Religion and Spirituality in Psychiatry

Edited by

Philippe Huguelet

University Hospital of Geneva and University of Geneva, Switzerland

Harold G. Koenig

Duke University Medical Center and Veterans Administration Medical Center, Durham, North Carolina

CAMBRIDGE UNIVERSITY PRESS

Contents

List of Contributors *page* vii

1 Introduction: Key Concepts 1
Philippe Huguelet and Harold G. Koenig

2 Spirituality and the Care of Madness: Historical Considerations 6
Samuel B. Thielman

3 Theological Perspectives on the Care of Patients with Psychiatric Disorders 19
Joel James Shuman

4 The Bible: Relevant Issues for Clinicians 31
Armando R. Favazza

5 Religion/Spirituality and Neuropsychiatry 48
Nader Perroud

6 Religion/Spirituality and Psychosis 65
Philippe Huguelet and Sylvia Mohr

7 Delusions and Hallucinations with Religious Content 81
Sylvia Mohr and Samuel Pfeifer

8 Religion/Spirituality and Mood Disorders 97
Arjan W. Braam

9 Spirituality and Substance Use Disorders 114
Alyssa A. Forcehimes and J. Scott Tonigan

10 Religion, Spirituality, and Anxiety Disorders 128
Harold G. Koenig

11 Religion/Spirituality and Dissociative Disorders 145
Pierre-Yves Brandt and Laurence Borras

12 Self-Identity and Religion/Spirituality 158
Pierre-Yves Brandt, Claude-Alexandre Fournier, and Sylvia Mohr

13 Personality, Spirituality, Religiousness, and the Personality Disorders: Predictive Relations and Treatment Implications 173
Ralph L. Piedmont

14 Religion, Spirituality, and Consultation-Liaison Psychiatry 190
Harold G. Koenig

15 Community Psychiatry and Religion 215
Marcus M. McKinney

16 Religious and Spiritual Assessment in Clinical Practice 232
Sylvia Mohr and Philippe Huguelet

17 Integrating Spiritual Issues into Therapy 244
René Hefti

18 Explanatory Models of Mental Illness and Its Treatment 268
Laurence Borras and Philippe Huguelet

19 Psychiatric Treatments Involving Religion: Psychotherapy from a Christian Perspective 283
William P. Wilson

20 Psychiatric Treatments Involving Religion: Psychotherapy from an Islamic Perspective 301
Sasan Vasegh

21 Psychiatric Treatments Involving Religion: Psychiatric Care Using Buddhist Principles 317
Charles Knapp

22 Teaching Religious and Spiritual Issues 332
Elizabeth S. Bowman

23 Conclusion: Summary of What Clinicians Need to Know 354
Philippe Huguelet and Harold G. Koenig

Index 369

2 Spirituality and the Care of Madness: Historical Considerations

SAMUEL B. THIELMAN

SUMMARY

Spiritual and religious issues are sometimes neglected or misrepresented in histories of psychiatry. This chapter outlines a historical approach to understanding how spiritual and religious ideas are expressed in medical and religious writings dealing with madness. Sacred writings, inscriptions, ancient architecture, commentaries, pastoral letters, medical texts, and religious and spiritual publications all reflect a range of ideas about the role of spirituality and the supernatural in the etiology and treatment of mental disorders. Beginning with ancient pagan and Jewish writings, and continuing with the writings of the early church fathers, medieval physicians and Puritan divines, the chapter describes ways in which spirituality influenced the care of emotionally distressed patients. The chapter discusses the ways in which both naturalistic and supernaturalistic views of madness are reflected in practice in the roots of modern medicine in the eighteenth century and how psychiatrists and others dealt with religious issues during the more secular nineteenth and twentieth centuries. The chapter argues against the position that there has been steady progression from a supernatural to a naturalistic understanding of madness and shows how religious and spiritual ideas continue to affect the psychiatric approach to mental disorders.

INTRODUCTION

The history of psychiatry has often been written as though the emergence of psychiatry involved a transition from superstition to reason, from religion to science, and that only in the modern era have we come to understand that madness is not the result of the influence of spirits, demons, and curses. In fact, the relationship among ideas of madness and religion, medicine and theology, treatment and ritual is complex and varied. Although natural explanations seem to compete with religious explanations, in fact, people actually caring for the mad often (although not always) held these explanations in mind concurrently, and doctors, clergy, and families used this understanding as a basis for managing those for whom they cared.

Different religious traditions, of course, have had different approaches to the mad. This chapter focuses primarily on care given in the Christian tradition in Europe and North America because it is this tradition that has shaped modern psychiatry's way of dealing with religious and spiritual issues. Historical accounts of the Islamic approach to the mad indicate a variety of ways of dealing with madness – from the traditional Islamic methods that involved casting out the devil, to Koran-based methods, to an approach that involves a naturalistic understanding.(1, 2) Hinduism and Buddhism have their own approaches to madness as well.(3–5)

I. THE BIBLE AND MADNESS

For a variety of reasons, including missionary activity, European colonialism, and the adaptable nature of Christian belief, Christians are present in significant numbers in most parts of the modern world.(6) The Bible is, arguably, the most globally influential of ancient religious texts, and

it has influenced the West, both physicians and lay people, since the time of Constantine, so it is important to understand how the Bible presents madness. The Bible has several sections that have shaped views of madness – although in different ways at different times.

The Bible was written and edited over many centuries. The Old Testament (or Hebrew Scriptures), assumed its present form in about 90 AD.(7) The New Testament canon was established at the Council of Nicea in 325 AD. All Christian groups accept the parts of the Old Testament that Jews regard as canonical. Roman Catholic, Eastern Orthodox, and Coptic Christians, variously, include additional edifying Jewish writings that were not accepted as canonical by Jews.

Madness is portrayed in the Old Testament in several ways, sometimes in naturalistic terms, sometimes otherwise. Illustrative of the various ways madness is viewed in the Bible are the accounts of madness in 1 Samuel. In Chapter 21, the young David, not yet king of Israel, finds himself in a dangerous situation in the presence of Achish, a Philistine king, and his comrades. According to the Bible, "he changed his behavior before them, and pretended to be insane in their hands and made marks on the doors of the gate and let his spittle run down his beard" (1 Sam. 21:13, NRSV). Achish was disgusted and declared, "Do I lack madmen, that you have brought this fellow to play the madman in my presence? Shall this fellow come into my house?" (21:15). David was able to escape and carry on unharmed. In this setting, madness is presented as a natural phenomenon that is not unusual.

The same book of the Bible, five chapters earlier, includes an account of Saul that describes a supernatural cause of madness or, in Saul's case, despair. The writer records, "Now the Spirit of the Lord departed from Saul, and an evil spirit from the Lord tormented him" (1 Sam. 16:14). In this story, David was summoned to play his lyre for Saul, because David had musical talent, and David's music greatly consoled Saul. Saul hired David to work for him, and "whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand. So Saul was refreshed and was well, and the evil spirit departed from him" (16:23).

In the New Testament, madness is sometimes attributed to demons. In the Gospel of John, Jesus's opponents at one point say, "He is demon possessed and raving mad. Why listen to him" (John 10:20). In another incident, Paul tells the recipients of one of his letters, to make a point, that he is speaking as though he is mad, with no implication of a supernatural aspect at all.

These examples illustrate something that is true throughout the Old and New Testaments: when madness is portrayed, it is often seen in naturalistic terms, but the Lord often has something to do with the madness (for example, Deut. 28:28, Jer. 25:16 and 51:7, and Zech. 12:4).

Not only does the Bible contain information on an ancient way of viewing madness in spiritual terms, but it also contains large portions of wisdom literature that is analogous to modern self-help literature, although religious readers would consider it help from God. Wisdom literature exists in many writings from the ancient world, and there are parallels in the Bible to Egyptian wisdom literature. The books of Proverbs, Ecclesiastes, Wisdom, and Sirach all contain advice on how to live life and how to understand life's difficulties.

2. MADNESS AND RELIGION IN THE ANCIENT WORLD

The ancient world presents a wide range of worldviews and a number of philosophies of healing. Religion, psychology, and medicine were intertwined, for example, in the ancient healing cult, the cult of Asclepius. The cult of Asclepius was the most widespread healing cult in the ancient world, originating with the ancient Greeks and lasting until after the time of Christ. Asclepius was a god of healing whose temples were places of healing. One of the principal methods of healing in the temple was making a votive offering of a small replica of the diseased organ and waiting for healing. Healing often came through dreams in which Asclepius would

appear. The Asclepian physicians were practitioners of rational medicine who, when they could not heal through rational medicine, directed the sick to the Asclepian temple (p. xviii).(8) Certain psychological methods were attributed to the god Asclepius. Galen of Pergamum (c. 130–216 AD), the well-known physician of the second century, offered this insight into how Asclepius, the deity, ordered psychological means to cure disordered emotions:

> And not a few men … we have made healthy by correcting the disproportion of their emotions. No slight witness of the statement is also our ancestral god Asclepius who ordered not a few to [write] odes … he ordered hunting and horse riding and exercising in arms.… For he not only desired to awake the passion of those men because it was weak, but also defined the measure by the form of exercises" (pp. 208–209).(8)

More significant for religion in the West were the Hippocratic writings and Plato and Platonism. Hippocratic medicine is highly valued in modern accounts of medical history because it encouraged observation over theory, and because it generally eschewed supernatural explanations of madness.(9)

Early church writers generally respected the work of physicians and had a view of madness that incorporated a spiritual perspective, while acknowledging the physical influences that cause mental distress as well. The writings of John Chrysostom (c. 347–407 AD) reflect this approach. John Chrysostom was bishop of Constantinople, a highly regarded preacher, and a person with considerable skills as a pastor. In a series of letters to Olympias, a deaconess who apparently suffered from bouts of despair, Chrysostom provided a wealth of information about his views on despair and its relationship to physical illness. Melancholia per se is not mentioned. Instead, Chrysostom referred frequently to *athumia* and its relationship to illness. Olympias apparently suffered from a chronic complaint of unclear origin, and this condition was accompanied by a sense of despair and gloom. Chrysostom at times tried to comfort her by assuring her that physical illness often caused despair. "[Job] was not tortured by despondency [until] he was delivered over to sickness and sores, then did he also long for death" (p. 294).(10)

As his correspondence with Olympias progressed, however, Chrysostom began to become somewhat more impatient. In rebuking her for persisting in her state of dejection he told her that he believed that her physical illness was caused by her sense of dejection:

> You lately affirmed that it was nothing but despondency which caused this sickness of yours.… I shall not believe that you have got rid of your despondency unless you have got rid of your bodily infirmity (p. 296).(10)

He then went on to rebuke her for taking pride in her sorrow:

> I …reckon it as the greatest accusation that you should say 'I take a pride in increasing my sorrow by thinking over it': for when you ought to make every possible effort to dispel your affliction you do the devil's will, by increasing your despondency and sorrow. Are you not aware how great an evil despondency is? (p. 301) … Do not then now desire death, nor neglect the means of cure; for indeed this would not be safe (p. 296).(10)

Finally, Chrysostom offered pastoral advice for her dejected state: he suggested that she pray, that she read his earlier letter, and even that she memorize it. He also suggested that she compare the blessings God had given her to her adverse circumstances to help her obtain consolation for her feelings of despair (p. 297).(10)

To the despondent, John Chrysostom recommended the Christian faith as a remedy in his homily on St. Ignatius: "If any is in despondency, if in disease, if under insult, if in any other circumstance of this life, if in the depth of sins,

let him come hither with faith, and he will lay aside all those things, and will return with much joy."(11) Yet his letter to Olympias, directed as it was to a more specific case of despondency, is nuanced and humane.

