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# **Second Opinion**

**health, faith, and ethics**





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*Second Opinion*, as its name implies, recognizes that the complexities of modern health care make it increasingly difficult to find the single “correct” action, thought, or method. Each situation is open to a variety of apparently legitimate and appropriate interpretations and applications. But such confrontations with ambiguity need not lead to discouragement. They can instead elicit greater research, discussion, and thought.

By inviting contributions from a wide range of perspectives, *Second Opinion* stimulates interdisciplinary conversations between members of fields relating to health, faith, and ethics. While other publications deal with one or two of these concerns, *Second Opinion* distinctively seeks to address all three. The Park Ridge Center created this publication in the hope that it will help form one public out of a number of related constituencies. This public will not only wish to relate ethics and faith to health issues, but should also, through lively and enlightened interchange, be better equipped to do so.

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# Second Opinion

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## *Initial Comment*

# From A to . . .

AIDS. Anorexia. Aging. One could scan the table of contents of this issue of *Second Opinion* and hazard the guess that in the absence of a more systematic approach to modern health care problems the editorial staff had decided to work its way through the alphabet. Such an approach, despite its pedestrian shortcomings, has its justifications. Paying attention to specific diseases keeps the ethicist's feet—and those of anyone else with an interest in human well-being—to the fire of human suffering. And moving from A to Z provides an inexhaustible agenda. *Second Opinion* could spend years in the A's moving from alcoholism to Alzheimer's to anencephaly to . . . Given the proliferation of new syndromes and diseases, however, our staff and readers would undoubtedly succumb long before Zollinger-Ellison Syndrome had its turn.

A second look at our table of contents will reveal that more than an alphabetical approach was at work in the shaping of this issue. AIDS, anorexia, and aging share an especially urgent character. They are among our culture's insolubles, which by the sheer weight of their presence expose pathological dimensions of our current ways of living and habits of thinking. AIDS brings into view the distinctively modern configuration of the enduring human bafflement about sexuality. Anorexia warns of the danger lurking within popular images of health which exalt taut abdomens and promote new asceticisms of diet and exercise. Our society's

dread of dying and its cult of youth become apparent when the subject of care for the aging is raised.

There are other common features. In more dramatic ways than do most other "health problems," these three place us in what theologians call "limit-situations." Sufferers meet their biological and biographical limits. So do those who care for them. When the seemingly bottomless medical cupboard is finally bare, when the family no longer has the emotional and financial resources to care for a loved one, when suffering and pain become relentless companions, then diseases like AIDS or biological processes like aging confront people with all the mysteries and uncertainties that are normally pushed to the margins of life.

One more consideration stands behind the shaping of this issue. In a slim but weighty book, *Illness as Metaphor*, Susan Sontag mourned the fact that "it is hardly possible to take up one's residence in the kingdom of the ill unprejudiced by the lurid metaphors with which it has been landscaped" (p. 3). After discovering how various cultures projected their feelings about evil on to "master illnesses" like tuberculosis and cancer, Sontag concluded that "the healthiest way of being ill" was "one most purified of, most resistant to, metaphoric thinking." Sontag's warning about the dangerous side effects of our conventional descriptions and understandings of illness sounds a note that reverberates throughout this issue.

The article by **John Godges** on San Francisco's

experience with AIDS, for example, points to the role religious descriptions and understandings play in people's response to a frightening new disease. Whether or not AIDS will become the new "master illness" which dethrones cancer, Godges's portrayal of how various religious groups respond to AIDS in terms set by long-held attitudes toward homosexuality provides one amplification of Sontag's point about metaphors. His article also demonstrates how experience can challenge established patterns of thought and lead to new ways of perceiving.

The attention given by **Linda-Marie Delloff** to atypical anorectics provides further elaboration of this theme. Mention anorexia nervosa and watch a stereotype come to mind—the affluent, bright, but insecure young woman. This stereotype, Delloff claims, has had consequences for men and older women who battle this disease but do not fit the mold. It has also posed problems for their therapists, who have to contend with their own preconceptions.

Historical perspective on the adequacy of the ways humans label their maladies is provided by **Ronald and Janet Numbers** in their article on "religious insanity." As they trace the use of that once-popular diagnostic category from its heyday in the first half of the nineteenth century to its disappearance from the psychiatrists' manuals in the twentieth, the authors challenge the absolutisms of those who assume that current perceptions of illness and its causes are the final and most enlightened chapter of a long story. Their article also takes readers into the midst of the debate about the relationship between religion and mental illness. Together with comments by **Thomas Jobe, Patrick Staunton, and Bonnie Miller-McLemore**, this article makes the point

that just as images of illness have consequences for physical health, so too ideas about the place of religion in mental well-being have implications for how people respond to mental crises and the forms of therapy employed to deal with them.

In *Second Opinion's* interview with **Mark Siegler** readers will encounter a physician who is calling for new ways of thinking about medical ethics. Siegler takes issue with those who approach bioethical issues with preconceived notions or principles that are to be applied to clinical situations. His alternative, clinical ethics, seeks to be more responsive to the particularities of each bedside encounter. Such an approach, Siegler believes, will result in better patient care.

One of the purposes of this journal is to inform our readers and Associates about important discoveries in the Center's research program. **Mark Noll** pioneers this effort with his review of *Caring and Curing*, the Center's new volume on health and medicine in the Western faith traditions. Noll found convergences among the faith traditions but also identified key differences. One implication of these twenty chapters is that it will be far more difficult to advance simplistic generalizations about the relationships of faith and medicine.

**Joseph Sittler** completes this issue of *Second Opinion* with his Perspective piece on aging. The religious images and the ethical understandings which people bring to the end of life are being tested by the life-prolonging capacities of modern medicine. Sittler's call for new ways of thinking about "letting go" of life underlines the point that the ideas and images humans carry into their life and death experiences play far more significant roles than they realize.

*J.P.W.*

James P. Wind, Editor





# *Healing a City*

## AIDS in San Francisco



NOBODY IN 1981 COULD EXPLAIN why young, previously healthy gay men began to die of incurable ailments. But even before French scientists in 1983 isolated the virus that causes AIDS (acquired immune deficiency syndrome), Fr. Giles Valcovich, a Franciscan chaplain at St. Francis Memorial Hospital in San Francisco, began to perceive another, even more pernicious, source of the suffering.

The soft-spoken Valcovich, a priest for thirty-eight years, noticed how much the patients had been hurting inside, "how much they hated being ostracized, being categorized, as if they were all atheists. It was a revelation

to me that God was very, very important in their lives, and it only intensified their hurt when they were tabbed as nonreligious people." According to Valcovich, many AIDS patients have a tremendous desire to be recognized as part of the church. "I try to assure them that even though the vast majority of them have not been churchgoers for a long time, they've not been ostracized by God, that he has always been there." It's been so long since some patients have received the sacraments that when Valcovich gives them communion, "they're crying, and I'm crying, too."

