practical parish studies beyond the standard four-year B.A. or B.S. degree. A doctorate represents a minimum of two years' residence study beyond the Bachelor of Divinity degree. These doctorates are usually Ph.D. degrees if given by a theological school in connection with a university, as Yale Divinity School; or, they are Th.D. (Doctor of Theology) degrees if given by a seminary apart from a university.

The above degrees refer to the training of a minister. They are earned degrees. The Doctor of Divinity degree, D.D., is an honorary degree, usually conferred by a college or a university for some meritorious service of long standing, or as a result of some political pressure or necessity the institution

has felt. Such degrees are occasionally quite spurious.

The kind of school that conferred these degrees is important, also. The American Association of Theological Schools lists the schools which have met the national standards of accreditation for such schools. The psychiatrist can usually distinguish an educated minister from an uneducated one by asking him about his schools. This is a perfectly legitimate and appropriate question to ask. The minister who has had an effective theological education will be glad to give the information, and one who has not will usually explain something of his own personal struggles in having entered the ministry late, economic privation, and so on. Likewise, a minister without formal theological education may have some other valuable experience or training which will be important to the psychiatrist in his ministry to patients. For instance, it is not unusual to meet ministers who were originally trained as schoolteachers, businessmen, or as social scientists of one kind or another. An increasing number of ministers are getting their Ph.D. degrees in psychology. Some research needs to be done at this point to see to what extent this is true.

A third measurement to note in a minister's training is the presence or absence of distinctly clinical types of theological education, which include medical, psychiatric, and correctional types of information and experience. These courses are usually listed under such titles as pastoral care, pastoral psychology, and pastoral theology. The National Conference on Clinical Pastoral Education has published a set of

standards for such education, which is aimed to prepare a minister to work effectively with other professional people, particularly the psychiatrist. This set of standards is given in the Appendix of this book. The January, 1955, issue of *Pastoral Psychology* includes a full description of facilities for such training in this country.

2. Another guide to the effectiveness of a minister may be the degree and kind of community participation in which he is involved. Mental hygiene weeks, family relations institutes, community agency boards, and institutional service groups have a way of attracting the attention of ministers who are flexible, whose interest in people extends beyond those in their particular church, and who have been disciplined in the importance of community service.

3. Another procedure for distinguishing therapeutically helpful ministers is by watching for those ministers who make direct referral of patients and call for advice as to ways whereby they may be helpful. Such a conversation, more than any other direct contact, will reveal what sort of minister this person is. The psychiatrist, in the case of direct referral, will probably get a referral letter from a trained minister. A return call from the psychiatrist will further establish such a relationship as a ground of professional confidence.

4. A fourth procedure for evaluating a minister's competence is to hear the man preach. He usually puts whatever "best foot" he has forward at this point. The kind of relationship a pastor builds with his congregation and his balance of emotional con-

text with appropriate ideas tend to be indices to his personality and his procedures with people. Likewise, the life spirit of the church fellowship of which he is pastor reveals something of the character of the man, in that a church tends to reflect the personhood of the minister in one way or another.

5. But more basic than all of these external concepts of ministers is the man's basic health and capacity to form enduring friendships. He lacks this when he manifests either a deferential or an accented hostile relatedness to the psychiatrist. The interchange of insight and of mutual professional regard becomes the principle of healing helpfulness between the psychiatrist and the minister which makes for the good of the patient. Psychiatrists and ministers have the simplest criterion of relationship, apart from any particular achievements of their own: their devotion to the welfare of the patient.

Occasionally psychiatrists express the desire to talk of religion in terms of its clinical applications and not merely at the philosophical level alone—and this apart from the participation of doctors and ministers in an actual treatment situation. They express a kind of wistfulness to confer with persons of religious faith who are flexible enough to do so in terms of the deepest resources of religion for personal and corporate living, and not merely in defense of this or that religious dogma. But they also admit a feeling of despair of ever meeting such persons with whom they can talk meaningfully.

This author, on the other hand, has been unusually fortunate in finding psychiatrists who can flexibly

confer with him about the deepest resources of psychiatry for the enrichment of the religious living of his own life and the lives of those to whom he ministers. But lest one assume that all relationships run the more or less ideal course suggested in this chapter, it is important to face some of the considerable barriers that prevent psychiatric help from reaching patients in their deepest needs, and prevent their religious needs from maturing in psychiatric therapy.

EIGHT

Therapeutic Problems in Relation to the Religion of the Mentally Ill

THE RELIGIOUS IDEAS of the mentally ill present some challenging problems in therapeutic strategy, from the points of view of both the psychiatrist and the minister. These problems come up, or "surface," in a variety of ways as doctors and ministers work either together with or independently of each other in attempting to meet the needs of the patient. These problems may be called "areas of tension," for that matter, inasmuch as the minister and the psychiatrist tend to have trouble understanding each other at these points. Therefore, these areas of tension provide opportunity both for creative discovery and for failures of communication between the minister and the psychiatrist, on the one hand, and between them and the patient, on the other hand.