Not all of the early church writers held a balanced view. Tatian (c. 160) was a disciple of Justin Martyr, a skilled speaker and theologian. In *Oration to the Greeks*, Tatian asserted a view that demons follow sickness.(12) The cure of madness is from God, not from the amulets that madmen were apparently supposed to wear.

> A disease is not killed by antipathy, nor is a madman cured by wearing amulets. These [cures from amulets result from] visitations of demons. … How can it be right to ascribe help given to madmen to matter and not to God? [The] skill [of those who use such means to cure] is to turn men away from God's service, and contrive that they should rely on herbs and roots.(12)

Tatian, however, did not always hold views consistent with orthodoxy, and his view of "herbs and roots" was probably not shared by many early church leaders.

3. RELIGIOUS APPROACH TO MADNESS IN THE MIDDLE AGES IN EUROPE

Of the few extant sources for learning about the spiritual side of the treatment of madness during the Middle Ages, perhaps the Leechbook of Bald is the most interesting. The Leechbook consists of three books owned by Bald, presumably a physician, and compiled in the ninth century in England.(13) The Leechbook contains remedies for all sorts of ailments. Many of the remedies are plant remedies, but the book also contains incantations and rituals to be used in the treatment of disease. Book I of the Leechbook of Bald contains several references to madness and interestingly distinguishes between demon possession and lunacy. Even for demon possession, the physician is to treat the demon-possessed man with an herbal concoction: "For a fiendsick man, or demoniac, when a devil possesses the man or controls him from within with disease; a spew drink, or emetic, lupin, bishopwort, henbane, cropleek; pound these together, add ale for a liquid, let it stand for a night, add fifty libcorns, or cathartic grains, and holy water" (p. 137).(14) This mixture is put into every drink that the possessed man will drink, and he is then directed to sing Psalms 99, 68, and 69, then drink the drink out of a church bell and let a priest say mass over him. For the lunatic the writer prescribes another herbal concoction of costmary, goutweed, lupin, betony, attorlothe, cropleek, field gentian, hove, and fennellet. A mass is to be sung over it, and the lunatic is to drink the mixture for nine mornings, then give alms and earnestly pray to God for mercy (p. 139).(14)

There is an additional instruction for lunatics in Leechbook III, thought to be the most rooted in contemporary Anglo-Saxon medicine.(13) "In case a man be a lunatic; take skin of a mereswine or porpoise, work it into a whip, swinge [beat] the man therewith, soon he will be well. Amen" (p. 335).(15) There was also a formula for dealing with temptation: "Against temptation of the fiend, a wort hight red niolin, red stalk, it waxeth by running water: if thou hast it on thee, and under thy head bolster, and over thy house doors, the devil may not scathe thee, within nor without" (p. 343).(15) Clearly, Anglo-Saxon medicine incorporated a religious worldview, and they used for treatment both material means (the herbal remedies) and religiously symbolic means (drinking a concoction out of a church bell, saying masses as part of the treatment, and singing psalms as a means of receiving healing).

4. EMERGENCE OF A MORE NATURALISTIC CLINICAL APPROACH TO MADNESS AMONG ENGLISH PURITANS

Although in some spheres there was an increased interest in the occult and the supernatural during the Renaissance, those dealing with the mad moved even further away from relying

on supernatural explanations. Reginald Scott's (d. 1599) book, *Discoverie of Witchcraft* (1584) reflects a point of view that grew in the sixteenth century: that people who are sad or distressed suffer from a natural malady and not from supernatural influences. Scott was a surveyor, not a physician, and was active in the county government of Kent, England. *Discoverie of Witchcraft* is primarily an extended and entertaining argument against the notion that witches actually have supernatural powers. In the process, Scott reveals a lot about charlatanism in the sixteenth century, and the book even explains a number of card-and-ball deceptions that in our time are considered to be magic tricks. Scott also touches on the treatment of the insane and, in so doing, reveals how religious reasoning was used by families to help those suffering from religious delusions.

Scott recounts the case of Ade Davie, wife of Simon Davie, a farmer from Scott's home county of Kent, and a person known to Scott. At some time in her early adulthood, Ade, who had no prior history of any sort of melancholy or madness, "grew suddenlie (as her husband informed me…) to be somewhat pensive and more sad than in times past." Simon was worried, but did not tell anyone for fear that he would be thought guilty of "ill husbandrie." But Ade became worse. She could not sleep, she cried, she began sighing and "lamenting," and although her husband pressed her, Ade would not provide any reason for her sadness. Finally, Ade fell to her knees and confessed to Simon that she was depressed because she had sold her soul to the devil. Her husband replied, "Thou has sold that which is none of thine to sell… Christ… paid for it, even with his bloud…, so as the divell hath no interest in it." The husband reasoned with her in this fashion. His wife then told him, "I have yet committed another fault and done you more injurie: for I have bewitched you and your children." But her husband reasoned with her, "Be content… by the grace of God, Jesus Christ shall unwitch us: for none evill can happen to them that feare God." With time, Ade recovered, "and remaineth a right honest woman… shamed of hir imaginations, which she perceiveth to have growne through melancholie" (pp. 31–32).(16)

Scott's account and his general view of melancholy and the supernatural indicate that by the latter part of the sixteenth century, naturalistic explanations for mental disorders were prevalent even among educated laymen. In fact, naturalistic explanations for melancholy were prevalent among physicians throughout the Middle Ages, although spiritual/religious factors were acknowledged as playing a role in mental distress as well.(17)

By the seventeenth century, a rather sophisticated practical way of dealing with psychological distress emerged from the thinking of Puritan writers. These writers, because of their concern with spiritual experience, conversion, and the inner spiritual life, were often very attuned to the existence of states of mental distress and despair. Many offered pastoral advice that reflects a concern for the psychological well-being of the individual and provides a variety of spiritual explanations and remedies.

Among the most influential of the Puritan writers on emotional distress was Richard Baxter (1615–1691), an Anglican priest who, in those tumultuous times, became a "dissenter." Because he could not in good conscience comply with the British Act of Uniformity, he could not preach, and so he had a lot of time to write. Baxter wrote prolifically about many aspects of living a Christian life, and he also wrote about depression. During the 1660s, Baxter wrote *A Christian Directory* (1673), a gigantic compendium of thoughtful and well-organized spiritual counsel on a range of topics, including marriage, business ethics, lawsuits, government, dealing with sickness and dying, church government, recreation, and, most of all, how to lead a spiritual life.(18)

In *A Christian Directory*, Baxter wrote a lengthy set of instructions on identifying and treating melancholy. He thought of melancholy as a "diseased craziness, hurt or error in imagination and consequently of the understanding" (p. 294).(19) It was characterized by preoccupation with having irreparably sinned, perplexing thoughts, and the inability to divert thoughts to

pleasant subjects. He, like many other Puritan writers, rejected the idea that the devil was primarily responsible for melancholy.

Baxter counseled that those who were melancholy reduce the time spent in religious exercises so that religious duties would become less burdensome. He advised the melancholy to seek cheerful company, to oppose blasphemous thoughts with reason, and to avoid "thoughts upon your thoughts." In addition to many other similar pieces of advice, Baxter advised, "Commit yourself to the care of your physician and obey him" for "I have seen [many people] cured by physic; and till the body be cured, the mind will hardly ever be cured, but the clearest reasons will be all in vain" (p. 267).(19)

Timothy Rogers (1658–1728) took a similarly medically oriented approach to depression, which nonetheless incorporates the religious worldview of Christianity in a nonmagical way. Rogers was a Presbyterian minister in England who became depressed in his early twenties. Although he subsequently was very effective as a preacher, he wrote extensively on the proper spiritual approach to melancholy.(20) Not surprisingly, his most well-known book, *Trouble of Mind and the Disease of Melancholy* (1691), contains practical wisdom shaped by his own experience. In Rogers' estimation, melancholy was a condition like gout or a gallstone, because it created great misery for the sufferer and the sufferer was helpless against it. Rogers advised those who cared for the melancholy person to educate those who suffered about the nature of the "disease" (his term). Empathy was also important:

> Look upon those that are under this woeful Disease of Melancholy with great pity and compassion. And pity them the more, by considering that you yourselves are in the body and liable to the very same trouble; for how brisk, how sanguine, and how cheerful soever you be, yet you may meet with those heavy Crosses, those long and painful and sharp Afflictions which may sink your spirits. (p. v)(21)

He counseled against harshness, which only poured oil on the flames and would chafe and exasperate them. He advised reassuring the patient that people recover from melancholy. He also pointed out that, although the devil was at work in melancholy,

> Do not attributed the effects of meer Disease, to the Devil; though I deny not that the Devil has an hand in the causing of several Diseases.… [I]t is a very overwhelming thing, to attribute every action almost of a Melancholly man to the Devil, when there are some unavoidable Expressions of sorrow which are purely natural, and which he cannot help, no more than any other sick man can forbear to groan (p. xv).(21)

Like Richard Baxter, he valued medical treatment, writing, "I would never have the Physician's Counsel despised." But he believed that the physician and the minister should work together, because both the soul and the body need attention in depression (p. iv).(21) The physician, by physic and diet and "harmless diversions" would prepare the troubled soul for the more complicated task of dealing with spiritual troubles. Clearly the Puritans, like many Christian writers before them, valued both medical and spiritual methods of treatment and believed that the two together were needed to treat melancholy.

Patients wrote of spirituality and the care of madness as well. The way in which spirituality was incorporated into thinking about madness in the seventeenth century emerges clearly from the account of George Trosse (1631–1713) of his own madness. Trosse was a Presbyterian clergyman who left a very readable autobiography that was published posthumously in 1714. Born in Exeter, he purposed early on to travel, make money, and live a life of luxury. He drank a lot, flirted a lot, and had very little use for religion.(22) Then, in 1656, when he was 25 years old, he began to experience emotional distress and hallucinations.