Valcovich adheres to his church's proscription



*AIDS healing service at the San Francisco Foursquare Church.*

against homosexual activity, but working with AIDS patients for five years has been a “great awakening” for him. “To consider that God is perhaps a lot more real for them than for people who are thought to be God-fearing,” he says and pauses, “it’s changed my whole outlook. I just don’t generalize any more. The last thing you want to be is judgmental or condemnatory—you’ve got to just take an individual from where he is at and go from there.”

The personal battle Valcovich had to wage with his

own convictions in order to minister effectively to AIDS patients contains lessons for society as a whole. Certainly greater understanding and greater compassion are required if society is to overcome its initial paralysis in dealing with the threat of AIDS to the public health.

The city of San Francisco is generally considered to be a model for AIDS treatment and education. Home of the largest number of AIDS patients per capita of any major city in the nation, with 97 percent of the 2,546 patients being gay or bisexual men (compared with 73 per-

**Photographs by Marc Geller**  
*except as noted*



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cent of the national caseload of 27,254), San Francisco has fought the disease with the coordination of a remarkable network of volunteer agencies, the innovation of home health care programs, vast public education campaigns, and centralized planning by Mayor Dianne Feinstein. The churches of San Francisco, too, have become engaged in this effort, struggling with the religiously motivated hostility toward homosexuals which has often impeded efforts to deal with this epidemic accidentally associated with homosexuality.

**T**hese efforts contrast starkly with the efforts of the federal government. A report prepared for Congress by the Office of Technology Assessment in February 1985 suggests that the Reagan Administration was slow to concern itself with AIDS. Whereas the epidemic was clearly foreseen in March 1981, research at the National Institutes of Health did not begin until 1983 and then, the report says, only with inadequate funds. The report also criticizes the U.S. Public Health Service for minimizing public education about AIDS. Education has been all along the only known way to prevent the spread of the illness. "Perhaps most controversial," the report states, "has been the provision of advice to gay men and intravenous drug abusers. One reason may be that providing advice on preventive practices may be viewed as condoning bisexuality, homosexuality, or intravenous drug abuse."

San Francisco was able to galvanize its resources because gay people there did not have to fight for acceptance in order to fight AIDS. Dr. Dean Echenberg, director of communicable disease control at the San Francisco Department of Public Health, explains that "the gay community is part of the fabric of society in San Francisco. It's never 'us' doing anything for 'them.' It's essentially us doing something for ourselves." Openly gay people hold positions of influence in banks, insurance companies, law firms, medical societies, and city

government. In a city of 700,000, there are an estimated 70,000 gay men and 30,000 lesbians. "Gays make up one-fourth of the registered voters in this town, and they always vote," says Randy Shilts, a gay reporter for the San Francisco *Chronicle* and the only full-time AIDS reporter in the country. "No politician would oppose funding for AIDS, because the politicians in office are already sensitive to the needs of the gay community."

Education has worked in San Francisco. The San Francisco AIDS Foundation, one of several agencies initiated by volunteers and supported by the city's health department, disseminates safe-sex guidelines in explicit detail in English, Spanish, Chinese, Japanese, and Tagalog. One measure of the drop in high-risk sexual activity is the marked decline in sexually transmitted diseases among gay men. Reported cases of rectal gonorrhea in San Francisco plummeted an astonishing 95 percent between January 1980, when there were 550 cases, and May 1986, when there were 27.

San Francisco's quick response can be attributed to the ability of gay doctors to identify immediately the nature of the illness and to instruct the medical community at large how to understand the victims of the disease. In June 1982 the Bay Area Physicians for Human Rights (BAPHR), a group of 225 gay physicians, initiated local education efforts by issuing the safe-sex guidelines, which have since become the international model for AIDS prevention. The primary transmission of the AIDS virus occurs during anal intercourse in which the semen from an already infected man permeates the rectal lining of another man. (Although AIDS does spread through heterosexual intercourse, it is much more difficult for a man to infect a woman because the vaginal walls have several protective layers of cells, compared to the rectal lining with only one cell layer.) Unsafe sexual activities include anal intercourse without using condoms, rimming (oral-anal contact), fisting (inserting the entire hand into the rectum and balling it into a fist), and taking



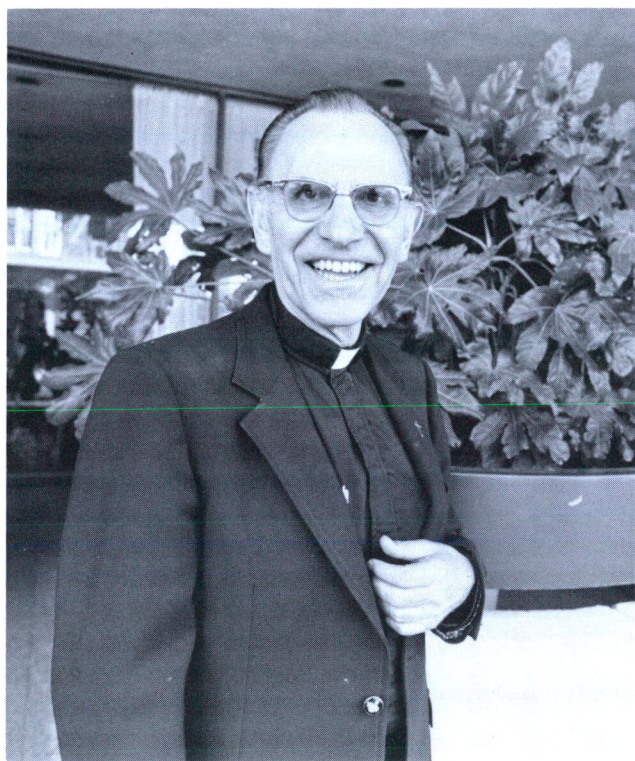
semen or urine into the mouth. Safe sexual practices include dry kissing and mutual masturbation. The weak AIDS virus requires direct injection into a person's bloodstream in order to survive, which explains how some hemophiliacs and blood transfusion recipients contracted AIDS before the nation began screening its blood supply. The highest incidence of AIDS among heterosexuals in this country occurs among intravenous drug abusers who share needles infected with the AIDS virus.