The religious ideas of a mentally ill patient tend to symbolize the self-estimate and the difficulties in interpersonal living the patient himself has. At the

same time, these religious ideas have the power to activate the self-estimates and personal beliefs of both the minister and the psychiatrist as to the nature and destiny of man. When the ideas of the patient so activate the basic philosophy of his doctor and his minister, to that very extent they present a problem in therapy itself. Thus, it seems, the religious needs of the patient condition—if not determine—the outcome of the treatment the patient receives. To illustrate:

A patient was told by her minister that she needed to seek psychiatric aid. She adamantly refused to do so because, as she said, she was depending upon her mother's prayers to get her well. The mother considered the need for psychiatric help as a sign of a lack of faith in God. Continued resistance both from the daughter and the mother delayed the treatment of the patient for three years beyond the time when the patient first began actively to hallucinate and to withdraw completely from her accustomed mode of relationships. Of course, Protestants have long emphasized the fact that one needs no intermediary at all in finding his way to the solution of his difficulties, that a rugged individualism in faith calls for a refusal of help from others, and that Christians ought to take everything to God in prayer. People who are already healthy know what the exhortations mean and act wisely in response to them. But the men-

tally ill person *hears* these teachings much in the same way the patient and her mother mentioned here understood them. Therefore, the efficacy of prayer becomes a scapegoat for the unwillingness of the person to change. When this happens, a real tension has developed, and it does not appear full-blown until a family insists upon taking a mentally ill patient out of the hospital against the advice of the doctor.

In some instances, the minister of the family and the patient aids and abets their resistances to therapy. For instance, a thirty-six-year-old man was hospitalized for an attempted suicide. He was under constant attention in the hospital for further threats and attempts to kill himself. One evening he had to be restrained physically by two attendants, to keep him from fracturing his skull by thrusting his head against a plastered wall. The next morning, his family, led by his pastor, came to the hospital demanding his release. The chaplain and the superintendent both tried to persuade them to leave the patient under treatment, but met with no success, even though the family had been informed of further attempts by their son to kill himself. They persisted and removed the patient, under the coaching of the pastor, and were later disillusioned by his promises of healing for the patient through prayer groups. Finally they permitted the son to return to the hospital and remain for a full term of treatment.

Here the religious ideas, attitudes, and relationships affected the program of therapy from beginning to end. The amount of tension between the psychiatrists and the minister involved with the family was offset to some degree by the conciliatory work of the chaplain. However, simply to talk about the "common ground" between religion and medicine in general does little to alleviate or help to understand the real tension that exists in such cases as the ones just cited.

A second area of tension arises in the therapeutic situation in the difference between the role of the minister and that of the psychiatrist in society. The social role of the counselor—whether he is medical or nonmedical—is one of the controlling factors in the initiation, progress, and culmination of the therapy of an emotional problem. It stands to reason, and is demonstrated in practice, that the mentally sick person takes his problem to the person who fills the place in society most akin to his, the patient's, diagnosis of his own difficulty. For instance, a cancer patient developed a serious depression in addition to the illness that preyed upon her body. She sent for a minister and asked him to deal with the particular problem of guilt which she was bearing. He, having had thorough training and professional recognition as a clinical psychologist in addition to his theological education, dealt with the problem totally within the context of religion, although he was perceptively aware of the dynamics of the woman's adjustment to life. Later, in talking with a group of clinical psychologists, he was asked the question:

"Could not any good psychotherapist have done what you did without reference to religion at all?"

He answered the question by saying that a psychotherapist without the role of a minister would never have been called by the woman, because *she* perceived her problem as a distinctly religious need. Then, too, he said, the woman would have rejected him as a clinical psychologist if he had sought to re-adapt the contextual role in which she had cast him in her search for help. He agreed that the basic principles of technique were much the same, but the long-term values of religion determined not only the initiation but also the direction and outcome of the counseling situation, inasmuch as the person's primary concern was in finding the forgiveness of God.

A third area of tension arises in therapy when the minister and the psychiatrist begin to evaluate and call upon the various resources for therapy and rehabilitation of mental patients. For instance, a psychiatrist may say to a patient that he needs some "small group life" with people who understand him. The minister may hear this as a fellowship group, a study group, or a project group in his church. However, he may question the psychiatrist's "use" of religion as a "resource" for the "socialization" of the patient, whereas the psychiatrist does not accept the validity of the religious claims of the group. At best the minister feels that this is a limited attitude on the part of the psychiatrist, and if the psychiatrist feels that the religious claims of the church are actually untrue, then the referral represents a kind of

contempt both for the patient and the church, a treatment of one delusion with another.

The psychiatrist, on the other hand, may see that the church actually did participate positively in reconstructing a secure family out of the healthy relationships it afforded the convalescent patient. However, he might sincerely question whether anything happened in this process that could not have been reproduced from the case records of any secular casework agency. In fact, just as the zoning commission of many communities classifies church buildings as "public school buildings," many hospitals seem tacitly to consider ministers and their churches as a kind of "social work agency." However, the minister experiences some tension at this point in that the fact remains that the social casework agency actually does not exist in every community, whereas the church is usually present and at work. Furthermore, the social casework reconstruction of a family setting is too often on a temporary and makeshift basis, whereas the church relationship is an enduring one. And finally, the motivation of the church relationship has a very different interpretation in the mind of the patient and the people who minister to him. It differs in that it moves on the assumption of at least a degree of health and not disease, and in that it is the action of a corporate community rather than an isolated continuity of individuals. In addition to being a group, the church is a community. In addition to having finite objectives, goals, and meanings, the church is also set into a larger context of infinite goals, objectives, and meanings.