> If I walked in the *Garden*, (as there sometimes I took many distracted turns) I would fancy all about me *Places* of *Burning*, and *Torments*, and *Devils*.… Thus I discovered the *Confusion* and *Distraction* of my *Mind* where ever I went [Italics added]. (pp. 98–99)(23)

He was taken by friends to the house of a physician who specialized in the treatment of mad people.

> But at length, thro' the *Goodness of God*, and by His *Blessing* upon *Physick*, a *low Diet*, and *hard keeping*, I began to be ordered and *civil* in my *Carriage* and *Converse*, and *gradually* to regain the use of my *Reason* [Italics added]. (p. 101)(23)

Trosse read the Scriptures, memorized portions of Scripture, began to "favor somewhat matters of *Religion*," and prayed with a Christian woman who was one of the employees of the mad-house (p. 181).(23) He began to improve. Trosse suffered two relapses shortly afterward, but he recovered, attended university, and had an active career as a Presbyterian minister until his death at age 81.

5. DEVELOPMENT OF A MORE SECULAR MEDICAL APPROACH TO MADNESS DURING THE ENLIGHTENMENT

During the seventeenth and eighteenth centuries, philosophers and physicians began to think of the soul less in religious terms and more in philosophical or scientific terms. Likewise, those dealing with the mad began separating religious causes from other causes and religion/spirituality became a category of madness. This way of thinking about madness is most clearly laid out in Robert Burton's *Anatomy of Melancholy* (1621), in which Burton coined the term "religious melancholy" and wrote at length describing the condition and offering recommendations for cure.

In the eighteenth century, Enlightenment thought permeated the philosophical aspects of medicine, and the Reformation had created religious change all over Europe. A reform was also taking place within madhouses and asylums in Europe where the asylum began to be viewed as having a therapeutic as well as a custodial purpose. Although management and medicine had been part of the regimen of madhouses for some time (p. 8),(24) several physicians for the mad began outlining the need for a particular regimen of management in the asylum and began to present the asylum as a therapeutic institution.(25)

Several individuals instituted extensive reforms for institutions for the mad. Sometimes these reforms were driven by a religious motive, as in England at the York Retreat. Sometimes it was driven by a rationalist/secular reform motive, as in the case of Philippe Pinel and his reforms in France at the Salpetrière and other hospitals. Sometimes the motives for humane reforms were a mixture of these things, as they were at the South Carolina Lunatic Asylum in Columbia, South Carolina and at the Eastern Lunatic Asylum in Williamsburg, Virginia.(26) But whether reform motives were secular or religious, patients and their religious views had to be considered.

In France, Philippe Pinel (1745–1826) instituted reforms at Bi¢etre and Salpetrière, and these reforms sprang from an Enlightenment/rationalistic motive (pp. 9, 47, 53, 78–81).(27) In fact, like his revolutionary contemporaries in France, Pinel did not have much use for religion. Pinel was very much motivated by the pursuit of knowledge and by the need to treat mad patients humanely and with a degree of respect. He criticized physicians' reliance on contemporary theories of inflammation to understand the brain, advocating instead that they focus on the "management of the mind," that is, moral therapy (pp. 4–5).(27) Pinel's approach to "religious enthusiasm" was to separate the religiously delusional patient from others; encourage physical activity; remove from view every book, painting, or other object that could remind them of religion; order them

to devote time during the day to philosophical readings; and instruct them by "drawing apt comparisons between the distinguished acts of humanity and patriotism of the ancients, and the pious nullity and delirious extravagances of saints and anchorites" (p. 78).(27) Pinel recounts one instance when the directors of civil hospitals, in 1795, ordered that all religious objects be removed from hospitals. Although Pinel viewed this act as extreme, he did notice that, when implemented with goodwill and evident good intention on the part of hospital managers, it resulted in seeming improvement of many of the religiously delusional patients (pp. 80–81).(27)

But in other places, asylum reforms grew out of religious motives, especially among the Quakers and the hospitals under their influence in England and America, and religious exercises were an integral part of asylum management. The story of the reforms at the York Retreat is well known but inspiring. In 1790, a 42-year-old Quaker widow, Hannah Mills, died in the York Asylum in England six weeks after she had been admitted for melancholy. Local Quakers, who had tried to visit her to offer spiritual consolation, were denied access to her by officials at the asylum. William Tuke, one of those concerned about the death, was so moved by the way the case had been handled that he decided to establish a place of treatment for the mentally distressed that would provide care for Quakers. Although a physician was employed to provide medical treatment at the Retreat, laymen offered a gentle but religiously oriented therapy intended to calm those with mental disorders. Harsh management was not allowed, and patients were treated with dignity. In contrast to the authoritarian approach used by Pinel, Tuke's approach harnessed the gentle religious outlook of Quakerism to push patients toward wellness.

In 1813, Samuel Tuke published an account of the way the Retreat was managed, *A Description of the Retreat,* that became highly influential in inspiring similar reforms elsewhere (pp. 24 ff). (28, 29)

The Tukes believed that religious influences could be very helpful to the mad, and they were straightforward in stating their view. Samuel Tuke wrote:

> To encourage the influence of religious principles over the mind of the insane, is considered of great consequence, as a means of cure. For this purpose, as well as for others still more important, it is certainly right to promote in the patient, an attention to his accustomed modes of paying homage to his Maker. (p. 161)(30)

In the United States, especially, the model provided by the Retreat served as an inspiration for many of the early asylum superintendents as they established public and private institutions for the insane throughout the country in the early decades of the nineteenth century.

6. EMERGENCE OF THE MODERN MEDICAL APPROACH TO RELIGION AND MADNESS

By the nineteenth century, any notion that psychiatric disorders were directly the result of supernatural influence had vanished from medical writings and from most records of treatment. But interest in the influence of religion in mental disorders was prevalent, and there was an interest in both the positive and negative aspects of religion.

Indisputably, the most influential American physician who wrote about madness during the late eighteenth and early nineteenth century was Benjamin Rush (1746–1813). Not only was Rush an experienced general physician, but he was a prolific writer, a signer of the Declaration of Independence, and a firm advocate for reform of the care of mad people. Rush's book, *Medical Inquiries and Observations Upon the Diseases of the Mind* (1813), was in some ways an American counterpart of Pinel's *Treatise on Insanity* (1801; English version 1806). Both books were concerned with the classification and treatment, medical and "moral," of madness. Both books advocated humane treatment of patients. But

philosophically, they differ significantly in their treatment of religion, because Rush, unlike Pinel, was a devout Protestant Christian.

Rush, like many physicians of his day, adopted a view of disease that placed heavy emphasis on the role of inflammation as a primary cause of many diseases. In the case of madness, Rush believed that disordered blood vessels were to blame. But this did not exclude the possibility of other influences, and religion was, in general, a positive influence.

Rush's book is sprinkled throughout with references to the Bible and to God and assumes throughout the correctness of his mildly Calvinistic perspective. For Rush, religion could influence patients both for ill and for good. On the one hand, a patient's madness might be precipitated by overstudy of Biblical end-time prophecies (p. 37)(31) or by incorrect doctrine (pp. 71, 83, and 115–116).(31) On the other hand, religion was in many instances helpful to patients. "Let not religion be blamed for these cases of insanity," Rush wrote. " [Its] tendency is to prevent [insanity] from most of its mental causes; and even the errors that have been blended with [religion] produce madness less frequently than love" (p. 45).(31)

Rush believed that there was a mental "believing faculty" that was disordered, for example, when people would "propagate stories that are probable, but false," a sort of paranoia (p. 272).(31) He thought this faculty was impaired in "persons who refuse to admit human testimony in favor of the truths of the Christian religion, [while] believing in all the events of profane history" (p. 274).(31)

As to treatment, Rush recommended, among many other things, reading the Bible as a way for patients suffering from hypochondriasis (or depression) to help themselves. Rush found that when hypochondriacal patients obsessed about having committed the unpardonable sin, reasoning with them seemed to help. In fact, Rush thought physicians should educate themselves about common religious problems of patients: "It is of consequence to a physician, to be fully prepared upon the subjects of the two errors [of belief: unpardonable sin, and creation for misery] that I have named, for they are the two principal causes of religious hypochondriasm" (pp. 115–116).(31) He also advised that physicians enlist the support of the clergy in such instances because "erroneous opinions in religion … must be removed, by advising the visits of a sensible and enlightened clergyman" (p. 115).(31)

Rush's views reflect the general respect in America for religious patients that existed throughout most of the nineteenth century. Although some American asylum superintendents and others who treated madness held to a broader view of religion, others held views very similar to those of Rush, and religion and experienced clergy who were bereft of extremism were welcome in American asylums.

During the nineteenth century, the focus on religion began to disappear from most of European and American psychiatry, even in the countries that had been affected by religious reform.

Johann Christian August Heinroth (1773–1843), a German physician, who wrote on mental disorders, viewed psychiatric disorders as conditions resulting from sin, but his approach was exceptional.(32) More typical were the views of physicians such as Wilhelm Griesinger (1817–1868) who wrote:

> The aid of religion in the treatment of insanity is not to be lightly estimated; the application of this remedy requires, however, great caution. Religious instruction should not be withheld from any patient who desires and requires it; it would, however, oppose the first principles of mental treatment to enforce such instruction, or attempt to interest in it any one who has no religion at heart. It would show total ignorance of the nature and circumstances of those diseases to aim at direct recovery by reforming or converting the patient by religious instruction. All such means should only aim at imparting quietude, trust, and hope to direct attention from the morbid representations to an earnest

> and remarkable theme to revive the modes of thought and sensation of his healthy state. (p. 347)(33)

In fact, Griesinger was concerned about the possibility of developing various forms of psychiatry that were religiously oriented.

> Several medical psychologists would have the whole treatment of the insane to be specifically Christian. But Jews also require the aid of the alienist and his science, and there is no abstract, only a confessional Christianity. Therefore there would require to be a special Protestant, Catholic, etc., and again a Jewish, heathen, psychiatrie. Possibly even this may be yet desired (p. 348).(33)

Griesinger's concern was that physicians needed to treat patients who came their way regardless of religious background, and a form of psychiatry that was too sectarian would not serve the field of psychiatry, or patients, well.