Most chilling about the AIDS virus is its ability to lie dormant for five years or more, enabling an infected person to spread the virus without even knowing he or she

is infected. The U.S. Centers for Disease Control (CDC) in Atlanta estimate that between 1 million and 2 million Americans are already infected with the virus, and at least 25 to 50 percent of those could develop full-blown AIDS and die within the decade, according to the National Academy of Sciences. Despite the high hopes raised among AIDS patients by the experimental drug AZT (azidothymidine), which slows the onslaught of the disease, the academy predicts that development of a safe, effective drug to halt or cure the disease or a vaccine that would prevent infection is at least five years away.

Echenberg points out that the "success" of San Francisco is dubious. Blood tests of 6,000 gay men who volunteered for hepatitis-B tests in 1978 now reveal, according to Echenberg, that 30 to 40 percent of them were already infected by the time the first article on AIDS appeared in the papers on 5 June 1981, in the *Los Angeles Times*. Fifty percent of San Francisco's 70,000 gay men have since been infected. Of the 2,546 cases of AIDS in San Francisco, 1,442 people have died. Roughly 100 new cases are now being reported in the city each month.

People do not die of the AIDS virus itself but of opportunistic infections which the immune system, impaired by the virus, cannot fight. The afflictions include pneumocystis carinii pneumonia, often accompanied by seizures; the purplish lesions of Kaposi's sarcoma, a skin



*Fr. Giles Valcovich, chaplain at St. Francis Memorial Hospital, San Francisco. "It was a revelation to me that God was very, very important in their lives, and it only intensified their hurt when they were tabbed as nonreligious people."*



cancer; candida albicans, a fungus that cakes the mouth and throat, making it painful to speak and eat; cryptosporidiosis, which causes diarrhea; and toxoplasmosis, which causes brain damage.

More than 27,000 cases of AIDS have been reported nationwide, and more than 15,000 of those patients have died. By 1991, the U.S. Public Health Service predicts, a total of 270,000 cases will have resulted in 179,000 deaths—three times the American death toll in the Vietnam War. An additional 200,000 are already suffering from AIDS-related complex, or ARC, which severely weakens the immune system but usually is not fatal unless it develops into AIDS.

According to Dr. William Kapla, president of BAPHR, because there is no scientific cure for AIDS patients, doctors have had to reacquaint themselves with the “art of medicine,” the art of caring above and beyond the science of curing. He says gay doctors have shown other physicians how to care for AIDS patients.

The AIDS ward at San Francisco General Hospital, run primarily by gay nurses, has institutionalized the emphasis on care over cure. Cliff Morrison, director of the medical nursing division at the hospital and founder of the ward, chose workers who are sensitive to issues of sexuality and diverse lifestyles as well as issues of death and dying. Morrison observes that AIDS has made health



*Dr. Dean Echenberg, director of communicable disease control, San Francisco Department of Public Health. “There is a tremendously high rate of sexually transmitted diseases and intravenous drug abuse among minority youths, and these are ideal conditions for heterosexual transmission of AIDS.”*



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care providers more aware of the psychosocial aspects of a person's health. "We need to know signs of depression. All people who have been discriminated against internalize that hostility to some extent, and that affects how they deal with the dying process." With AIDS patients, he says, health workers must be sensitive to self-hatred and internalized homophobia.

"We have to know the social background of the patients, the problems with their families," says Dr. Paul Volberding, chief of the hospital's AIDS Activities Division. "Estrangement for gay people is very real, and we can't draw on family resources if a person was kicked out of Nebraska." Hospitals have come to rely on the "gay family" of friends, lovers, and volunteers, he says. "Physicians are not the most important people for a lot of patients. They have attendant care, someone to help them shop, cook meals, take them out. They need group therapy discussions. These are not medical needs, but they make life possible for some patients." Patients rely on programs like the Godfather Fund, which provides personal care items, the Bay Area Lawyers for Individual Freedom, who offer free legal advice, and the AIDS Hospice Program, which provides home care for patients in the usually agonizing final days.

Not needing to hide, gays in San Francisco were free to create the myriad volunteer groups: 300 volunteers at the Shanti Project give patients emotional and practical support, 400 volunteers at the AIDS Foundation operate an AIDS hotline and arrange emergency housing and food services, 500 volunteers with the Stop AIDS Project have enrolled thousands more gay and bisexual men in informal "town meetings" in people's homes to discuss how to stop the spread of AIDS.

These and other volunteer groups have not only provided superior patient care and preventive education but have also drastically cut medical costs to the city. A CDC study of the first 9,000 AIDS cases estimated hospital costs at \$140,000 per patient, but Dr. Philip Ran-

dolph Lee, president of San Francisco's Health Commission, has estimated the average hospital cost for an AIDS patient in San Francisco at \$25,000–\$32,000.

The city's investment in volunteer agencies and home care programs has meant the average AIDS patient in San Francisco stays in the hospital 12 days, compared to 50 days in New York City. Only 10 percent of San Francisco's AIDS patients are in the hospital at any given time. Observers, especially visitors from out of town, are amazed at the outpouring of volunteer support from the gay community.

Some have speculated that AIDS has forced gays to grow from a collective adolescence into maturity. The heyday of the gay liberation movement of the 1970s brought to San Francisco thousands of gay men who had been denied their adolescence, who had never been allowed to date, who had gone through their teenage years being told that what they were feeling toward other men was forbidden. Coming to this tolerant city gave them the opportunity to release a huge reservoir of frustration. Gay liberation was as much an emotional emancipation as it was sexual or political.

But Bert Bloom, who moved to San Francisco in 1978 and is now outreach coordinator for the Stop AIDS Project, says the period before AIDS was emotionally confining in another way. "It wasn't a really nurturing part of my life. It was about how many people went through my life, and a lot of people's bedrooms just became revolving doors." AIDS, he says, has hastened the "evolution" of gay men who, having experimented with sex, are now experimenting with love. The rap groups he organizes have been one mode of that experimentation. "I've been with groups of twenty or thirty men sitting in a room and crying with each other. I can't imagine that happening five years ago. You would never have had permission to do that. You would have looked like an outcast to show your emotions in front of one man let alone a group of men."



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Furthermore, AIDS has all but obliterated the separatism between gay men and lesbians. Even though lesbians are at least risk for contracting AIDS, they have volunteered in droves and have sponsored blood drives proclaiming "Our Boys Need Blood." Mary Cantrell, who also works for the Stop AIDS Project, says she feels more connected to the gay community than ever before. "Eight years ago, I can remember walking down Castro Street [the hub of San Francisco's largest gay district] and feeling like I was on another planet, and probably they wished that I hadn't walked down their street."

But to say the gay community is "growing up" is, according to *Chronicle* reporter Randy Shiltz, "very condescending. If that's the case, then I'd say heterosexuals are in a chronic state of infantilism. I don't know if heterosexuals would respond as well if the epidemic affected them. I've certainly never seen anything like this in the heterosexual community—maybe during a flood or something, but nothing sustained like this year after year."