Another area of tension over religion in the therapy of mental patients centers in the psychiatrist's concept of himself as a scientist. When the larger philosophical and theological problems of his task appear, the psychiatrist may desensitize himself to these issues, lest he get outside of the bounds of his picture of himself as an *exact* scientist. The doctor, for instance, who views mental illness as a purely biological phenomenon which can ultimately be cured by a drug or an operation apparently does so on the assumption of the exactness of his science. The psychiatrist who develops this close legalism with reference to his role as a scientist may, however, find the observation of Valer Barbu correct: "Consciously or unconsciously such limitations will lead to a philosophy of cynicism or to a worship of force."¹ Likewise, as Braceland suggests, the psychiatrist who perceives himself as an exact scientist may follow the precision of the physicists so faithfully that he suddenly realizes that certain uses of some of his discoveries are actually immoral, as may be said about the atomic bomb.

Yet, the psychiatrist has more tangible risks at stake than his own possibility of becoming a cynic; his professional reputation is at stake when he "becomes seriously interested" in philosophical and theological concerns. In many instances his colleagues may not appreciate his extension of his domain to concerns that are not, according to their definition of science, relevant to the task of the true scientist.

¹ Valer Barbu, "Psychoanalysis and Philosophy," *The American Journal of Psychoanalysis*, Vol. V, No. 1, December, 1945, pp. 59-65.

His colleagues have reason to probe his motives for his extended interest.

The development of philosophical and theological concerns on the part of the psychiatrist may be alloyed with more mundane motives. Such interests may be motivated by an appeal to the sensational, the failure to get sufficient patients through the normal channels of professional relationships, and the need to express deviously a certain amount of hostility toward his more "irreligious colleagues." Likewise, in a few isolated instances, an elaborate show of compulsive religious concern and philosophical preoccupation has proved to be a compensatory way of handling sheer incompetence as a physician, to say nothing of open "mayhem" as a quack psychiatrist.

Ministers seldom realize this practical ground for the reticence of psychiatrists to overextend themselves in identification with religious groups. Their fellow psychiatrists may think them "to be getting old and turning to religion." Ministers can appreciate this if they have become closely enough identified with psychiatrists to have felt the "recoil" of their own colleagues in the ministry who isolate them because of their interest in the care of the mentally ill. Likewise, ministers, also, have to examine their own motives for such extended interests lest they, too, be quite mundane.

These problems reveal another area of tension in the therapeutic relationships of psychiatrists and ministers in their approach to encounter the religious needs of the mentally ill. The processes of se-

cularization have perceptibly taken over one after another of the great ministries to human need. Through the separation of church and state, education has been secularized, and in turn has developed a vast specialty, filled with subspecialties. In the early phases of scientific medicine, even surgery was outlawed by the church, much in the same way that some forces in the church treat psychiatry today.

When the mental hospital chaplain and the psychiatrist, especially, approach the mentally ill patients in their hospital, they meet the end results of these secularizing forces of specialization. In staff conference they meet the clinical psychologist, the psychiatric social worker, and occasionally the internal pathologist, all representing highly competitive specialties. Careful medical histories show how the patient has moved from one specialist to another, receiving one kind of therapy after another. State hospital psychiatrists and chaplains can enter with feeling into the plight of the woman who came to Jesus after having spent "all she had on doctors." Their patients come to them with much of their surgically removable equipment already gone, with a plethora of diagnostic certainties of clinical psychologists, a multiple listing of different psychiatric diagnoses of the past, and saturated with religious advice and interpretation of the whole conglomeration by an equally varied group of preachers, pastors, ministers, priests, and rabbis.

Nowhere in modern culture can the caricatures of fragmented human knowledge and shattered human culture be seen more sardonically than in a state

hospital. The loss of the oneness of truth, the pluralistic distortion of communication, and the depersonalization of human personality seen here reflect not merely the broken personality of an individual psychotic person; they also testify to the Tower of Babel of a culture that gets its men and material for construction from American colleges and universities. Neat departmentalization and overspecialization in theological seminaries reflects itself in the fragmentation of the gospel and the life of the churches. These same failures to develop interdisciplinary education at the university level reflect themselves in the modern hospital setting.

Psychiatry in its modern clinical developments is in a position to do for the treatment of the sick a signal service in its sustained reaffirmation of the wholeness of man, the development of an interdisciplinary approach to medical education, and the reaffirmation of the distinctly personal aspects of the patient's needs. The interest the psychiatrist shows "in the individual . . . implies a deep conviction in the value of an individual personality. It recalls the value religion places on saving a soul."² Similarly, the minister of religion can exert this influence in the culture as a whole through his co-operative confrontation of the needs of persons as individuals at the clinical level of his own pastoral ministry, both in and out of institutions.

The temptation of the minister who is striving for a place in the care of the disturbed and unhappy

² Barbu, *op. cit.*

people which implements the more exact and empirical insights of clinicians is to try to create a subprofession of the ministry in this field. Such was the way which religious education took. In the effort to overcome the problem of large churches in their need for specialized educational leadership, a subchurch vocation was formed. Evidence is now available to justify the conclusion that churches are beginning to develop a subprofession of counselors.

Cabot and Dicks speak wisely when they say that religion is essentially an "anti-specialistic force." To make counseling another religious specialty takes something intrinsic to religion out of both the role of the pastor of the church and the role of the counselor. Likewise, the trend implies the possibility of further schematizing the church after the pattern of the secular order of overspecialization. Nevertheless, one who teaches pastoral care and counseling finds himself thrust into the role of a semi-specialist again and again, against his own predilection in the matter. Regardless of such pressure from society, this author feels that Cabot and Dicks are right when they say: "If the minister is to counteract the evils of extreme specialism, he must not become another specialist like the doctor or social worker."³

Thomas M. French said to a group of ministers that the various specialties in an already overspecialized culture are like bricks in a building: they need something to hold them together. He interpreted the role of the minister as a "cementing" effect between

³ Richard C. Cabot and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: The Macmillan Co., 1947), p. 3.

the specialties. He said: "What we need is not the additional jargon of a new specialty, but more basic understanding of the real troubles that people who seek all our help are up against."

