
The largest and most sophisticated epidemiological study of mental illness was launched in 1979 by an agency of the federal government, the National Institute of Mental Health, and is still in process. In the Catchment Area Epidemiological Survey (CAE) some twenty thousand randomly selected persons in five distinct geographic areas of the country—New Haven, Baltimore, St. Louis, Los Angeles, and Durham, North Carolina—were interviewed. Findings to date indicate that 15–20 percent of the population are suffering from severe mental illness at any one time. Only about 20 percent of these are actually receiving any treatment from a psychiatrist or other mental health professional. Another 60 percent have contact with some primary care physician who may or may not be providing some treatment for the mental illness. The remaining 20 percent of this group have no contact with any health professional. There is much that is interesting about these findings, not the least of which is the high prevalence in our society of serious mental illness. But for whatever reasons the vast majority of persons suffering from serious mental illness do not receive care and treatment from a psychiatrist. One possible explanation is that the mental illness model as an explanation for madness is far from being unanimously accepted in our society. Although good reasons for this may exist, it would be interesting to find more specific answers. ☺



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Despite differences in perspectives, twentieth-century health care professionals would most likely agree with each other, as did asylum physicians and Millerite leaders themselves, that some kind of intimate connection exists between mental health or illness and religious beliefs or world views. Even the most doubtful and secularized stop short of repudiating a relationship. But we find, now as then, fairly intense controversy about how the two

domains affect one another. What are the problems with the nineteenth-century definition of religious insanity from a modern perspective? What changes have since occurred to alter our view of the relationship between religious declarations and the human psyche?

One of the problems with the diagnosis of religious insanity relates to the problems of diagnosis in the modern medical model in general. In the late 1800s Louis Pasteur, Joseph Lister, Robert Koch, and other scientists succeeded in isolating the germs of one infectious disease after another. One factor, a lone bacterium, proved the cause of a specific disease. One solution, a sole vaccine, cured. The idea was simple and compelling: one germ, one disease, one therapy. In recent years, what sociologist Renée Fox (1979) calls “post-modern medicine” began to challenge this monocausal theory of disease. Some questioned the medical myth of the “magic bullet” or vaccine, arguing that such factors as improved sanitation, education, and diet, not the discovery of some miracle drug, lie behind the elimination of infectious disease and the large decline in the mortality rate in the last century (Dubos 1971). Current research links chronic diseases like heart disease and cancer to factors as diverse as exercise, smoking, eating habits, and somatic conditions. Medical experts have had to reevaluate and expand their understanding of causation of disease to include social and psychological factors.

Likewise, as the Numberses point out, as early as the 1860s, the uncertainty and ignorance surrounding etiological understandings of mental illness were acknowledged. Doctors willingly admitted the likelihood of confusing cause and effect, more so when religion became a variable. And “skepticism regarding the usefulness of identifying the supposed causes of insanity, such as religious excitement, continued to grow.” From a modern perspective, the authors qualify their telling of this history, as most modern readers of their article would also, by prefacing the claim that religious excitement *causes* abnormal behavior with words like *allegedly*, *possibly*, *apparently*, *seemingly*, and so on. Just as a multicausal theory of disease began to debunk the monocausal theory in the realm of physical illness, one-to-one correlations between religious excitement and mental disorders have lost their place, not just in the world of modern psychiatry, but among the general public. Today few would accept the claim that “religious enthusiasm” causes illness or that “religious insanity” connotes an “etiologically distinct mental disease.”



So we may rejoice that an era has ended. Yet what has replaced it? Neglect? Disregard? Omission of the term *religion* in the current *Diagnostic and Statistical Manual of Mental Disorders*? If not a causal relationship, what kind of connection can we posit? Disdain for simplistic religious *explanation* of disease does not render theological and moral *meanings* superfluous.

We can hardly study the history of this relationship without mentioning Sigmund Freud, the founder of modern psychiatry at the turn of the century. Freud did attend to the place of religion. But rather than exploring the complex relationship, he closed more doors than he opened. He restricted religious beliefs to illusion and eventually delusions. In his growing antipathy toward the religious, he equated the religious with the neurotic. He came to regard religion itself as a universal obsessional neurosis and finally as mass delusion. In its extreme, religion equals pathology. In his monocausal theory, the cure lies in the ever-steady replacement of religion by science, the development beyond regressive childhood impulses and obsessions to adult rationality. Freud reflected the tendency of the rational Enlightenment mind-set to compartmentalize religious emotion as irrational and bordering on the insane.

Many retain some fear about intense religious emotion. Stories abound of parents concerned over lost children caught in the wave of cultic religious fervor. At the same time these parents would hesitate to vanquish from their own faith and its practice the positive power of moving rituals and the amazing working of the spirit that brought conversions and change in their own lives. Religion does and must for its own survival promote a distinctive view of reality that at times finds itself at odds with the culturally dominant conception. On the one hand, religion would die without its power to grasp, move, and transform persons. Yet on the other, this very element becomes, in extremity, the downfall of persons and communities of believers. Religious ideas *are* disturbing. The complexity emerges when we attempt to uncover and comprehend the workings of religious emotions and world views on the mental health of individuals.