There were those who had concerns about the relationship of religion to mental health for other reasons as well. While Benjamin Rush, writing at the beginning of the nineteenth century, believed that religion tended to be a positive influence, others, even in the United States, did not share his view. Amariah Brigham (1798–1849), an American asylums superintendent and the first president of the American Psychiatry Association (then known as the Association of Medical Superintendents of American Institutions for the Insane), wrote an entire book about the effect of religion on mental health, *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind* (1835). He was particularly concerned about the effects of "religious excitement" on mental health, observing, "It should, however, never be forgotten, that of all the sentiments imparted to man, the religious, is the most powerful," and, therefore, like other "exciting influences," could cause insanity (p. 285).(34)

Similarly, Isaac Ray (1807–1881), an American alienist known, among other things, for his expertise in forensic psychiatry, wrote in *Mental Hygiene* (1863) that religious excitement could be a powerful force in creating mental imbalance in those predisposed to insanity. Because religion involved nothing less than a person's eternal destiny, it was bound to have a negative effect on people who were emotionally unstable (p. 190).(35) So Ray counseled that people should "carefully avoid all scenes of religious excitement, and indulge their religious emotions in quiet and by ordinary methods, always allowing other emotions and other duties their rightful share of attention" (p. 193).(35)

7. LATE NINETEENTH AND TWENTIETH CENTURY

During the latter part of the nineteenth century, psychiatry itself in Europe and the United States tended toward a view of mental illness that was more pessimistic and focused on heredity and biology. The number of people in psychiatric hospitals increased substantially. In the late nineteenth century, however, there was also an increased interest in hysteria and the effect of the mind on the unexplainable presentations of disease. This period also saw the increased professionalization of medicine, medical specialization, and the beginnings of outpatient psychiatric practice and psychotherapy. With the interest of physicians in milder forms of mental disorder and in psychotherapy came a concurrent interest in the role of religion in psychological development. In the United States, psychologist William James (1842–1910) of Harvard explored, in *Varieties of Religious Experience* (1902), the role of religion in the life of ordinary individuals seeking to make sense of existence. James saw religious experience as a major way through which human beings dealt with the emotional complexities of their lives. It was also the way people made sense of the good and the evil that they experienced as they lived their lives.(36)

For medicine, however, the most important influence of the late nineteenth and early twentieth centuries was the work of Sigmund Freud (1856–1939), who, more than anyone else, was

responsible for bringing psychiatrists out of the hospital and into the psychotherapy consulting room. Freud was an unabashed atheist, and his later works make very clear that he viewed religion as a shared delusion, helpful for some, harmful for others, but ultimately something that was an indicator of psychological immaturity. It was a way through which humans came to terms with the fear of death and the concern about meaninglessness.

Freud's thinking embodied the materialistic conception of medicine that continues to be influential and that, during Freud's time, was taught to him in London, Vienna, and Berlin.(37) In *The Future of an Illusion* (1927), Freud proposed that religion was a common but false belief and that God was a projection of internal desires. In *Civilization and Its Discontents* (1929), he wrote that religion was a delusion of the masses that could relieve some anxieties, but that fostered immaturity and restricted choice. Freud's view of religion set the tone for the psychiatric view of religion in the West, particularly the United States, during much of the twentieth century.

But some analysts were uncomfortable with Freud's hostility to religion (notably Carl Jung, but also Gregory Zilboorg) and, in fact, Freud's thought could be adapted to the purposes of religionists. A number of American Protestant clergy, interested in applying the insights of Freud to pastoral work, used psychoanalytic thought to enrich pastoral work. In 1906, the Reverend Elwood Worcester (1862–1940) and the Reverend Samuel McComb, both clergymen, set up an education and psychotherapy program through the Emmanuel Church in Boston and collaborated with an early psychoanalyst, Isidor Coriat, as well as prominent Boston physicians Joseph Pratt, James Jackson Putnam, and Richard Cabot. This effort, which became known as the Emmanuel Movement, continued until 1929. The program was intended to counter the influence of the new "healing cults" that were sweeping the United States. However, as it developed, it foreshadowed the modern pastoral counseling movement.(38–41)

Psychiatry itself tended to relegate religion to the province of hospital chaplains and clergy. In the United States, psychoanalytic thought and psychoanalytic psychotherapy, usually somewhat hostile to religiosity, became a major force in psychiatry through the 1960s.(42) Psychoanalysis, which in its early days had included practitioners from a range of disciplines, came to be comprised largely of psychiatrists, especially after 1938 when the American Psychoanalytic Association made psychiatric training part of the requirements for membership.(25) (In Europe, psychoanalysis was less influential, but more professionally inclusive.)

During the latter part of the twentieth century, the influence of psychoanalysis on clinical practice waned as psychiatry came to be influenced much more directly by the neurosciences and cognitive psychology. In addition, the spiritual, yet nonsectarian perspective of Alcoholics Anonymous, which came to national prominence in the 1940s and 1950s, highlighted the potential therapeutic benefits of spiritually oriented programs.(43) With the lessening philosophical opposition to religion, some psychiatrists and others interested in mental health explored more fully the role of religion in mental health. In 1968, the Committee on Psychiatry and Religion of the Group for the Advancement of Psychiatry published a report noting the positive as well as the negative influences of religion on mental health.(44) In 1986, the *American Journal of Psychiatry* published a seminal review article by Larson and colleagues documenting the lack of adequate literature on the mental health effects of religion.(45) During the 1990s and early 2000s, interest in religion and spirituality grew substantially and was evident in many geographical regions. The Royal College of Psychiatrists began the Spirituality and Psychiatry Special Interest Group in 1999, the World Psychiatric Association recently established a Section on Religion, Spirituality and Psychiatry, a journal of Muslim mental health has been founded, and the number of articles on religion in peer-reviewed journals has grown substantially.

It seems likely that interest in religion and spirituality will continue to be a focus of psychiatry, even if it is not a central focus. The United States continues to be a religious country. Europe, though much more secular, has been indelibly shaped by its religious heritage, and South America, Africa, Asia, and the Middle East all have populations for whom religion is a vital part of the fabric of life. As a result, it is very likely that psychiatric patients will often have psychopathology shaped by their religious beliefs and will frame their understanding of their life and inner concerns in religious or spiritual terms. Physicians for the mad have been dealing with religious problems for centuries, trying to reassure patients, offer comfort, and work out ways to use their own religious/spiritual/philosophical perspective to bring healing to their patients.

The opinions expressed in this chapter represent the personal views of the author and do not represent the views of the U.S Department of State.

REFERENCES

1. Dols MW, Immisch DE. *Majnun: The Madman in Medieval Islamic Society*. Oxford: Clarendon Press; 1992.
2. Sengers G. *Women and Demons: Cult Healing in Islamic Egypt*. Leiden, Netherlands: Brill; 2003.
3. Pach A. Narrative constructions of madness in a Hindu village in Nepal. In: *Skinner D, Pach A, Holland D, eds. Selves in Time and Place: Identities, Experience and History in Nepal*. Lanham, Md.: Rowman & Littlefield Publishers, Inc.; 1998:111–128.
4. Bhugra D. Hinduism and Ayurveda: Implications for managing mental health. In: Bhugra D (ed.), *Psychiatry and Religion: Context, Consensus and Controversies*. New York: Routledge; 1997:97–111.
5. Obeyesekere G. Depression, Buddhism, and the work of culture in Sri Lanka. In: Kleinman A, Good B, eds. *Culture and depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*. Berkeley: University of California Press; 1985:134–152.
6. Barrett DB, Kurian GT, Johnson TM. *World Christian Encyclopedia: A Comparative Survey of Churches and Religions in the Modern World*. New York: Oxford University Press; 2001.
7. Metzger B. *The Canon of the New Testament: Its Origin, Development, and Significance*. Oxford: Oxford University Press; 1997.
8. Edelstein EJL, Edelstein L. *Asclepius: Collection and Interpretation of the Testimonies*. Baltimore: Johns Hopkins University Press; 1998.
9. Temkin O. *Hippocrates in a World of Pagans and Christians*. Baltimore: Johns Hopkins University Press; 1991.
10. Chrysostom J. Letters to Olympias. In: Schaff P, Wace H, eds. *A Select Library of Nicene and Post-Nicene Fathers of the Christian Church*. Grand Rapids, Mich: Eerdmans; 1978:2d series, vol. 9.
11. Chrysostom J. Homily on St. Ignatius. In: Schaff P, Wace H, eds. *A Select Library of Nicene and Post-Nicene Fathers of the Christian Church*. Grand Rapids, Mich.: Eerdmans; 1978:2d series, vol. 9.
12. Whittaker M, ed. *Tatian: Oration ad Graecos and Fragments*. Oxford: Clarendon Press; 1982.
13. Cameron ML. *Anglo-Saxon Medicine*. Cambridge: Cambridge University Press; 1993.
14. Leechbook I. In: Cockayne O, ed. *Leechdoms, Wortcunning, and Starcraft of Early England*. Bristol: Thoemmes Press; 2001:vol. 2.
15. Leechbook III. In Cockayne O, ed. *Leechdoms, Wortcunning, and Starcraft of Early England*. Bristol: Thoemmes Press; 2001:vol. 2.
16. Scot R, Summers M. *The Discoverie of Witchcraft*. New York: Dover Publications, Inc.; 1972.
17. Gowland A. The problem of early modern melancholy. *Past and Present*. 2006;191:77–120.
18. Keeble NH. Richard Baxter (1615–1691). Oxford Dictionary of National Biography. Oxford University Press; 2004. Available at: http://www.oxforddnb.com/view/article/1734. Accessed 6/26/08.
19. Baxter R. *The Practical Works of Richard Baxter*. Morgan, Pa.: Soli Deo Gloria Publications; 2000.
20. Wright S. Timothy Rogers (1658–1728). Oxford Dictionary of National Biography. Oxford University Press; 2004. Available at: http://www.oxforddnb.com/view/article/24002. Accessed 6/27/08.
21. Rogers T. *A Discourse Concerning Trouble of Mind, and the Disease of Melancholy*. London: Thomas Parkhurst and Thomas Cockerill; 1691.
22. Wright S. George Trosse (1631–1713). Oxford Dictionary of National Biography. Oxford University Press; 2004. Available at: http://www.oxforddnb.com/view/article/27758. Accessed 6/27/08.
23. Trosse G. *The Life of the Reverend Mr. George Trosse*. Montreal: McGill-Queen's University Press; 1974.
24. Parry-Jones WL. *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*. London: Routledge & Kegan Paul; 1972.
25. Shorter E. *NetLibrary Inc.: A History of Psychiatry from the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons; 1997:xii, 436 p.
26. Thielman SB. *Madness and Medicine: The Medical Approach to Madness in Antebellum America, with Particular Reference to the Eastern Lunatic Asylum of Virginia and the South Carolina Lunatic Asylum*. Department of History, Duke University, 1986:244.