Another area of tension in the therapy of religiously concerned mental patients is that of semantics. Each specialty has developed what was necessary to deal with its own aspect of the patient's problem, without developing hypotheses it can do without. Therefore, this use of the "simplification-technique," suggested by William of Occam in the fourteenth century, has developed tightly constructed semantic systems in each of the great professions. These systems seal off communication with persons who are working in other professions, attempting to solve different kinds of problems. Psychiatric theories quite often differ in terms of the kinds of clinical problems the various theorists are seeking to solve. The most obvious example of this is the conflict within psychiatry itself with reference to the merits and demerits of psychoanalytic techniques. Naturally, this is only one of a great many bases of difference between "schools" of psychiatric therapy.

Ministers likewise develop close-knit semantic systems of cherished words and concepts that become "open sesame" into their own close-knit guilds. Ministers are likely to address themselves to solving the legitimate respectability needs of their parishioners and regularizing them into smoothly working church organizations. Their cherished concepts enable them to get the most done with the most people, they feel. To bother with concepts that are strangely

stated, unevenly applied, and which allow for problems with which they are not accustomed to deal is a "waste of time." They are likely to consider the needs of mentally ill people as something other than, different from, and alien to their task. They may even say that their main task is to interpret what the gospel is to people by teaching the Bible. All the while they do not see the relevance of what the Bible has to say about the same problems with which the psychiatrist is concerned.

This "closedness" of ministers gives in to modern secularism at the point of making religion a specialty. The ministry becomes a "mutual protective association" rather than the prophetic witness to the wholeness of the gospel. Each specialty becomes so semantically involved in its own trade names that any break-through of the spirit of reconciliation is really a miracle of human personality. But such miracles are occurring every day in clinical centers all over the country, where the common concern of different professions for the wholeness and sacredness of personality is issuing in a kind of togetherness where "each hears in his own language" and the shattered vestiges of a religious culture are being woven into a composite, meaningful pattern again.

However, overcoming semantic barriers reveals the areas of tension between the minister and the psychiatrist which are not due solely to terminology differences. Once professional defenses are relaxed, specialization handicaps laid aside, and semantic confusions clarified, ministers and psychiatrists can understand each other acceptingly enough not to

"gloss over" their real differences at the point of the mentally ill person's best interest. Then, they can consider the patient himself as a person, what he is like, what his destiny is, and in what way he differs from and shares in the common plight of all human-kind. When such understanding is achieved, the work of dealing with deeper dilemmas in the therapeutic situation appears.

For instance, the psychiatrist and the minister cannot easily "harmonize" the presuppositions of mechanical theories of personality development with the religious presupposition of self-autonomy and self-determination. Mechanistic determinism may take at least three turns in therapy. The first turn has been discussed in the "pure" scientism of the biological determinist. The second turn is in the determinism of the more culturally oriented psychiatrists. Such determinism is stated succinctly by Leon Saul, who defines religion as a "projection of man's struggle with his instincts . . . and the restraining and socializing forces of parental authority."⁴

Such a concept of the deterministic power of the unconscious tends to create the impression that mankind is unconsciously being determined toward evil, toward destruction. Eduard von Hartmann⁵ rightly emphasizes the fact that this determinism works in the direction of the nobler and more exalted expressions of human personality also. The unconscious

⁴ *Emotional Maturity* (Philadelphia: J. B. Lippincott Co., 1947), p. 107.

⁵ *Philosophy of the Unconscious* (London: Kegan Paul, Trench, Trubner & Co., Ltd., 1931), Vol. I B, pp. 38-39.

forms, preserves, repairs, and appropriately guides the organism. It ennobles mankind and conducts the race "historically steadily to the goal of its greatest possible perfection." The unconscious often guides men where their conscious thoughts have left them helpless. "By its inspiration in small as in great matters, and in mysticism it guides mankind to the presentiment of higher and supersensible unities."

The biblical emphasis upon sin and righteousness calls attention to this more positive kind of determinism. In the giving of the Ten Commandments.

as recorded in Exodus 20, attention is called to the fact that God visits the iniquity of the fathers unto the third and fourth generation. But in Psalm 103, the benevolent determinism is at work, in that the mercy of God is from everlasting to everlasting upon them that fear him.

This mechanistic determinism shows up in the treatment of the mentally ill patient as the therapist constantly engages in the business of distinguishing between what is *true* and what is *deceptive*, what is *real* and *unreal* in the communications of the patient. He sifts out suspicious from honest motives. He necessarily assumes that there is "something behind" what the patient is saying "that has not yet come out." Consequently, he may consciously or unconsciously impress the patient that *nothing* that he, the patient, consciously perceives to be his problem can be *really* what is bothering him. One patient, after four years of psychoanalysis, described her feelings thus: "I am so driven back into myself in the search for what is real that I dare not let one little seed of truth stay

in my consciousness long enough to take root. I must go and dig it up and take it apart." According to Pascal, the self is a bottomless abyss. Such a feverish search for the "really" real *behind* the apparently real pushes one further and further into the unplumbed depths without ever reaching the end.⁶

From the vantage point of Christian theology, the real point of beginning is in the assumption that man is a sinner—whether he is in or out of the church; is a steady-eyed recognition that *all* have sinned and come short of the grace of God. Therefore, no individual has any claim to superiority, and his general and specific inferiorities are the nerve endings of his sense of need and the beginning of salvation. As William James classically defined conversion, so it can be said of realistic therapy: "To be converted denotes the process, gradual or sudden, by which a self hitherto divided and consciously wrong, inferior and unhappy, becomes unified and consciously right, superior and happy in consequence of its firmer hold upon religious realities."⁷

Likewise the quaint wisdom of a Christian hymn sets this insight into verse:

*Come, ye weary, heavy-laden
Lost and ruined by the fall;
If you tarry till you're better,
You will never come at all.*

⁶ Karl Heim, *Christian Faith and Natural Science* (London: Student Christian Movement Press, 1953), p. 246.