Kapla attributes the widespread volunteerism among gays to deeper psychological forces unknown among straights. "It's inherent from childhood," he says.

"You raise a child in a straight environment, and he knows there is something different about himself and that if he lets anyone know, then he can die. He can get thrown off a bridge in Maine and die. He can get bashed in. We've all felt the risk to our lives in the streets simply because of what we are. The individual gay person lives an extremely cautious life, and gay people develop a mind-set, a focus to fight for their lives." Now in San Francisco, he says, there's been an "astounding reversal. We don't have to fight so intensely, because the city accepts us. But to publicly fight a disease like this is what we've done personally all our lives."

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Volberding believes AIDS has destroyed the historical barriers between gays and at least most straights who work directly with AIDS patients. "One of the hardest stresses we face in treating AIDS patients is that a lot of us are in our thirties, and when you see people your own age dying, all the defense systems you have to prove to yourself that it's not you in that bed are challenged," says Volberding, who is thirty-seven. Especially hard, Volberding says, is when doctors and nurses get to know the lovers of AIDS patients, only to see those lovers return in six months or a year with AIDS themselves. "To see people you get close to also dying of AIDS," his voice cracks, "it's. . . it's really a problem."

Yet there remains a strain of homophobia in San Francisco's medical community, he says. "For a lot of male physicians, especially young males, there is a lot of anxiety about treating AIDS patients, because people who have gone through our medical schools have gone through what is the longest delayed adolescence in history, and they're still working out their sexual identities. That's still happening among the interns. Working with AIDS kind of makes you ask yourself, 'who are you?' Most people can decide who they are. Others remain uncomfortable and avoid AIDS patients."

But avoidance on a grand scale breeds injustice in a country where politics often determines who gets good health care. In New York and Los Angeles, Volberding says, direct support to AIDS patients has been much less than in San Francisco. "Is it fair that patients in one city suffer while in others they don't? Should costs be more evenly distributed?"

At hearings held in July 1985 by the Congressional Subcommittee on Intergovernmental Relations and Human Resources, Dr. Philip Lee of the city's health commission observed that "the key question—for AIDS patients, as well as for all Americans—is what is the federal government's role in health care financing?" With the decreasing reliability of private insurance, Lee





*Holly Smith, San Francisco AIDS Foundation, Community Education Director, with some of the foundation's safe-sex and information posters. (Photograph by Thomas Michael Alleman.)*

said, "We will soon have to face the question of how best to finance health care for all Americans." According to Lee, the plight of AIDS patients points to sorely needed reforms in national health care. "In the current climate of competition, deregulation, and decentralization—or abrogation of federal responsibility, as I believe it should more appropriately be designated—the AIDS victim must spend down his resources and then apply for public assistance. Only in the United States of America and South Africa, among all Western industrialized nations, would such a fate befall a sick patient with catastrophic health care costs."

Only after five years of the epidemic and the loss of 15,000 lives, and only after the perceived threat of AIDS to non-drug-abusing heterosexuals, has the federal government begun to fight AIDS in earnest. On 22 October 1986, Surgeon General C. Everett Koop, who once referred to the gay rights movement as "anti-

family," issued a report calling for sex education as early as elementary school that would include information on heterosexual and homosexual relationships with an emphasis on the prevention of AIDS and other sexually transmitted diseases. President Reagan approved the report as well as a fiscal 1987 allotment of \$410.7 million to fight AIDS, a 75-percent increase over the 1986 amount. On 29 October 1986, the National Academy of Sciences, chartered by Congress in 1863 to give advice to the federal government, charged the government with an inadequate response to AIDS and called for a minimum \$2 billion annual educational and research budget to avert a medical catastrophe.

Still, because health care in the United States is not equally distributed to the poor and the nonwhite, the chances that AIDS will spread to the broader population are very real. At the San Francisco health department, Echenberg worries that AIDS, along with other sexually



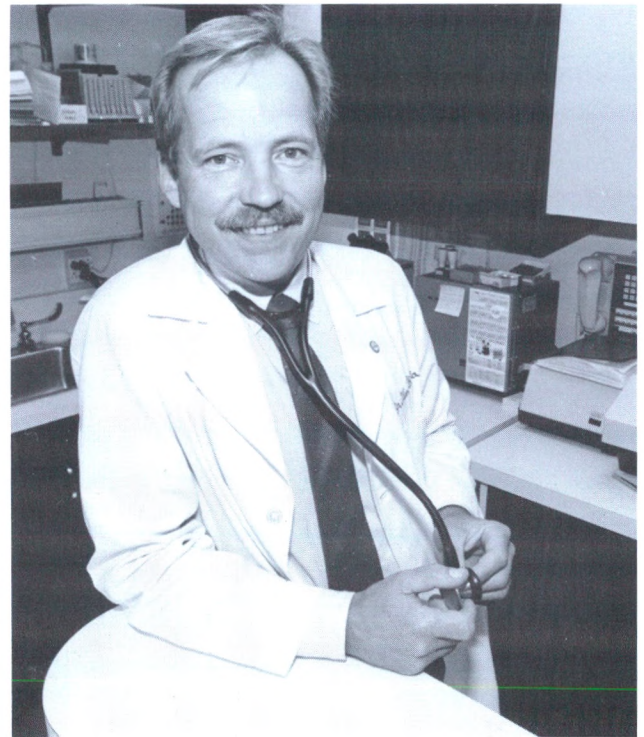
transmitted diseases, is on the verge of spreading across the country to minority youths, who are much harder to educate than middle-class gay men. "There is a tremendously high rate of sexually transmitted diseases and intravenous drug abuse among minority youths, and these are ideal conditions for heterosexual transmission of AIDS," he says. Genital sores associated with venereal disease greatly increase the chance that the AIDS virus will be passed on through vaginal intercourse.

Echenberg cites Haiti, where the primary mode of AIDS transmission has changed from drug abuse and homosexual activity in the early 1980s to heterosexual activity today. In the United States exist the "exact same circumstances," he says. "Wherever there are low economic conditions, we find high rates of venereal disease and drug abuse. That's absolutely fertile ground for the AIDS virus. We have thousands of potential little Haitis in our own backyards." As hard as it has been for San Francisco to fight AIDS, all agree that it will be much harder in other cities where gays fear identifying themselves. Yet AIDS is spreading to communities that have not yet accepted gays, let alone confronted AIDS. Whereas New York and California reported more than 75 percent of all AIDS cases into 1982, now less than half of new cases reported to the CDC come from those two states.