27. Pinel P, Davis DD. *A Treatise on Insanity*. New York, published under the auspices of the Library of the New York Academy of Medicine by Hafner Publishing Co.; 1962.
28. Cherry CL. *A Quiet Haven: Quakers, Moral Treatment, and Asylum Reform*. Rutherford, NJ: Fairleigh Dickinson University Press; 1989.
29. Digby A. *Madness, Morality, and Medicine: A Study of the York Retreat, 1796–1914*. Cambridge: Cambridge University Press; 1985.
30. Tuke S. *Description of the Retreat, an Institution near York, for Insane Persons of the Society of Friends. Containing an Account of Its Origin and Progress, the Modes of Treatment, and a Statement of Cases*. York, England: W. Alexander; 1813.
31. Rush B. *Medical Inquiries and Observations upon the Diseases of the Mind*. New York, published under the auspices of the Library of the New York Academy of Medicine by Hafner Publishing Co.; 1962.
32. Steinberg H. The sin in the aetiological concept of Johann Christian August Heinroth (1773–1843). Part 1: Between theology and psychiatry. Heinroth's concepts of "whole being," "freedom" "reason" and "disturbance of the soul." *Hist Psychiatry*. 2004;15(3): 329–344.
33. Griesinger W, Robertson CL, Rutherford J. *Mental Pathology and Therapeutics*. London: New Sydenham Society; 1867.
34. Brigham A. *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind*. Boston: Marsh, Capen & Lyon; 1835.
35. Ray I, Curran FJ. *Mental Hygiene*. New York, published under the auspices of the Library of the New York Academy of Medicine by Hafner Publishing Co.; 1968.
36. Holifield EB. *A History of Pastoral Care in America: From Salvation to Self-Realization*. Nashville, TN: Abingdon Press; 1983.
37. Gay P. *A Godless Jew: Freud, Atheism, and the Making of Psychoanalysis*. New Haven, Conn.: Yale University Press; 1987.
38. Stokes A. *Ministry after Freud*. New York: Pilgrim Press; 1985.
39. Worcester E, McComb S. *Body, Mind and Spirit*. Boston: Marshall Jones Company; 1931.
40. Worcester E, McComb S, Coriat IH. *Religion and Medicine: The Moral Control of Nervous Disorders*. New York: Moffat Yard; 1908.
41. Cunningham RJ. The Emmanuel Movement: A variety of American religious experience. *A Q*. 1962;14(1):48–63.
42. Hale NG. *The Rise and Crisis of Psychoanalysis in the United States, 1917–1985: Freud and the Americans*. New York: Oxford University Press; 1995.
43. Cheever S. *My Name Is Bill: Bill Wilson: His Life and the Creation of Alcoholics Anonymous*. New York: Simon & Schuster; 2004.
44. Committee on Psychiatry and Religion. The psychic function of religion in mental health and illness. In Reports and Symposiums, Group for the Advancement of Psychiatry; 1968;642–725.
45. Larson DB, Pattison EM, Blazer DG, Omran AR, Kaplan BH. Systematic analysis of research on religious variables in four major psychiatric journals, 1978–1982. *Am J Psychiatry*. 1986;143(3): 329–334.

3 Theological Perspectives on the Care of Patients with Psychiatric Disorders

JOEL JAMES SHUMAN

SUMMARY

The inclusion of religious considerations in psychiatry and clinical psychology affords both clinicians and patients an important resource in understanding and therapeutically addressing mental illness. Yet that inclusion also presents potential difficulties that may be avoided only by careful theological reflection; that is, by critical consideration of religious belief and practice from the perspective of one or more of those historical traditions we call "religions." To avoid theological reflection is to risk reducing religion to a technique valued only for its therapeutic utility, which clearly threatens the integrity of most religious traditions. In this chapter, I

1 offer an account of tradition and explain what it means to think theologically from within a religious tradition;
2 suggest the ubiquity of theological and atheological assumptions in the worldviews of every patient and clinician;
3 follow theologian George Lindbeck in likening thinking theologically to being part of a "cultural-linguistic" system constituting an entire way of life;
4 discuss two significant theological difficulties likely to arise at the intersection of psychiatry and clinical psychology for persons shaped by participation in the Jewish and Christian biblical narratives;
5 suggest the therapeutic significance of some religious communities as resources to be cultivated by clinicians.

A cursory glance at recorded history suggests that conditions like those we now call "mental illnesses" have been with us for a very long time, as have the attempts of various cultures to accommodate and care for their mentally ill members.(1) And while modern psychiatric medicine has made great strides in the recognition and effective treatment of mental illness and the destigmatization of the mentally ill, the discipline arguably has also followed a pattern typical of the applied sciences in modernity, a pattern characterized by an escalating spiral of specialization, reductionism, fragmentation, and alienation.(2) Just so, while medicine now knows more than ever about the neurochemical aberrations associated with depression, anxiety, psychosis, and so forth, these conditions are increasingly regarded as individualized pharmacological problems to be resolved clinically, as efficiently as possible. This slide toward reductionism is one reason the reintroduction into psychiatry and clinical psychology of religious considerations is, from my perspective as a theologian, so promising, for it calls into question the ready division of life, so characteristic of our time, into the respective domains of ostensibly discrete disciplines. It has become possible once again to see mental illness as more than a matter to be dealt with by the clinician and the individual patient in relative isolation. Clinician and patient alike, along with the members of their respective communities, may now understand psychiatric illness as a theological matter as well, one that may be addressed fully only in light of a measure of theological reflection.

Psychiatrists and other mental health professionals who wish to take seriously their patients' religious faith need to develop some sense of the theological issues at stake in such consideration.

By "theological" I mean first of all having to do with disciplined, critical reflection on religious belief and practice. Properly theological questions about matters at the intersection of religion with psychiatry are not primarily questions about the plausibility of religious belief from the perspective of current psychiatric theories, nor are they questions about the psychotherapeutic efficacy of religious belief and practice. Questions of both these sorts are clinically important and often theologically interesting, but neither accounts adequately for what it means to think theologically about psychiatry and religion. Rather, theological questions about psychiatric matters should begin by critically examining a patient's beliefs and dispositions in light of his or her association (or lack thereof) with the particular religious tradition of which she counts herself a member. A theologically sensitive clinician, that is, attempts to see and interpret a patient's condition not simply from the perspective of what course of action might be therapeutically effective in the short term, but also from the perspective of what would, to the greatest extent possible, respect the integrity of the particular religious tradition of which a patient is a member. This is not to say that the clinician should feel compelled to make the internal coherence of her patient's religious tradition the sole or even the primary arbiter of her judgment of that tradition or of her care for that patient; clearly some religious traditions have better stood the test of time, are more plausible, and more conducive to human flourishing than others. Yet to make clinical judgments about a religious tradition based solely on its therapeutic utility or its perceived threats to mental health is to avoid thinking theologically and risk doing violence, both to a particular patient and her religious tradition.

1. THEOLOGY AND TRADITION

I have suggested that theological reflection is always informed with reference to a particular religious tradition. A tradition, in the sense I am using the notion here, is best understood as a long-standing communal conversation that is both synchronic and diachronic, which is simply to say that it is a conversation among members of an historically continuous community that has for generations engaged voices from its past with respect to matters of enduring significance, while never failing to ground itself in the present or look toward the future.(3) A theological tradition is thus an enduring, never-completed argument about the nature of both proximate and ultimate reality and about the proper relationship of humanity to divinity, which is to say a theological tradition is to a significant extent also an extended conversation about the human condition and the best way for women and men to live. The possibility of such a conversation presumes the sharing of what might be called *canonical narratives* – that is, venerable stories about the origins of things, the way things are, and the way things ought to be – by the conversants. To the extent people live under the authority of the same canonical narratives, look to the same exemplars of virtue, and engage in the common practices evoked by those narratives, they may engage as well in intelligible theological discourse.(4) As such, theology is a discipline usually undertaken *from within* a tradition, at least in the sense that the theologian – I use the word here loosely to refer to anyone engaged in informed theological reflection – has an adequate working knowledge of the language, logic, and way of life characteristic of the tradition in question.(5)

And yet, a somewhat-more-than cursory understanding of a patient's faith tradition is only one part of the theological task of the clinician. The clinician should also be aware of his own theological situation, for even when the clinician does not count himself a member of a religious tradition or has no faith in anything resembling a god, his view of the world and of his patients is *nolens volens* based on theological (or atheological) suppositions. Every person, religious or not, lives with certain tacit and explicit assumptions about the way things are and the way they should be. A significant part of what it means to be human is consciously to consider the world one understands oneself to inhabit, and to order one's desire for the various goods one finds in

that world. Such assumptions and ordering are acquired and develop along with the languages we use to describe our worlds; together, they constitute what are commonly called *worldviews*, all of which are in some sense theological. As Nicholas Lash puts the matter, "It is taken for granted, in sophisticated circles, that no one worships God these days except the reactionary and the simple-minded. This innocent self-satisfaction tells us little more, however, than that those exhibiting it do not name as 'God' the gods they worship."(6)

Just so, clinicians should practice their craft not only with a sensitivity to their own commitments and an awareness that the languages and logic of their discipline are in a broad sense "theological," but also with a conscious awareness of the genealogical connections of modern psychiatry and psychology to the Jewish and Christian faiths, especially as those faiths were understood and called into question by Continental thinkers of the mid to late nineteenth century, including Feuerbach, Nietzsche, and Freud. Freudian psychology has long since died the death of a thousand qualifications, but the specter of Freud's account of religion continues to haunt psychiatry and clinical psychology, such that even those mental health professionals who are themselves religious believers often carry with them the influence of Freudian categories, at the very least assuming a clear boundary between the realms of clinic and congregation. Yet, a clinician attentive to such matters will see that these presumed boundaries are not so clear. She may even recognize significant family resemblances (to borrow a phrase from the philosopher Wittgenstein) among the modern taxonomy of psychiatry and the recorded spiritual struggles of innumerable women and men of faith over the past three thousand years, discovering that religion has historically been far more than wish fulfillment, reality avoidance, or a less-than-optimal form of coping.(7)

The possession of an informed theological perspective on a patient's beliefs and dispositions may help the clinician better understand how such beliefs and dispositions relate to a particular patient's religious tradition. Those beliefs and dispositions may follow "naturally" from the patient's religious commitments, or they may be pathological in nature. As I have indicated above, these are not mutually exclusive alternatives. Religious belief and mental health (or the lack of either) may coexist in a wide range of complex and ever-changing arrangements, very few of which correspond in any uncomplicated way to the traditionally pejorative psychotherapeutic view of religion, which maintains that religious faith is both a cause and sometimes a sign of maladaptive thinking. Religious faith may not be a prerequisite for mental health, but neither is it an indicator *in se* of mental illness; people of faith are by no means all delusional, neurotic, or socially disabled.