⁷ *The Varieties of Religious Experience*, p. 189.

*Let not conscience make you linger
Nor of fitness fondly dream;
All the fitness he requireth
Is to feel your need of him.*

Patients express feelings of unreality in the therapeutic relationships. They talk to their psychiatrist about religious feelings or confusing philosophical problems, in their search to find out who they are and where they are going. On the one hand, the patient may turn the therapeutic interview into a philosophical tête-à-tête, inasmuch as this is easier than therapeutic work with the psychiatrist. It enables the patient to avoid the more arduous task of self-confrontation and therapeutic progress. Yet, the psychiatrist may so consistently assume the patient's philosophical problems to be "diverting" tactics that the patient gets the feeling that the psychiatrist does not feel that *anything* has any objective reality in the realm of religious concerns. This poses a real problem in therapeutic skill for a psychiatrist as he handles the dilemma of weighing the reality and unreality of religious problems in the therapeutic situation. The minister, on the other hand, can provide real teamwork for the psychiatrist if he relieves him of some of these problems by taking the religious concerns, per se, of the patient seriously. The patient is really confused if he cannot confer with the minister on something of a "give-and-take" basis about his religious ideas, attitudes, and needs.

The more one evaluates these problems, the more he is forced to re-examine the mechanistic presup-

positions of some forms of psychotherapy. Particularly is this true if F. J. Braceland, M.D., of the Department of Neurology and Psychiatry at the Mayo Clinic is correct when he says that even as Janet, Du Bois, Liebault, and Charcot "failed to come forth with a comprehensive theory of human character and its vicissitudes," contemporary medical psychologists, "after sixty years of medical psychology," still have not developed a "theory of the neuroses based upon a premise which refutes the exclusively mechanistic view of man's nature."⁸

Yet, Braceland points to the weaknesses of considering psychiatry as a science of man in his totality, concluding that "no problem of human nature can be solved by considering the mental side of it alone." An example he draws of this is the commonly espoused assumption "that certain traits observed by the psychiatrists in abnormal minds are identical with those observed in normal minds." In a highly significant quotation, he says:

. . . to take ideas gleaned in the study of mental disease and apply them uncritically to normal minds has not been proved justifiable. No one has answered the objection yet that to judge normality in the light of abnormality is a perversion in the order of things. Normality precedes abnormality. Until much more proof is presented it is hardly permissible to assume that

⁸ In an address, "The Philosophy of Psychiatry," read at the Hartford Institute of Living, Hartford, Conn., April 13, 1949.

abnormality is only an exaggeration and is reinforcement of traits characteristic of normality.

From the point of view of the therapeutic task, Braceland suggests that the results of considering psychiatry an all-inclusive science of man as a totality prompt psychiatrists to a type of rashness which causes them to exceed their limitations, and to over-extend their efforts, and, as he puts it, "to be found wanting when we are called upon to produce."

For instance, evidence is apparent in the popular press, in which psychiatrists and psychoanalysts are resorting to lecture-sermon forms of communication to get their concepts across to more people than can possibly be reached in the clinic and the consultation office. In turn, these procedures create an overwhelming demand for the kind of service a psychiatrist can effectively render. Doctors, therefore, spend much therapeutic time with persons who are looking for a comprehensive philosophy of life, rather than with patients who are suffering from clinically identifiable syndromes of symptoms. This is a hunch on which one would be perfectly willing to be proved wrong, and on which research needs to be done in order that such wrong may be so proved. Nevertheless, the remarks of Viktor Frankl and C. G. Jung seem to indicate that this is a trail which would bear investigation. Likewise, the impossibility of reproducing highly personal insights at the mass level results in a "watering down" of therapeutic concepts into popular clichés that caricature rather than mature the science of psychiatry.

On the other hand, certain Christian philosophers, sensing these areas of tension, manifest an ordered concern for a more comprehensive approach to the religious needs of the mentally ill. Possibly they will lay the ground for something more than and different from a purely mechanistic and finite kind of therapy. They are moving along several lines that merit consideration.

First, Paul Tillich, the Christian philosopher-theologian, has written the first volume of a *Systematic Theology*⁹ which comes to grips with the problems of the fragmentation and estrangement of modern man in a depersonalized culture. Tillich describes man as he handles the problems of detachment, the worship of objectivity, and the need for reconciliation with himself through the discovery of an ultimate ground of being to serve as a bottom of the abyss of the selfhood, of which Heim speaks. This ultimate meaning and ground is God.