In the past several years a new openness has characterized the discussion of this subject. Cultural theorists such as Marthe Robert (1976) and John Cuddihy (1974) have begun to uncover other ways in which religion motivated and infiltrated Freud's life and reflections, even maintaining that in his psychological theories he sought ways to work out his religious quan-



daries. Such scholars as Philip Rieff (1959, 1966), Paul Ricoeur (1970), and Don S. Browning (1975, 1980, 1986) have demonstrated the moral, religious, and philosophical horizons not only of Freud's thought but of other modern psychologies. Likewise, in the realm of medicine, institutes like the Hastings Center (Institute for Society, Ethics and the Life Sciences), the Kennedy Institute of Ethics, and The Park Ridge Center have sponsored seminars, conferences, and research devoted to broader understandings of the practice of medicine, opening doors to input from ethics, theology, and philosophy.

But the most obvious sign of openness is the advent and continuing growth of the relatively new field of pastoral psychotherapy, represented externally by the American Association of Pastoral Counseling, one of the major accrediting bodies for those engaged in the profession of pastoral psychotherapy. Although not a large population—members of AAPC total around 2,600—the organization has grown steadily since its formation in 1963. The general public, including psychiatrists as well as lay parishioners, is finding the term *pastoral counselor* more familiar and less threatening; the pastoral counselor has become, in some cases, a welcome partner in the ongoing conversation about the health of the whole person. A few in the world of modern psychiatry have begun to see the need to redefine and recognize a more complex role for religion.

Those within the relatively new discipline of pastoral care and counseling forfeited for a time most overt religious understandings and values for scientific, and most often psychological, explanations and interpretations. Acceptance and credence as a profession seemed to demand the sacrifice of elements that might set the field of pastoral counseling apart. Developmentally, the field has now attained a stage of recognizing and even promoting these differences in its movement to full-fledged maturity.

The field displays a readiness to claim its authority, even to a public that may appear either uninterested or hostile at times. Answers to the question "What is pastoral about pastoral counseling?" are being provided. Don S. Browning writes in his introduction to the *Clinical Handbook of Pastoral Counseling*: "Pastoral psychotherapy resembles, as its name suggests, more nearly the goals of psychotherapy in general. . . . But pastoral psychotherapy is still pastoral because it takes place within the moral and religious assumptive world associated with the Judeo-Christian tradition" (1985:6). Terms like *hope*, *guilt*, *sin*, *love* need not be thrown out as antiquated; they may be more relevant and useful to a fuller understanding of the person than



first believed. Clearly terror, religious anxiety about condemnation, consciences stricken with a sense of sin, and unbearable guilt can and have harmed mental health and upset mental equilibrium, while not necessarily *causing* illness.

However, the interest of pastoral therapists and those who reflect upon the discipline lies less in formulating theories about the religious causes of illness and more in developing ways to understand possible religious and moral components that interact with other elements to affect mental health. As theoreticians have come to agree that the basis of human thinking is not rational concepts but some prerational level, pastoral therapists and theorists have begun to explore the prerational metaphors and images, religious and otherwise, that shape a person's self-understanding. They can test and judge the meaning, truth, and value of these formative images as part of the individual's mental health.

The "moral and religious assumptive world" of the Judeo-Christian tradition differs at several critical points from the assumptive worlds of various contemporary psychologies. In the conversation among the disciplines of psychology, theology, and medicine, the differing models of health lend themselves to comparison and critique on various levels of practical reasoning. As Browning spells out, we can turn to "metaphysics to help make. . . assessments about the relative adequacies of different metaphors and models referring to the ultimate context of experience, to moral philosophy to help assess the relative adequacy of the various theories of obligation, to axiology for its assessments of the nonmoral goods vital for life, and to various empirical disciplines to make judgments about context and consequences" (1984:156). On this basis, pastoral psychotherapists may judge certain psychologies more adequate to understanding the person within the Judeo-Christian world view. Moreover, they can begin to distinguish explanatory, descriptive psychological ideas from prescriptive, normative judgments and assumptions operating in various psychologies. These kinds of judgments about the available psychological theories allow the pastoral counselor to return to the client with greater integrity and understanding. Increased awareness of specific religious traditions and communities and their impact on our understanding of the human psyche allows greater receptivity and response to a person in need of understanding.

Optimally, the effort of those within the field may lessen embarrassment and ignorance in dealing with the religious dimensions of mental



health. At this juncture consensus exists that a diagnosis of religious insanity as an exhaustive explanation smacks of simplicity, but as an element involved in mental health problems—and also as part of the resolution—religion most surely has a place. ☉

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