Cliff Morrison, who works with an AIDS volunteer group at a Catholic parish in the city in addition to his

work at San Francisco General Hospital, believes churches have the opportunity to do more than any other institution in society to fight AIDS and especially the homophobia that has hindered preventive education.

Mainstream religions have always considered it morally and ethically right to care for the sick. Judeo-Christian dogma has deemed homosexuality morally wrong, however, breeding hostility toward homosexuals and half-hearted concern for AIDS patients. AIDS has placed religious social workers in the awkward position of seeing how their moral scruples, by generating that hostility, have actually gotten in the way of good medicine, of good ethics.



*Dr. William Kapla, president of the Bay Area Physicians for Human Rights. "We don't have to fight so intensely, because the city accepts us. But publicly to fight a disease like this is what we've done personally all our lives."*



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Morrison calls AIDS a “test for organized religion to either turn its back, throw up its hands, and say this is the wrath of God and gays deserve it, or to take this opportunity to practice unconditional love and not judge people. When religious leaders do that, that will be the best model that can happen anywhere. Other institutions throughout society will follow suit. The church and organized religion have an enormous responsibility—maybe the most responsibility.”

AIDS has shaken the religious community in San Francisco. For the most part, traditional judgments have been put aside in order to simply care for the sick. Like Giles Valcovich, spiritual leaders have felt the psychological suffering of AIDS patients, the loneliness, the alienation, all of which has softened the hearts of some once categorically opposed to homosexuality. Some Episcopalian leaders in San Francisco have even concluded that one way churches can fight AIDS is not to condemn homosexual activity, but to condone strong gay relationships.

Yet the response of San Francisco religious groups to AIDS certainly has not proceeded with cheerful unanimity. The theological crisis spread by the AIDS epidemic is best illustrated by the schism it has provoked within the local Southern Baptist church, driving one San Francisco congregation closer to the gay community and further away from other congregations.

With 14.3 million members, the Southern Baptist Convention is the largest and one of the most conservative Protestant denominations in the country. Former president of the denomination Rev. Charles Stanley declared in January 1986 that “AIDS is God indicating his displeasure” with homosexuals.

“That was one of the most disgusting statements I’d ever heard,” says Rev. Jim Lowder, pastor of the Dolores Street Southern Baptist Church in San Francisco. “To use human suffering as an excuse to condemn people is absolutely intolerable and un-Christian.” Members of

Lowder’s church volunteer with AIDS patients and take food and blankets to the ongoing AIDS protest vigil at the federal building in downtown San Francisco. The congregation has lost \$15,000 in annual funds from state and national Southern Baptist organizations because of Lowder’s pro-gay stance.

“Jesus never mentioned homosexuality,” he says, but taught “one ethic of human relationships, whether you’re gay or straight. We’re called to be faithful, loving, caring, life-enhancing, and not destructive or manipulative.” Accused of “teaching sexual perversion,” Lowder has been removed from teaching duties at the Southern Baptist Golden Gate Seminary. In a final blow, the San Francisco–Peninsula Southern Baptist Association removed his fifty-member church from its fellowship after Lowder refused to reconsider his position. Says Lowder: “It constantly amazes me how many people feel upset and challenged by this little church which is simply attempting to be compassionate.”

Luckily, AIDS has not been as divisive an issue for other outspoken San Francisco religious leaders, not even for Rev. Charles McIlhenny, who in 1978 fired an organist for being gay and then created the Christian Rights Defense Fund to fight the city’s gay rights ordinance. McIlhenny now collects food for the AIDS Foundation at his fundamentalist Orthodox Presbyterian church. Gays still distrust him, he says, but “if they don’t want my scripture—OK, fine—let me give food.”

For McIlhenny, who believes that “AIDS is the wrath of God,” AIDS has also meant greater sympathy for the gay community. “I’m a diabetic,” he says, “and that’s God’s judgment on my sin, too. Death, disease, poverty—they’re all God’s judgment on our original sin. AIDS is in that category. But don’t think a guy with AIDS is more sinful than others.” He cites Luke, chapter 13, in which Jesus argues that eighteen people killed by a falling tower in Siloam were no more guilty than anyone else in Jerusalem.



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When McIlhenny spoke about AIDS at an anti-gay rally in San Diego a couple of years ago, he stressed compassion and the importance of being a good Samaritan. The crowd, he says, was disturbed by his liberal point of view, and he has not been invited back to any more rallies. "These fellows [gays] are not Martians, not from another planet, but ordinary human beings. A lot of fundamentalists could call me a compromiser."

Since July 1983, a number of San Francisco Methodist, Lutheran, Southern Baptist, Presbyterian, Catholic, Buddhist, Jewish, Episcopalian, and evangelical congregations have joined the AIDS Interfaith Network to serve AIDS patients, their lovers, families, and friends. To counter the "religious right," the network points to the Gospel of John where Jesus rejected the popular assumption that a blind man's suffering was the direct result of sin. "It was no sin, either of this man or of his parents," Jesus said (John 9:1-3).

Since January 1986, the Protestant evangelical community, once considered off-limits to gays, has co-sponsored monthly AIDS "healing services" with the Interfaith Network. At the fundamentalist San Francisco Foursquare Church, the Reverend Greg Romine beseeches the Lord to visit miracles upon the AIDS victims attending his services. Yet David Hummel, the network's codirector, feels something of a miracle already has occurred: activist gays and conservative Christians are worshipping together. "This is a tremendous breakthrough," Hummel says. "You have people here who have been at each other's throats for years. This is the first time we've seen the evangelical community react to the gay community in a positive way."

Until the Foursquare Church opened its doors to gays, the Interfaith Network had difficulty finding a fundamentalist church that would accept persons with AIDS without condemning their homosexual behavior. Romine's services represent a historic turning point. "From the suffering of people with AIDS," Hummel says,

"we're learning to love each other more intently than ever before. There's a tremendous healing at a community level and for many, many individuals."

At the service, Romine declares that the "love of Jesus Christ is helping us tear down the walls of our ideologies." In a later interview, he qualifies that statement. "My desire is to see the gap narrowed—not for gays to see things in the same theological reference that we do, neither for us to accept homosexuality as a fine lifestyle." An acceptable lifestyle for gay people is "something they have to work out in their relationship with Christ."

He believes AIDS will make both gays and straights realize "sexual fulfillment is not nearly as important as spiritual fulfillment." A husband and a father, Romine predicts God will mobilize an army of young celibates to go to any part of the world to spread the gospel. Gays are crucial to his unique vision, for they have "no family ties as a result of the estrangement from their families and a culture not prepared to understand them."