More, active mental illness of various kinds is not incompatible with generally orthodox religious belief. A patient may be or desire to be profoundly faithful to his tradition even as he is at the same time profoundly sick; in many cases mental illness is an occasion for or even a cause of theologically problematic assumptions that factor into a patient's inability to live well. At the same time, a theologically orthodox faith may for many patients prove powerfully effective in a broadly (albeit unconventionally) therapeutic sense, offering them the means, often in conjunction with more conventional therapies, to cope with even serious mental illnesses. One thinks here of the protagonists in the novels of the American writer and physician Walker Percy; those characters' struggles with melancholy and other disturbances of the mind proved notoriously resistant to the interventions of psychiatry but were often responsive to the characters' immersion (or sometimes reimmersion) as a catechumens in an unfashionably orthodox Christian faith. One might also consider the role of the Christian Daily Office – a traditional regimen of daily liturgical prayer – as a useful adjunct to medication and therapy in Kathryn Greene-McCreight's chronicle of her struggles with major depression and bipolar disorder, or of Jeffery Smith's discovery of the writings of ancient Christian monastics on the "Dark Night of the Soul," which offered him an ultimately satisfying

way of understanding and coping with his long history of serious depression.(7–12)

2. RELIGION AND RELIGIONS

I have advocated shifting the focus on matters at the intersection of religion and psychiatry from the individual patient's beliefs and the therapeutic utility of those beliefs to the ways her beliefs are shaped by her membership in or association with a religious tradition. My advocacy is based on the conviction that it is more descriptively accurate, not to mention more clinically useful, to talk about psychiatry and a particular religion, such as Judaism, Christianity, or Islam, than to talk about psychiatry and religion in general. The truth is that it is impossible to say very much about psychiatry and religious faith in general, because there really isn't any such thing as religious faith *in general*. The notion of a generic "religion," as Nicholas Lash has shown, is in essence an epiphenomenon of the shifting philosophical ground of early modern Europe, one aspect of which included an emerging suspicion of what traditionally had been a conspicuously "public" Christianity.(13) This is not to say that there are no resemblances among the traditions we call "religions." Certainly there are commonly held beliefs and practices among the adherents of various traditions (or those of no tradition who still call themselves religious or spiritual). More, the faiths we commonly call "Abrahamic" (Judaism, Christianity, and Islam) share a common historical heritage and comparable canonical narratives.(14) Still, too easily associating the beliefs, practices, and narratives of even these traditions avoids, rather than encourages, theological scrutiny. It has become fashionable in recent years in a wide variety of medical specialties, psychiatry not excepted, to investigate and in some cases even to commend the therapeutic effects of actions and dispositions broadly regarded as "spiritual" or "religious."(15) The operational assumption in most of this work has seemed to be that the subjective act of belief is more significant than the objective content of what is believed, insofar as the various historical religious traditions are but ways of referring to a universal characteristic of human subjectivity, which we might name religious feeling or religious belief. The traditions, that is, are but species of a common *genus* named "religion," or now, more commonly, "spirituality." As such, they may be exchanged or hybridized according to therapeutic effectiveness and the needs of the religious consumer.(13, 15)

Such a view of "religion" corresponds to what the theologian George Lindbeck has called "experiential-expressivism," wherein the theological focus is on interpreting the always personal, usually inward, and often private experience of the believer. The content of the believer's experience, the raw material informing what theologians typically call *doctrine*, is seen from this perspective as "noninformative or nondiscursive symbols of inner feelings, attitudes, or existential orientations."(16) This way of understanding religion not only fits, but also emerges as part of, the contemporary North Atlantic sociopolitical context. The world inhabited by most mental health professionals and their patients is characterized by radical individualism and a sharp egalitarian impulse, a paradoxically reactionary suspicion toward traditional authority, and a belief that some form of scientific reason is the only legitimate arbiter of public truth. Subsequently, we tend to assume the existence of a deep division between the public and private realms, whereby we suppose that religious belief is a private, individual matter that cannot and should not be critiqued with respect to its content.(15, 17)

Yet such a highly individuated, private, experientially grounded understanding of religion falls decidedly short of accounting for what it has for most of history meant to "be religious." Lindbeck argues that the traditions we call "religions" are better understood as entire ways of life, which may be participated in properly only through initiation, extensive training, and lifelong ritual reinforcement. Here he draws on the work of Wittgenstein in arguing that religions are not unlike languages, in that they *make possible* "the description of realities, the formulation of

beliefs, and the experiencing of inner attitudes, feelings, and sentiments." Moreover, insofar as languages emerge from and are made intelligible by their association with the ways of life of particular communities, theological language cannot be dissociated from the practice of a common life. A religious tradition's "doctrines, cosmic stories or myths, and ethical directives are integrally related to the rituals it practices, the sentiments or experiences it evokes, the actions it recommends, and the institutional forms it develops. All this is involved in comparing a religion to a cultural-linguistic system."(16) Just so, a clinician can often assess the relationship of her patient's illness to that patient's religious faith only by taking into account not simply the fact that her patient believes, but also the entire cultural-linguistic framework within which that belief is acquired and exercised. In accounting for the cultural and linguistic history of her patient's faith, the clinician may be surprised to discover that her patient is part of a tradition that historically has afforded a generous space to those we today call the mentally ill and that also possesses abundant resources for wrestling with the particular theological and existential questions raised by mental illness.

3. PSYCHIATRY AND THEOLOGY IN TENSION AND IN CONVERSATION

The kinds of theological challenges mental health professionals are likely to face with respect to their patients' religious commitments depend to a significant extent on the particular religious tradition with which the patient is affiliated. Mental illness and its treatment will present different kinds of theological challenges to different religious traditions. In what follows I want to discuss what I take to be two ultimately inseparable challenges that mental illness and its contemporary treatment present to my own tradition, Christianity. Although adherents of other traditions, Judaism in particular, may recognize analogies with my account, I do not presume to speak here on behalf of any tradition other than my own.

A first type of theological challenge the clinician is likely to encounter at the intersection of psychiatry and religion is with the connotation elicited by the very category "mental" illness. Psychiatry's traditional suspicion of religion is often greeted with a corresponding antagonism by religious believers. Psychiatrists and other mental health professionals may have to contend with religious patients who are suspicious of and even hostile toward the very idea of modern psychiatry. Although this suspicion is clearly in part a defensive reaction, it is more complex than that. Judaism and Christianity have for centuries recognized and wrestled with the existence of melancholia, anxiety, and other conditions that bear undeniable resemblances to what modern psychiatry identifies as disorders of mood, affect, and personality. In the world of the Bible, such conditions are generally and for the most part understood as "spiritual" challenges, or perhaps as "sicknesses of the soul," the appropriate responses to which are similarly "spiritual," which is to say, religious. The psalms and prophetic writings in particular are replete with both communal and individual laments made by women and men confronted by the apparent absence of God from their lives and those of their communities. The "absences" lamented in these texts range from existential despair over the apparent meaningless of life, to expressions of the real or imagined fear of imminent death, to expressions of remorse over the commission of sins, to protests against God's failure to meet his covenant obligations to the psalmist's or prophet's community. In many cases, these laments include nothing less than pointed demands that God give an account of godself. And yet in spite of their introductory tone, these texts linger neither in anger nor despair, but transition without fail to expressions of praise and gratitude in response to anticipated liberation by the very God who at the time seems totally absent. Given the undeniably liturgical character of much of this literature (that is, the fact that it appears to have been written to be performed in the gathered public worship of the community), these transitions appear to correspond to declarations of forthcoming salvation

by "a trusted, authorized official… not unlike the 'fear not' formula of Isaiah 43:1":

> But now says the Lord,
> he who created you, O Jacob,
> he who formed you, O Israel:
> Do not fear, for I have redeemed you;
> I have called you by name, you are
> mine.(18)

This suggests that the public, communal performance of these texts was an important resource that sustained the community and its membership, not simply in extraordinary times, but also in the difficult conditions that characterize the ebb and flow of everyday life. The psalmists and prophets seem to understand that, even at its most pedestrian, life frequently presents us with tragic circumstances that we cannot imagine resolved to our satisfaction, apart perhaps from the extraordinary intervention of God, which in the short term, as the poet Michael Blumenthal says, is "oblique and obscure and not even assured."(19) One might argue, of course, that it is the sense of penultimate pathos characteristic of the psalmists' and prophets' worldview that is the problem, and that it is not necessary, much less healthy, to experience the ebb and flow of everyday life as fundamentally tragic.(11) Yet in the view of the biblical authors, this objection itself might be part of the problem. One prominent scholar of the Old Testament goes so far as to claim that one of the primary purposes of the prophetic writings is to call a people numbed by the comfortable social and economic stability typical of life in a politically powerful state to move beyond their superficial contentment and "engage their experience of suffering to death." The solution to the tragic and sometimes apparently absurd human condition is not blissful sleepwalking, but a hopeful engagement with an emerging reign of peace and righteousness secured by the love of God. Such an engagement can be sustained only by an imaginative countercultural community devoted to the mutual well-being of its entire membership.(20)

But how is any of this threatened by the modern notion of "mental" illness? There appears to be a trajectory within modern psychiatry that calls into question the biblical embrace of pathos, and in particular the undeniably social character of that embrace. On the one hand, this questioning takes the form of identifying religious belief, and communal religious practice in particular, as collective delusion; religious practice in this view is, at best, a less-than-optimal means of coping with the Sturm und Drang of life and, at worst, a dangerous avoidance of reality that needs to be unlearned by a rigorous course of therapy.(7) A more contemporary and much more common form of questioning, however, comes from the recent ascendancy of applied neuroscience and psychopharmacology, which tends to reduce the experience of mental illness to aberrations in the particular brain chemistry of the individual. I do not wish to take issue with the efficacy of contemporary psychopharmacology, which has proven itself, notwithstanding thoughtful social and philosophical interlocution; rather, I wish to visit the question of the theological significance of this efficacy.(10, 11) What are the implications for biblical faith of psychoactive medications that can, in a remarkably short time, effect deep changes in mood, behavior, and even personality?(21) What does it mean to have a "soul" so profoundly susceptible to chemical manipulation that personality itself appears to be transformed, quite apart from a change in circumstance or the mutual help and support of a faithful community?