Furthermore, Tillich comes to grips with the "psychiatric moralisms" of complete maturity-perfection and complete freedom from anxiety which become the moving assumption and objective of psychotherapy. The Ponce-de-León search for eternal youth and the ascetic quest for perfect peace have reappeared. They have taken the form of psychological truisms. The moralizing mechanisms of mass thinking have turned much that psychiatrists have said into a new form of platitude. For example, in two hundred years of such preaching and teaching,

⁹ Chicago: University of Chicago Press, Vol. I, 1951.

one may suppose that persons will complain of an Oedipus complex in the way they do now about the unpardonable sin! Tillich points out that the "psychotherapy of the mechanistic type tries to transform men into well-functioning homomuncili or artificial men. But none of them works permanently; on every level freedom breaks through managed perfection."¹⁰ Tillich further helps with this problem in his approach to the problem of anxiety, indicating that basic anxiety is characteristic of man's existential nature, and pathological anxiety is incidental to it. To try to remove *all* anxiety is to destroy man's basic nature.¹¹

The point of view of Gotthard Booth indicates that Tillich is not alone in his search for a spiritually meaningful and more-than-mechanistic concept of therapy. He says:

It is beyond the competence of a psychiatrist to decide whether the health of a devout Christian or of a militant atheist is better, but he has theoretical and empirical reasons to believe that either one is healthier than the person who has found nothing in the world for which he wants to live or die.¹²

In this same discussion, Booth appeals for a more "existential" kind of therapy which takes into ac-

¹⁰ Paul Tillich, "Human Nature Can Change: A Symposium," *The American Journal of Psychoanalysis*, Vol. XII, No. 1, 1952, p. 67.

¹¹ Tillich, *The Courage to Be*.

¹² *The Church and Mental Health*, Paul Maves, ed., p. 15.

count the distinctly spiritual needs of men for an abiding meaning. This underlines Viktor Frankl's conception of therapy as the discovery of a power to suffer creatively and meaningfully rather than to avoid all suffering through the perfectionism of some types of therapeutic endeavor.

Harold Kelman forthrightly admits that this kind of therapy calls for some *objective* structure of authority in the world of the patient. He draws the distinctions between rational and irrational authority, saying that "the feeling of rational authority has the attributes of being spontaneous, plastic and dynamic, while the feeling of irrational authority has the attributes of being autocratic, rigid, and static."¹³

He picks up the theme of Booth in further describing rational authority in his life and reflects less concern about self-preservation and self-maintenance which becomes "less paramount because should the occasion arise he may choose to die for ideals which have essential meaning for his life." Of course, this insight appears in a Christian hymn, also.

*There's a wideness in God's mercy,
Like the wideness of the sea;
There's a kindness in his justice,
Which is more than liberty.*

Apparently the element of self-dedication and self-direction, even to the point of taking up one's cross and going to death itself, does have a place in the

¹³ "Rational and Irrational Authority: A Holistic Viewpoint," *The American Journal of Psychoanalysis*, Vol. XII, No. 1, 1952, p. 57.

kind of therapy about which these philosophers and psychiatrists are speaking. Up until now, the Christian concepts of self-giving have found little if any place in the ethical mechanism of much that has been taught about therapy. But here the authority of a love which asks for all of life upon having given all of its life, as being central in therapy, breaks the power of bondage to inner conflict and manifests itself outwardly in personality change. Freud himself stated that way of life as one "which makes love the centre of all things and anticipates all happiness from loving and being loved."¹⁴

Martin Buber, as has been said before in these pages, in his philosophical poem, *I and Thou*, gives the most succinct and transversally applicable statement of the structure of the relationship which embodies this kind of love. When applied to the treatment of mentally ill patients, the kind of relationship which treats the person as a thing, objectivates him, depersonalizes him, and makes an entity out of a being is the I-It relationship. When religion drops to this level, it ceases to be religion and becomes magic, and God is responded to not as a person who relates himself through ethical love. Rather, God becomes to such a believer, capricious force, and subject to man's neurotic sense of omnipotence whereby through cleverness he can be "used" to the patient's own ends. This is the fallacy of much popular preaching about mental health: it makes God a *means of health* rather than a person in his own

¹⁴ Sigmund Freud, *Civilization and Its Discontents* (New York: Jonathan Cape and Harrison Smith, 1930), p. 37.

right to be loved "in sickness and in health." Buber perceives this kind of relationship to be one in which the doctor, the minister, and the patient involved "use" each other as tools rather than relate to each other as persons. They become manipulative, demanding, destructive, possessive, and consuming.

All of this is converse to Buber's concept of the I-Thou relationship, which emphasizes and embodies the elements of participation, considerate involvement, and the communication of persons who treat each other as ends in themselves rather than as means to some external end. The hallmark of this kind of relationship is dedication, self-transparency, and nondefensiveness.¹⁵ In the I-Thou relationship, therapy or healing is the by-product and not the end intention of a person's faith in God. One counselee told the author that she had tried religion as a means of getting her estranged husband back. It had failed. Now, she said, "I have no use for religion. I want my husband to love me for my own sake and not because I am religious." The author gently suggested that he felt that God felt the same way toward her: that he wanted her to love him for his own sake and not *in order* to get her husband back. Whether she gets her husband back or not, she will need God.

From a therapeutic point of view, Professor Carl Rogers of the University of Chicago describes his therapy of counselees as entering into a subjective I-Thou relationship with the counselee:

¹⁵ Martin Buber, *I and Thou*.

I find his [Martin Buber's] description of what he calls the "I-Thou" relationship is the kind of relationship I am seeking with clients who come to me, not what he calls an "I-It" relationship; in other words, it is a relationship between two persons meeting at a deep and significant level, not between a person and a complex object.¹⁶

Likewise, the formulations of Harry Stack Sullivan represent a more realistic kind of psychiatric therapy as a process of reciprocal participation between the psychiatrist and the patient. He does not view it as a detached "balcony view" of life on the part of the psychiatrist or minister as they view the patient *as if* they were not in any way involved in the picture which the patient is presenting of himself. Such an approach to the therapy situation implies a new type of dedication, insight, and discipline on the part of the psychiatrist which the more detached "pure scientist" approaches did not afford.