This is all very well for the church, he says, for the "gay community is laden with talent. It's already well-mobilized, it understands communication skills, and it knows how to organize. Many gays already have the skills the church desperately needs. They're highly motivated, have good business skills, they're well-dressed and health-conscious because of AIDS." Wherever Romine's ministry might take him, AIDS has ushered in a new era of opportunity and cooperation between himself, his church, and the gay community.

San Francisco Catholics have also found AIDS to present an opportunity for heightened cooperation with gays. Roman Catholic doctrines proscribing homosexual activity may remain intact for decades to come, but reconciliation between the church and the gay community in San Francisco has already begun on a personal, pastoral level.

The staff and parishioners of Most Holy Redeemer



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Catholic Church, located in the heart of the city's predominantly gay Castro District, have built a grass-roots network of support for AIDS patients, their friends, and families. About fifty volunteers now work with victims of the disease. In a joint venture with Coming Home, a nonprofit group serving terminally ill gays and lesbians, parish volunteers have helped to raise nearly \$450,000 to convert their unused convent into a fifteen-bed hospice for people with AIDS and other terminal illnesses. Construction began on 4 August 1986; the hospice should open in January 1987. Many professional services and much of the equipment are being donated; for the building itself the archdiocese will charge Hospice of San Francisco \$1,000 a month in rent. Meanwhile, weekly "Coming Home Hospice Bingo" games in

the church basement have become, according to one local gay newspaper, the "social event of the season."

Until the 1970s when the Castro District rapidly became a gay ghetto, the Most Holy Redeemer parish consisted primarily of large Irish and Italian families. For about a decade, there was peaceful, but often resentful, coexistence between the church and the gay community—until AIDS. "AIDS has brought us together," says Sister Clea Herold, pastoral associate at Most Holy Redeemer and member of the archdiocese's Board of Ministries for Gay and Lesbian People. Two formerly active members of Most Holy Redeemer's Gay and Lesbian Outreach Committee, in fact, are now working full-time for the church. Bill Reese directs the parish support group, and Dale Meyer coordinates the



*Bingo player, "Coming Home Hospice Bingo," Most Holy Redeemer Catholic Church, San Francisco.*





*Coming Home Hospice, San Francisco.*

AIDS/ARC programs for Catholic Social Service of San Francisco. The archdiocese in July 1986 hired an additional full-time AIDS services coordinator, Rick Cotton, who has ARC.

Herold describes the moral tightrope she walks in order not to upset the Roman Church hierarchy or even the archdiocesan Senate of Priests which, in 1983, affirmed the "objective immorality of homosexual activity." In working with AIDS patients, she says, "I'm separating the moral issue from compassion. We don't have to mix the two at this point. The church often moves very slowly. . . but momentum is gaining now."

Fr. Michael Lopes, appointed by Archbishop John Quinn as an AIDS minister, also walks a fine line. Besides his full-time assignment as a parish priest, Lopes supervises seminarians on the AIDS wards at San Francisco General, Mount Zion, and Presbyterian hospitals. When Dignity, a Catholic pro-gay group that had had no communication with the archdiocese for more than four years, offered its hospital ministry as relief to Lopes, he called for a reconciliation between the archdiocese and Dignity. Instead, Quinn approved a "rapprochement"

between the two groups which is a "recognition that we need to work together to fight the epidemic," Lopes says. "Reconciliation won't occur on an official level, but we need to work together. We can't cold-shoulder each other. So I'm in the middle." He preferred not to express his personal opinions.

Another indication that AIDS has brought the church and the gay community closer together here is the friendship it has engendered between Quinn and Cliff Morrison, the gay Catholic who founded the AIDS ward. For two years, Quinn has consulted Morrison about AIDS services and about the gay community. In return, Morrison has trained volunteers at Most Holy Redeemer and hasn't hesitated to share his opinions on homosexuality with the archbishop.

Morrison says Quinn was "shocked" when he visited the AIDS ward to discover that 75 percent of the patients at that time were Catholic. "There just happen to be many Catholics who left their hometowns for San Francisco," remarks Morrison, a native of northern Florida. But six years ago, Morrison felt like the only gay person in church. Now, "easily half the church is gay." Most Holy Redeemer would have changed eventually if only for economics, Morrison says, because "the only young middle-class blood in this community is gay." But he says AIDS hastened the process. "AIDS really forced the issues to the surface. This church needs us, and we need the church."

Bill Nelson, who left a Dominican seminary and now works as a nurse on Morrison's AIDS ward, feels "Rome won't understand the impact of AIDS for a long time." Although Catholic Social Service of San Francisco drafted a resolution in which the National Conference of Catholic Charities named AIDS a top funding priority and condemned homophobia within the church, "Rome is looking at 750 million Catholics around the world and only a small percentage with the disease," he says. "What might happen is that certain key theologians



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might start thinking about what the church stance toward this percentage of the population should be.”

Charles Curran, professor of moral theology at Catholic University of America, has written provocatively about homosexuality and other sexual issues and in August 1986 became the first American Catholic theologian to be censured by the Vatican. Six hundred North American theologians, including 110 Catholic college presidents, had sent statements to the Vatican in support of Curran. Fr. Xavier Harris, president of the Franciscan School of Theology in Berkeley, teaches from Curran’s writings at the Graduate Theological Union. Calling the Vatican censure a “disgrace,” he maintains that it is “inappropriate to censure one person for what a majority of us are teaching.”

In *Issues in Sexual and Medical Ethics* (1978), Curran argues that Catholic sexual morality is based on a false notion of “natural law.” Official church teaching dates back to Ulpian (d. 228), a Roman lawyer who defined natural law according to the sexual acts of animals in which the male deposits seed into the female. Curran faults the church for reducing human sexuality to a mere animal or biological process. Although the church has taught the contrary for centuries, Curran argues that producing children is not sexuality’s only purpose. In partial acquiescence to church authority, however, he strikes a “theory of compromise” stating that homosexuality is indeed a disorder reflecting the sinful situation of the world but that people can enter into a loving and committed homosexual relationship



*Dr. Paul Volberding (left), chief of the AIDS Activities Division, San Francisco General Hospital, speaking with Duncan Gwynn, an AIDS patient.*

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without doing anything morally wrong.

Issues of sexual morality, and homosexuality in particular, have been a recurrent theme in the recent Vatican crackdown on dissent within the North American church: after the censure of Curran in August 1986 came the revelation in September that the Vatican had stripped the authority from Seattle archbishop Raymond Hunthausen, one of whose most serious offenses seems to be his permission to Dignity to hold mass in the Seattle cathedral; then in late October 1986 the most strongly worded Vatican statement ever issued against homosexuality was released. The statement, written in English, not only agrees with previous doctrine stating that homosexual acts are sinful but goes further to condemn the mere inclination toward homosexuality as an "objective disorder," or a "tendency ordered toward an intrinsic moral evil."