Inarguably, neuroscience and the diagnostic and therapeutic interventions it has spawned challenge much conventional thinking about the soul. Some neuroscientists have gone so far as to claim that, since what was once identified as "soul" can now be accounted for largely in terms of brain chemistry, the very notion of "soul" is no longer tenable and should be regarded as one more decrepit member in the crumbling edifice of an outdated biblical worldview.(22) As it turns out, however, neuroscience and psychopharmacology are much more serious threats to the legacy of Plato and Descartes than to Judaism or Christianity.

Descartes, who is sometimes called the "father of modern philosophy" because of his emphasis on the human subject as the ultimate arbiter

of meaning, is best known for his *Discourse on Method* (1637). In response to the emergence of a widespread dissatisfaction with the Aristotelian methodology undergirding the intellectual discourse of that day, Descartes sought to develop an alternative philosophical method based on a foundation of absolute certainty.(23) Beginning with a determination to "reject as absolutely false everything in which I could suppose the slightest reason for doubt," Descartes set out to establish an "entirely indubitable" remainder on which certain knowledge might be established. (24) Descartes believed he had found such a foundation in the human *psyche*; his conclusion was that he, Descartes, was "a substance, of which the whole essence or nature consists in thinking, and which, in order to exist needs no place and depends on no material thing."(24) Hence we have Descartes' nearly universally recognized dictum: "I think, therefore I am."

Perhaps because much of what he says echoed the then two-thousand-year-old legacy of Plato, Descartes' *ego* – the "I" – came over time to be identified with the soul. The human essence – the thing that made humans unique – was an ineffable, immaterial, and immortal *res cogitans*, a "thinking thing." The body, meanwhile, was ultimately nothing more than a temporary, passive extension of the soul, a *res extensa*. In part because of its explanatory power and in part because of its surface resemblance to some strands of biblical anthropology, Cartesian dualism became the dominant paradigm for thinking about what it meant to be human. Some version of Descartes' anthropology became axiomatic for all fields of inquiry, including theology and, less directly, medicine. The suppositions of the Cartesian model also shaped the translation and interpretation of scripture and popular piety, such that it became common for Christians to assume that the biblical account of the human person was essentially dualistic – that humans were immortal, immaterial souls temporarily inhabiting mortal, material bodies.

Yet, as biblical scholarship and theological scholarship have shown, Christianity has virtually no stake in defending Cartesian (or any other variety of) dualism. Dualism was in fact at the center of some of the earliest and most persistent heresies faced by nascent Christianity. These heresies are collectively referred to as varieties of *Gnosticism*, which, generally speaking, maintains that the material creation, including the human body, is unimportant except in a temporary, strictly utilitarian sense. The limits inherent in material corporeality are to be ignored, struggled against, or fled, as often, as intensely, and as soon as possible. This earthly life is ultimately illusory; many Gnostics have gone so far as to liken it to a fleshy prison. But Gnosticism is patently inconsistent with the biblical narrative, which from the beginning insists on the goodness of creation and the significance of *embodied* human life, which the second-century Church Father Irenaeus called "the glory of God." Contrary to the Gnostic insistence that women and men ultimately are immaterial souls, the biblical portrayal of humanity is conspicuously corporeal; from the perspective of scripture, we are in this life and the next never less than our bodies. As Wendell Berry so succinctly explains the biblical story of the creation of Adam:

> The formula given in Genesis 2:7 is not man = body + soul; the formula there is soul = dust [earth] + breath. According to this verse, God did not make a body and then put a soul into it, like a letter in an envelope. He formed man of dust [earth]; then, by breathing His breath into it, he made the dust live. The dust, formed as man and made to live, did not *embody* a soul; it *became* a soul. "Soul" here refers to the whole creature. Humanity is thus presented to us, in Adam, not as a creature of two discrete parts temporarily glued together but as a single mystery.(25)

Thus, the categories so typical of modern thought, such as the distinction between the spiritual and the physical, or the body and the soul, or the natural and the supernatural, are from the perspective of scripture deeply problematic and useful only in a limited heuristic

sense. The mystery we name "human" (from the Latin *humus*, "earth") is from the perspective of scripture altogether consistent with what neuroscience and the philosophy of mind call "non reductive physicalism" in which the notions "soul and mind are physiologically embodied," and yet not exhausted by neurophysiological explanation. "Human mind and behavior have new emergent properties that cannot be exhaustively explained by lower level physical phenomena. Thinking, deciding, willing, etc., are real and efficacious properties of embodied human life."(26) As Berry puts the matter, "Creation is one continuous fabric comprehending simultaneously what we mean by 'spirit' and what we mean by 'matter'.… The body, 'fearfully and wonderfully made,' is ultimately mysterious both in itself and in its dependences. Our bodies live, as the Bible says, by the spirit and breath of God, but it does not say how this is so. We are not going to *know* about this."(27)

Just so, the worldview of those who stand within the biblical-Christian traditions should not feel that the plausibility of their faith is threatened by the fact that their illness has a neurophysiologic aspect that responds to psychoactive medication. Because we are never less than our bodies, we are never less than an extraordinarily complex constellation of chemical reactions. More, we are no less real, less human, because of this.(28) Although there may in rare cases be good theological reasons to question the pharmaceutical manipulation of the human mind, members of the biblical traditions may generally and for the most part view them as gifts provided by God to facilitate human flourishing.

4. SUFFERING: WHAT IS THEOLOGY GOOD FOR?

As important as such assurances may be, they do not address an older and more intractable theological question with respect to mental illness, namely, the question of why such suffering afflicts good and faithful people. In philosophy, this is one version of what is typically called the problem of theodicy (from the Greek *theos*, "god" and *dikē*, "justice"), which is typically posed in the form of a question: "Why does a benevolent, all-powerful God allow the innocent to suffer?" In a therapeutic culture like our own, which teaches us to value individual happiness above all other goods, the long-standing human tendency to reduce God to the role of being a dispenser of whatever we happen to want is multiplied. (15) Our bent is simplistically to assume that God wants us to have what we want and that religious behavior of various kinds is but a means of achieving what has already been afforded. Insofar as suffering of various kinds is an impediment to this kind of happiness, suffering becomes a problem to be solved rather than a mystery to be contemplated or an affliction to be ministered to by friends and neighbors. Thus, when we suffer, we are likely to begin by asking what we have done wrong to deserve suffering or what we need to do differently to rid ourselves of it.

Of course, it is perfectly appropriate not to want to suffer and so to ask whether we may be able to do something to escape or alleviate whatever suffering we might be experiencing. More, the God revealed by the biblical narrative is accessible and active as a healer. Yet from the perspective of scripture, "why" questions about sickness and suffering are almost always the wrong place to begin. For while it is absolutely the case that the God revealed in scripture intends the redemption of all creation, including the life of every person, that redemption must be viewed from the perspective of what theologians oftentimes call "salvation history," which includes an irreducibly *eschatological* (oriented toward an ideal future consummation) component. The human experience of suffering demands a theological response. From the perspective of Christian tradition, such a response focuses on the past, present, and future history of God's saving activity, which does not attempt to explain, but does account for, human suffering.

It is important to note that scripture does not offer a single, univocal account of why we suffer or what can be done about suffering. Yet neither are the scriptural voices addressing suffering cacophonous. It is possible to discern a

kind of harmony among the scriptural accounts of suffering, which consists in five parts:

1 Suffering is not part of God's original or ultimate intention for any member of God's creation.
2 The world as we experience it is not the world God ultimately intends. Humanity has willfully alienated itself from God, from itself, and from the rest of creation, one typically inscrutable consequence of which is suffering.
3 God's activity toward creation is nonetheless fundamentally redemptive. God is sovereign over history – including the history of every person – and will ultimately consummate history to the benefit of God's creatures.
4 Christians therefore must cultivate an "apocalyptic sensibility" with respect to suffering, knowing that suffering has the penultimate, rather than the ultimate, word in their lives.
5 In the interim, suffering should not surprise us; indeed, it is in a broken creation in some sense inevitable. As such, it is an opportunity for Christians to serve those who suffer *and* a possible means by which God may further God's purposes in history.

Any account of suffering in light of the biblical narrative must begin with the insistence that suffering is part neither of God's original nor ultimate intention for the creation. Rather, creation exists as an expression of the fundamental goodness of God, for God is, according to scripture, love (1 John 4:8). A central tenet of Christian theology is that God is an *aseity*, which is to say that God is fully sufficient in and of godself (*a se*). God alone is self-sufficient; creation is therefore contingent, rather than necessary. All that is has been brought into existence and continues to exist by virtue of God's generous, playful, and totally gratuitous creative act – the overflowing of God's immeasurable love. All of creation, women and men in particular, exist joyfully to participate in God's love, to be God's friends.(29)

That God is love, and that God intends our flourishing and the flourishing of all creation, is to most of us far from self-evident. The world is full of suffering, as observation and personal experience plainly demonstrate. This antinomy, between the prevalence of suffering and the presumed goodness of God, evokes the theodicy question in its traditional forms. Yet this is a mistake precisely because it presumes that the existence of suffering is evidence of some defect in God. In fact, it is possible to see the existence of suffering as a function of God's *regard* for humanity. Insofar as humans are created in God's image and likeness, we possess a measure of freedom. It is by way of this freedom, Thomas Aquinas insists, that God "moves" us, which is to say that God is fundamentally noncoercive with respect to the human will; God's activity toward us is to entice us by attraction rather than to push us from behind. Of course, the correlative to the human capacity to choose God's intention is the freedom to choose against God's intention. Christian tradition calls the free human opposition to God's intention *sin* and suggests that it is sin that is the cause of various forms of suffering.

This is not so simple a claim as it would first seem, for "sin" here describes the state of a creation alienated from its Creator more than it describes any one person's discrete acts of opposition to God and God's intention. The two are of course not unrelated; as the biblical story of the "fall" indicates, creation's alienation from God has its origins in specific acts of human disobedience. More, certain "sinful" choices are quite obviously self-destructive and so contribute in relatively straightforward ways to the suffering of the sinner and those around him. Yet the biblical narrative, from the book of Job to the teaching of Jesus, for the most part rejects the idea that a given instance of suffering in a person's life is the result of a particular sin or sins that person has committed. Rather, the cumulative effect of generations of human disobedience is portrayed as a kind of collective centrifugal force that flings all of creation away from God toward disorder and chaos, such that even in the presence of the best of human intentions, nothing works quite the way it is supposed to.

Thus, suffering is one of the most obvious effects of sin, not in the sense that God punishes

sinners by making them suffer, but in the sense that sin is in a variety of ways its own punishment. Insofar as it not only separates the person from God, but also distorts and renders dysfunctional his relationships to other persons and to the earth on which his life depends, sin makes him an often unwitting participant in the violent brokenness of the world we all inhabit. As the twentieth-century Protestant theologian Dietrich Bonhoeffer explains, with the first act of human disobedience, "Man's life is now disunion with God, with men, with things, and with himself.… Instead of seeing God man sees himself."(30) Alienated from God and the creation, women and men are destined to suffer.