This kind of insight came to the author as a teacher of students in their pastoral ministry courses. The student was different, materially different, in his manner of life when the professor was not around, as compared with the times he was present. Direct observation of him introduced a kind of change that made of the situation something quite different. Of course, this is such a commonplace truism that every

¹⁶ "A Personal Formulation of Client-Centered Therapy," *Marriage and Family Living*, Vol. XIV, No. 4, November, 1952, p. 342.

farmer-parent knows it. But its very obviousness makes it slippery when counselors and therapists apply it to the complex, formal relationships of the treatment situation. As John Macmurray says, this calls for a sort of "psychology of psychiatry," inasmuch as the observing psychiatrist is compelled to make the distinction between the observer and the observed.¹⁷ William A. White has said, "Observing a phenomenon in some way changes it."¹⁸

Sullivan, who was a philosopher in his own right, perceived psychiatry as participant-observation from start to finish in therapy. Further, he prepared the way for a more existential involvement of the doctor and the patient as persons. Such involvement sets forth a creative approach to the meaning of suffering rather than just its eradication. This more constructive path, suggested by Frankl and Booth, opens a "corridor" at least for the psychiatrist to be something more than a mechanistic determinist, conducting his therapy on purely finite presuppositions toward finite sets of goals and ending in fatalism for his patients and cynicism for himself.

Albert C. Outler, in his book, *Psychotherapy and the Christian Message*,¹⁹ writes directly to the psychiatrist and psychoanalyst regarding ways and means whereby a more adequate philosophical framework for therapy can be developed. The closed deter-

¹⁷ *The Boundaries of Science* (London: Faber and Faber, Ltd., 1939), p. 158.

¹⁸ *Twentieth Century Psychiatry* (New York: W. W. Norton & Co., 1936), p. 135.

¹⁹ New York: Harper & Brothers, 1954.

minism of the mechanistic psychiatrists has resulted in discoveries in practical wisdom for which the church is continually indebted. Nevertheless, as White so aptly states: "I do not believe that the psychiatrist can avoid these philosophical considerations. More and more the world we live in demands in our thinking some comprehensive formulations."

The most intimate area of tension in the therapeutic situation in which the psychiatrist and the minister are participantly involved in relationship to each other and the patient arises at the point of the personal concern that ministers and doctors learn to feel for each other as they work together. The psychiatrist rightly becomes concerned about the mental health of the minister who deals with his patients. Increasing progress is being made whereby ministers are being measured and are learning to measure themselves by the criteria of mental health, as a prerequisite of their effectiveness in communication of religious faith to those who need them, especially to the mentally ill. For, it stands to reason that both religion and mental health are contagious. Daniel Blain has written a definitive statement in the symposium, *The Church and Mental Health*, on the mental health of the minister. This article deserves the attention of every minister who is concerned about improving his effectiveness in interpersonal relationships. Likewise, the minister will find that a frank friendship between him and his psychiatrist friends will increase his usefulness to the mentally ill person who has specifically religious problems, and will put him into touch with areas of human

need to which he would never have access apart from the private friendship with the psychiatrist. But more than that, the minister will find that this friendship will lead him to personal resources for mental health that he had not known before. And when the pressures of his taxing task become too great, he should no more hesitate to go for a check-up on his mental health than he would hesitate to insist that his children go to the pediatrician at the appointed time.

Likewise, the minister himself feels concern for his psychiatrist friends at the point of their personal religious needs. When one has observed the reverence of psychiatrists for their patients and has had his own concept of the depth and mystery of human personality enlarged by reading their writings, he is constantly puzzled that the concept of the Eternal as personal, self-giving Love has not been easily assimilated into their world view. But as one also studies the history of ideas, the development of medical education, and the misrepresentations from which these men originally drew their presuppositions about God, he is no longer puzzled. However, whenever one finds the epitome of the practical wisdom of psychiatrists in the infinite Love incarnated in the person of Jesus Christ, he longs to see these impediments of cultural, educational, and personal histories overcome by the higher disciplines and the more spontaneously productive presuppositions about life which the Lord Jesus Christ has to offer to their thinking.

Such a transformation of basic orientation would not do away with the conditioning power of personal history, of culture, and of specific disease entities with which the psychiatrist would exchange a "hard" determinism for a "mellowed" determinism. Some such miracle of transformation of insight and the renewed power to change life less by rote and more by relationship is in store for modern psychiatry. Otherwise, one has difficulty in discerning much hope for psychiatry. It seems headed for the same kind of encrusted tradition and legalism (in different terminology) into which much of the church has fallen.

But a re-centering of life in the Christian hope will make certain practical problems of the psychiatrist more easily solved. For instance, the *rigor mortis* of professionalism can get the best of a psychiatrist, even as it does the minister. He is likely to lose sight of his goal in life without a sense of clarification that comes from considering his profession as a vocation as well as a profession, a calling as well as a work. And he feels this tug of concern in reflecting on the plight of state hospital patients who do not have any qualified psychiatrists, whereas the large cities are often filled with psychiatrists in private practice competing with each other for patients. Likewise, one sees psychiatrists struggle with the decision as to how much time to spend with chronic patients, as compared with the patients more likely to get well. They must feel the press of the shortage of psychiatrists who are trained, and long for an opportunity to teach and to train their own kind. Yet, on the other

hand, they feel the press of the need to make enough money to be considered acceptable to those who would choose them as therapists as well as to their own fellow colleagues.