Many religious people who believe homosexuality is not a disorder, including the staff of the Episcopalian Parsonage on Castro Street, rely on the work of Yale historian John Boswell. In *Christianity, Social Tolerance, and Homosexuality* (1980), Boswell traces the history of Christian attitudes toward homosexuality from the early Greeks to the Middle Ages. He uncovers homosexual references expurgated from church literature down through the centuries and challenges popular notions about the church's past relationship to its gay members, among whom, he maintains, were priests, bishops, and even canonized saints.

Fundamentalists often cite the destruction of Sodom and Gomorrah as proof of God's disapproval of homosexuality, but the original Genesis account indicates the destruction occurred not because of homosexual activity, Boswell writes, but because of the citizens' inhospitality to the angels. He traces the story's homosexual associations to social movements of a much later period.

In the admonition of Leviticus—"Thou shalt not lie

with mankind as with womankind, it is an abomination"—Boswell detects a mistranslation combined with a quotation taken out of context. The literal translation from the Hebrew is "You shall not sleep the sleep of a woman with a man," suggesting that the passive lover in gay intercourse is the abomination. In the patriarchal context of ancient Hebrew culture, then, one stigma of homosexuality was that it "reduced" some men to the role of females. This misogynistic revulsion toward males doing anything "feminine" had little to do with homosexuality, Boswell holds, for there is virtual silence about homosexual relations between women in scriptural sources, despite the fact that lesbianism was well known in the Hellenistic world. Moreover, the word *abomination* in the Levitical context is translated from the Hebrew word *toevah*, which "does not usually signify something intrinsically evil, like rape or theft, but something which is ritually unclean for Jews like eating pork or engaging in intercourse during menstruation, both of which are prohibited in these same chapters." Such arbitrary prohibitions functioned as unusual practices to emphasize the distinction of Jews in relation to Gentiles, according to Boswell.

Anti-gay church leaders also point to the New Testament book of Romans, where Paul spoke of vile men who, "leaving the natural use of the woman, burned in their lust one toward another." Boswell answers that what Paul condemns are not homosexuals but homosexual acts committed by heterosexuals who had to "leave" what for them would be the "natural use" of women.

The Episcopalian Parsonage on Castro Street is perhaps the only mainstream religious body which actively promotes Boswell's point of view. But much of the Episcopalian Church in this country has been notably influenced, especially since AIDS, by the work of the Parsonage and by the liberal bishop of the Diocese of California, Rev. William Swing.



Founded in 1981 as an ecumenical ministry of gays, lesbians, and their friends sponsored by Swing and the Diocese of California, the Parsonage is the first formal organization within a major denomination to be dedicated to reconciling traditional church teaching with homosexuality. Classes and seminars focus on the Bible, sexuality, stereotypes, phobias, alienation, and loneliness.



For three days in March 1986, the Parsonage and Grace Cathedral in San Francisco hosted the National Episcopal Church Conference on the AIDS crisis, bringing 280 delegates from 65 dioceses in 41 states and the District of Columbia to San Francisco to learn how the church could best respond to AIDS. The meeting was called for by an AIDS crisis resolution drafted by Parsonage workers and approved unanimously in September 1985 at the 68th General Convention of the Protestant Episcopal Church in the United States. Tom Tull, former chair of the Parsonage, says there were actually two conferences during those three days in March: one on AIDS and another, less formal, on homophobia. He shared with conferees his conviction that more people are "killed" psychologically by homophobia than physically by AIDS. "Homophobia is much more devastating in the long run." The Parsonage has since set aside one office, called the Hope Help Center, to coordinate Episcopalian AIDS ministries nationwide as well as to fight AIDS-related discrimination.

Bishop Swing, who has witnessed the AIDS-related deaths of a church employee, a theological student, and at least three other members of the diocese, sees nothing intrinsically wrong with homosexual activity. "As for celibacy," Swing has written, "it is asking a great deal of one group of people to 'neuter' their sexual nature for a lifetime."

*Episcopal Bishop William Swing, Diocese of California, at a press conference on the Lyndon LaRouche-sponsored Proposition 64, which was defeated in November. Bishop Swing has led an attempt to integrate gays into a mainstream church.*



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The work of the Parsonage predates AIDS and will continue regardless of AIDS, but the crisis has been a turning point for the Episcopal Church locally as well as nationally. "The AIDS epidemic has changed us," says Swing. "The relationship between the bishop and the Parsonage has changed. It has evolved from mostly talk to mostly action."

Parsonage workers are still awaiting action, however, on the issue of gay marriages. Swing two years ago appointed a theological commission to devise a Covenant in Love for homosexual relationships, and the Diocese of California on 25 October 1986 endorsed a resolution directing Swing to "work with the clergy and the people of the parishes to develop such rites." Meanwhile, the Parsonage has initiated its own seminars on "Archetypes of Lesbian and Gay Love in the Bible": Ruth and Naomi, Jonathan and David, Elijah and Elisha, Elizabeth and Mary, and Jesus and John.

Boswell's essay "Rediscovering Gay History: Archetypes of Gay Love in Christian History" (1982) reveals that much of the most beautiful love poetry in the Christian tradition was in fact written by monks in love with each other or by nuns in love with each other. "A number of monastic writers specifically invoked the example of Christ and St. John," Boswell writes. He also uncovered what is "basically a gay marriage ceremony" recorded by monks from the Greek church of the ninth or tenth century. He says the rite could have been used to bless both same-sex marriages and same-sex friendships. In this ceremony for the making of "spiritual brotherhood," the priest asks the Lord to bless "these your servants. . . not joined by nature but by means of love." The priest instructs the two parties to hold over each other's head the crowns of marriage, which are still used today in the Orthodox church during marriage ceremonies.

No other mainstream church has discussed the possibilities of homosexual love as vigorously as have

the Episcopalians, but AIDS has motivated other groups to follow that church's lead in providing both health care and theological openness. Within months after San Francisco Episcopalians drafted a national AIDS resolution, San Francisco Jewish and Methodist groups followed suit.

Congregation Sha'ar Zahav, a gay temple in San Francisco, wrote a resolution unanimously passed in November 1985 by the Union of American Hebrew Congregations, the Jewish Reform Movement's organizing body in the United States and Canada. The resolution calls for congregations nationwide to provide education about AIDS and calls for an end to AIDS-related discrimination.