And yet, in spite of appearances to the contrary, God's activity toward creation is fundamentally redemptive, which is to say it is in opposition to chaos and suffering. God is sovereign over history, including the history of each person, such that although God allows innumerable proximate contingent circumstances that can and do cause suffering, God ultimately consummates history to a good that includes the restoration of all creation's original well-being. Although this pattern pervades the biblical narrative, God's activity in this regard is both ideally exemplified and perfectly established in the life, death, and resurrection of Jesus of Nazareth. Subjected to the humiliation of false accusation, verbal and physical abuse, and a sham trial, Jesus was eventually sentenced by Roman authorities to death by crucifixion. From the cross he cried out the opening lines of Psalm 22, an extended, desperate lament of God's absence which begins, "My God, my God, why have you forsaken me?" In spite of his persistently having rejected the view that God visits the pious with prosperity and the sinner with suffering, Jesus's declaration indicates that he associated his experience not simply with injustice, but also with his having been abandoned by the very God whose imminent reign he had come to proclaim and make present. Thus, there is in the narrative of the cross a dramatic tension created by the disparity between the tenor of Jesus's life and teaching and his fate at the hands of imperial power. This narrative tension is resolved by Jesus's resurrection from death on the third day. According to John Howard Yoder, the resurrection is to be understood as a vindication of Jesus's life and teaching and an assurance of the sovereignty of good in history, such that "the triumph of the right… is sure because of the power of the resurrection and not because of any calculation of causes and effects …. The relationship between the obedience of God's people and the triumph of God's cause is not a relationship of cause and effect but one of cross and resurrection."(31)

Jesus's patient faithfulness in suffering is regarded by Paul as an example made possible by the theological hope that his resurrection foreshadows the general resurrection of the dead at the consummation of history (1 Cor. 15). In the interim, Christians are invited to cultivate an "apocalyptic sensibility" with respect to suffering, knowing that God is active in particular and unexpected ways invisible except to the eyes of faith. (15, 32) Thus, the biblical story, and the story of Jesus's death and resurrection in particular, "inserts into our present setting a fulcrum capable of being leaned on to pry us away from the assumption that the world as we see it is the only way it can be."(33) Suffering of whatever kind is not generally an indication that the sufferer has done something wrong, nor is it a sign that if she did things differently her suffering would cease or never have occurred. Suffering is simply one of the inevitable consequences of our habitation of a broken creation. As Paul puts the matter, "The sufferings of this present time are not worth comparing with the glory about to be revealed to us. For the creation waits with eager longing … in hope that the creation itself will be set free from its bondage to decay and will obtain the freedom of the glory of the children of God."(34) In the meantime, it is inevitable that most of us suffer and that some of us have the misfortune to suffer the pain of mental illness.

5. SUFFERING, HEALING, AND THE PEOPLE OF GOD

It is extremely important at this point to note that an acknowledgment of the ubiquity of suffering is neither fatalism nor an abandonment of

the significance of this life in favor of a better life to come. Rather, from the perspective of the biblical narrative, the significance of suffering is shifted, such that suffering becomes, in spite of its potential horror, an opportunity for ministry and a means of faithful witness. According to the German theologian Gerhard Lohfink, the central theme in the biblical narrative is that God works in the world through a particular people whom God calls together for the purpose of bearing witness.(35, 36) This suggests that one of the, if not the most prominent, places where God's healing work may be seen is in and through the social ecology of God's people. In and through their common life, which proclaims God's love to the world, the people of God form a new society that makes possible a distinct way of dealing with suffering. They are given one another as friends pledged to share all manner of burdens, including, and perhaps especially, illness.(37) Suffering thus paradoxically becomes an opportunity for the people of God to care for each other in a way analogous to God's care for the creation: by patiently and lovingly being present to the brokenness and isolation suffering creates, by working to overcome the alienation endemic in a broken creation, and by proclaiming in so doing the emerging reign of God.

Thus, a mentally ill person who wants to know why God is allowing him to suffer or who is frustrated that his prayers for healing seem ineffectual may have his question redirected in the same way that Jesus redirected the questions of those who demanded to know whose sin was responsible for one man's congenital blindness: "Neither this man nor his parents sinned; he was born blind so that God's works might be revealed in him"(38). God is infinite not simply in mercy and compassion, but also in creativity. By bringing into existence a new community whose *telos* is to make God present to the world through their common life, God gives to those whose work is healing a powerful resource. By the provision of various forms of caring hospitality, the religious community becomes a locus of healing. Without assuming that every clergyperson and every religious community might be legitimate therapeutic resources, the clinician should at least be free cautiously and judiciously to cultivate partnerships among the religious communities of consenting patients.

6. CONCLUSION

By necessity this chapter is incomplete and fragmentary. I have tried here to account for some of the things at stake theologically in the incorporation of religious matters into the treatment of the mentally ill. In so doing, I hope that I have achieved a medium somewhere between the trite simplistic view that religious practice is a means of getting what we want (whether God exists or not) and the hopelessly difficult perspective that because God (whether he exists or not) is beyond our control, we are alone in the world with our medication and psychotherapy. For although it is true that God is certainly wild and uncontrollable, it is also the case that God is at work effecting our redemption. In the words of the morning prayer from the *United Methodist Hymnal*, "New every morning is your love, great God of light, and all day long you are working for good in the world"(39).

REFERENCES

1. Foucault M. *Madness and Civilization: A History of Insanity in the Age of Reason*. New York, Random House; 1965 (1988).
2. Berry W. Discipline and hope. In: *A Continuous Harmony*. San Diego: Harcourt Brace and Company; 1970:95.
3. Wainwright G. *Doxology: The Praise of God in Worship, Doctrine, and Life*. New York, Oxford University Press; 1980.
4. MacIntyre A. *After Virtue: A Study in Moral Theory,* 2d ed. Notre Dame, Ind., University of Notre Dame Press; 1984:204–225.
5. MacIntyre A. *Whose Justice? Which Rationality?* Notre Dame, Ind., University of Notre Dame Press; 1988:370–388.
6. Lash N. Reality, wisdom, and delight. In: *The Beginning and the End of "Religion."* Cambridge: Cambridge University Press; 1996:49.
7. Greene-McCreight K. *Darkness Is My Only Companion: A Christian Response to Mental Illness*. Grand Rapids, Mich., Brazos Press; 2006:112–127.
8. Percy W. *Love in the Ruins*. New York, Ballantine Books; 1971 (1989).

9. Percy W. *The Second Coming*. New York, Ballantine Books; 1980 (1990).
10. Elliot C. Pursued by happiness and beaten senseless: Prozac and the American dream. *Hastings Center Report*. 2000;30:2, 7–12.
11. Kramer P. The valorization of sadness: Alienation and the melancholic temperament. *Hastings Center Report*. 2000;30:2, 13–18.
12. Smith J. *Where the Roots Search for Water: A Personal and Natural History of Melancholia*. New York, North Point Press; 1999.
13. Lash N. The beginning and the end of "religion"? On what kinds of things there are, hollow centres and holy places. In: *The Beginning and the End of "Religion."* Cambridge: Cambridge University Press; 1996:10–13, 93–111, 188–191.
14. *The Journal of Scriptural Reasoning*. Available at: http://etext.lib.virginia.edu/journals/ssr/ (last accessed 6/18/08); *A Common Word Between Us and You*. Available at: http://www.acommonword.com/ (last accessed 6/18/08).
15. Shuman J, Meador K. *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity*. New York, Oxford University Press; 2003;38, 19–43, 80–93, 71–111, 109.
16. Lindbeck G. *The Nature of Doctrine: Religion and Theology in a Postliberal Age*. Philadelphia, Westminster Press; 1984:16, 33.
17. Brooks D. The neural Buddhists. *The New York Times* Available at: http://nytimes.com/2008/05/13/opinion/13brooks.html (last accessed 5/20/08).
18. Brueggemann, W. *An Introduction to the Old Testament: The Canon and Christian Imagination*. Louisville, Ky., Westminster John Knox; 2003: 280–282.
19. Blumenthal M. *The Wages of Goodness*. Columbia, University of Missouri Press; 1992:54.
20. Brueggemann, W. *The Prophetic Imagination*. 2d ed. Minneapolis, Minn., Fortress Press; 2001: 39–57.
21. Kramer P. *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self*. New York, Viking; 1993.
22. Wolfe T. Sorry, but your soul just died. *Forbes*. 1996;158(13):210–223. Available at: http://www.orthodoxytoday.org (last accessed 5/20/08).
23. Sutcliffe F. Introduction. In: Descartes R. ed. *Discourse on Method and the Meditations*. New York: Penguin; 1968:7–23.
24. Descartes R. *Discourse on Method and the Meditations*; 1968:53, 54.
25. Berry W. Christianity and the survival of creation. In: *Sex, Economy, Freedom & Community*. New York: Pantheon; 1991:106.
26. Brown W. Human nature, physicalism, spirituality, and healing: Theological views of a neuroscientist. *Ex Auditu*. 2005;21:114.
27. Berry W. Health as membership. In: *Another Turn of the Crank*. Washington: Counterpoint; 1995:91.
28. Flanagan O. *The Science of Mind*, 2d ed. Cambridge, Mass., MIT Press; 1991.
29. Waddell P. *Friendship and the Moral Life*. Notre Dame, Ind., University of Notre Dame Press; 1989.
30. Bonhoeffer D. *Ethics*. New York, Collier; 1949 (1986):20.
31. Yoder J. *The Politics of Jesus*. Grand Rapids, Mich., Eerdmans; 1972:238.
32. Toole D. *Waiting for Godot in Sarajevo: Theological Reflections on Nihilism, Tragedy, and Apocalypse*. Boulder, Colo., Westview; 1998:205–266.
33. Yoder J. Ethics and eschatology. *Ex Auditu*. 1990;6:119; Quoted in Shuman and Meador, p. 110.
34. Romans 8:18–21, NRSV.
35. Lohfink G. *Does God Need the Church?* Collegeville, Minn., Liturgical Press; 1999.
36. Yoder J. A people in the world. In: *The Royal Priesthood: Essays Ecclesiological and Ecumenical*. Grand Rapids, Mich.: Eerdmans; 1994:65–101.
37. Shuman J. God does not wear a white coat: But God can, does, and will heal us all. In: Laytham B. ed. *God Does Not*. Grand Rapids, Mich.: Eerdmans; Forthcoming 2009.
38. John 9:3, NRSV.
39. The United Methodist Hymnal, United Methodist Publishing House; 1989:877.