Occasionally one hears a minister sneer about a psychiatrist who himself shows signs of an emotional illness. Such callousness in a Christian minister merits deep resentment, because the emotional load that psychiatrists carry is seldom understood by such ministers. The major questions of overloaded psychiatrists are usually pressing and immediate. They are often primarily concerned about how to get one full night of sleep, about what patient is most likely to commit suicide, and about a possible lawsuit from the paranoid husband of the depressed patient to whom they talked this afternoon. Psychiatrists do not usually scale the transcendental heights of some Mount of Transfiguration, as did the favored disciples who were specifically selected by the Master. They are more likely to be the temporarily defeated fatalists—those other nine in the valley below—with the stench of the epileptic's froth and his teeth marks on their hands from trying to care for him and heal him. They will still be wanting to know *why* they cannot heal him, even after some spontaneous recovery has taken place through religious experience. Yet, one cannot but feel that the psychiatrist's task will be a more adventurous one and a less arduous one if he has the personal companionship of One who himself sweated at the same tasks they do long before their empirical tools were devised.

These are decisions that are made daily by the

psychiatrist, and they are not easy ones. They are all the more difficult, and sometimes they may even be made wrong consistently unless the psychiatrist's own destiny has a dependable plumbl ine of righteousness, health, and hope.

APPENDIX

Standards for Clinical Pastoral Education Adopted by the National Conference on Clinical Pastoral Training

October 1, 1952

I. DEFINITION OF CLINICAL PASTORAL EDUCATION

Clinical pastoral education is an opportunity for a theological student or pastor to learn pastoral care through interpersonal relations in an appropriate center, such as a hospital, correctional institution, or other clinical situation, where an integrated program of theory and practice is individually supervised by a qualified chaplain-supervisor, with the collaboration of an interprofessional staff.

II. QUALIFICATIONS OF THE CHAPLAIN-SUPERVISOR

1. Graduation from an accredited theological school upon the completion of a three-year graduate

course beyond the bachelor's degree or its equivalent.

2. An adequate period of pastoral experience, with ordination and denominational approval.
3. At least one year full time of clinical pastoral education, and in addition three months of supervised clinical teaching.
4. Professional competence including graduate studies, past experience, and demonstrated performance. Graduate degrees in appropriate fields with clinical orientation are recommended and may be evaluated as follows: Six months' credit toward clinical education may be given for an appropriate doctor's degree. Three months' credit may be given for an appropriate master's degree.
5. Personal qualifications to be appraised by an accrediting committee in a face-to-face interview.

III. REQUIREMENTS FOR THE CLINICAL TRAINING CENTER

1. A chaplaincy service which is well established and recognized as a functioning part of the center, with a chaplain accredited as a supervisor (see II).
2. A progressive institution, oriented toward therapy or rehabilitation, serving an adequate number of patients or inmates accessible to the chaplain's program, maintaining an interprofessional staff available for continuous teaching of theological students.
 - a. General appreciation within the institution of the role of a chaplain, recognition of theologi-

cal students as functioning members of the chaplain's department, and adequate opportunity for them to work in significant and appropriate clinical tasks.

- b. An alert and co-operative administration and staff, who will be ready to assume responsibility for implementing the clinical program.
3. Maintenance should be provided for students in training, or such provisions as may be comparable to the internship programs of other professional groups in the institution.

IV. MINIMUM ESSENTIALS OF CLINICAL PASTORAL EDUCATION

1. A supervised practicum in interpersonal relations.
2. Writing of clinical notes for consultation with the chaplain-supervisor.
3. A continuing evaluation of the student's experience and growth to be offered during the training period.
4. Frequent association with an interprofessional staff who are genuinely interested and qualified to teach students.
5. Adequate provision for group discussions, seminars, and other group experience for all students.
6. A continuing concern for an integration of psychological, ethical, and theological theory, with practical understanding of the dynamics of personality and facility in interpersonal relations.
7. A written evaluation of his experience to be made

by the student to his chaplain-supervisor at the end of the training period.

8. A final summary evaluation of the student's work and capacities to be written at the end of the training period by the chaplain-supervisor, discussed with the student, and with his knowledge made available to the appropriate responsible parties.

V. MINIMUM PROGRAM RECOMMENDED FOR CLINICAL PASTORAL EDUCATION

1. For the theological student who is preparing for the parish ministry:
 - a. An introductory course in clinical pastoral care during the entire academic year, with one day per week at an accredited center and under the direction of an accredited chaplain-supervisor who is a functioning member of the staff of the center; and
 - b. Clinical pastoral education for twelve weeks, full time.
2. For the student who is seeking a master's degree in pastoral care, at least six months' clinical pastoral education, full time.
3. For the advanced student preparing for the teaching of pastoral theology and pastoral care, an appropriate doctor's degree with at least nine months, full time, of clinical pastoral education, and in addition three months of supervised teaching of pastoral care.

VI. SPECIAL CONSIDERATIONS

1. For pastors and other religious workers seeking additional training:
 - a. Full-time participation in clinical pastoral education for six to twelve weeks is recommended.
 - b. Where this is not possible, participation in orientation programs at an accredited center is recommended.
2. For chaplains serving full time, at least twelve months' full-time clinical pastoral education is recommended, six months of which are to be in the type of institution which he serves. Where this standard has not yet been attained, hospital administrators are encouraged to release their chaplains periodically for the necessary training.



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