Rabbi Robert Kirschner of Congregation Emanu-El in San Francisco compared the passage in Leviticus calling homosexuality an abomination to another passage in Leviticus in which a sage says he would throw stones at a leper. "I am not proud of this passage," commented Kirschner. He feels AIDS in a similar way obliges us to "ask forgiveness for our sins" of banishing others. At his request, the temple has raised \$30,000 for AIDS support services in the city.

The AIDS resolution passed by the United Methodist Church—and written by ministers and laypersons from the San Francisco Bay Area—signals a turning point in that church's relations with the gay community. "We confess," the resolution states, "that we as a total church have not always responded lovingly in the midst of this epidemic in part because of deeply held fears and prejudices. We ask God's forgiveness in this regard." The resolution calls on United Methodists "in the midst of this epidemic. . . to accept people as they are." The 9.1-million-member church has directed its Board of Discipleship, which provides training and resources for the 38,000 local congregations, to develop counseling and support programs for those suffering from the disease.





*A candlelight march on 27 October 1986 marked the one-year anniversary of the ARC/AIDS vigil, which was begun to make four "moral appeals" to the federal government: for more money in AIDS research, for Social Security disability benefits for ARC victims, for approval of drug treatments available in other countries, and for official condemnation of the hysteria surrounding AIDS.*

The Presbyterian Church officially welcomes homosexuals as members but tries to change them. Meanwhile, they must remain celibate. "But that's exclusive. We don't ask that of anyone else," argues Trilla Jentsch, church administrator at San Francisco's Seventh Avenue Presbyterian Church, which accepts self-affirming homosexuals as full members. The San Francisco Presbytery is now challenging the denomination's prohibition against ordaining self-avowed homosexuals. Jentsch attributes homophobia in the church to the fact that most people, unaware of gays in their midst, have not had to deal with them on a personal level. But, in many cases, AIDS has changed all that. "When you see our choir director literally fade away from this life," she says, holding back tears, "it's been a day-to-day enlightenment."

The United Church of Christ is the only mainstream

church that has passed a resolution saying practicing homosexuals can be ordained. That resolution, which again originated from San Francisco, met approval from the general synod in 1983. Each local church, however, has the final say on whom to accept for ordination, and congregational votes can be more restrictive than the general synod.

But Jim Lawer is living proof of at least one congregation's reconciliation with homosexuality as a result of the AIDS crisis. After he had been graduated from Berkeley's Pacific School of Religion two years ago, Lawer was denied ministries in two congregations because he had admitted to being gay. In January 1986 he became the first AIDS minister for the United Church of Christ. He was ordained in September at the First Congregational Church of Berkeley, which previously had declined to sponsor his ordination. "The AIDS



ministry made it possible for me to be ordained," reports an ecstatic Lawer. "I'd been pushing for ordination, and with AIDS, they felt there couldn't be a better fit."

One of his first duties was to preach to a suburban Fremont congregation sponsoring a forum on AIDS. "They heard me talk about gay relationships in a Christian context, and they were very receptive," he says. "I'm personally finding a whole lot more acceptance than I ever thought I would within any of the U.C.C. congregations. There are always issues of homophobia, but reconciliation is happening."

Lawer believes full acceptance of gays into the churches can heal psychological wounds inflicted against gays long before the onset of AIDS. "When I think of healing," he says, "I think of a movement toward wholeness, which means loving and accepting oneself and one's relation to nature and to God. Gay people accepting themselves means knowing we're part of everything and that we're OK."

Many religious and gay leaders have concluded that churches, by alienating gay members and discouraging gay relationships, have actually promoted the promiscuity they officially condemn. "Where love is repressed, lust will enter," says Weston Milliken, chair of the Parsonage. "The church needs to create positive avenues for the expression of the love of gay men and lesbians." Modern gay ghettos, he believes, "compensate for the low self-esteem resulting from exclusion."

Changes in pastoral practices and theological attitudes as a result of disease has precedent in American religious history. When cholera first reached epidemic proportions in the United States in the nineteenth century, no one suspected it was caused by filth and unsanitary water and sewage systems. Ministers in 1832 urged morality upon their congregations as a guarantor of health, wrote Charles Rosenberg in *The Cholera Years* (1962). By 1866, however, "ministers were endorsing sanitary reform as a necessary prerequisite to moral im-

*AIDS healing service  
cosponsored by the  
Interfaith Network and  
the Foursquare Church.  
"From the suffering of  
people with AIDS, we're  
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other more intently than  
ever before. There's a  
tremendous healing at a  
community level and  
for many, many individ-  
uals" (David Hummel,  
codirector, Interfaith  
Network).*





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provement. There could be no public virtue without public health." Similarly, some ministers today suggest that a psychologically unhealthful environment could be at the heart of the AIDS crisis. They endorse liturgical reform and a blessing on homosexual partnerships as a necessary social support system for responsible, loving, and committed gay couples. San Francisco religious groups herald such a shift in moral perspectives that, if emulated, might ultimately allow this nation not only to combat the AIDS epidemic effectively but to heal centuries-old wounds inflicted by an exclusivistic theology.

**M**other Teresa of Calcutta, winner of the 1979 Nobel Peace Prize for her work with the poor, focused on AIDS patients when she spoke to San Francisco Bay Area audiences in June. She said poverty in the West is much harder to solve than in India, because poverty in the West often comes in the form of people who are unwanted, who "hunger for love." The Missionaries of Charity, an order of Catholic nuns founded by Mother Teresa, operates a fifteen-bed home for AIDS patients in New York City. She said the love of the sisters has completely changed the lives of the patients. "There is a wonderful change in their eyes because somebody wants them, somebody loves them." In the United States, she added, "loneliness is a much greater disease than cancer."

From his own experiences, A. J. Williams, a forty-year-old gay man from Berkeley who has ARC, shares how loneliness breeds disease. "Gay men go running to the back rooms of bars not because they're wicked, but because they're desperate for affection and don't know how to find it except for the superficial symbols of it." Williams, who was raised in the black ghettos of Oakland, sees more than an epidemiological link between gay men and intravenous drug abusers. "Drugs are all about alienation, about people who don't fit in, people who are desperate to escape. Are we in this society slowly killing ourselves from alienation? The question is not just AIDS, but how do we give meaning back to our lives so there's less of a need to escape, whether to sex or to drugs?" To Williams, the recent Supreme Court decision upholding a Georgia law against "sodomy" is not the answer. "At a time when people are suffering from loneliness and alienation, they dare pass a law condemning what goes on between two consenting people who are trying to love each other."

Yet he has not given up hope. "With the entire gay community struggling so hard now, perhaps that's one way for it to discover how to love itself." The religious community also has been struggling, and national religious groups have begun to follow San Francisco's lead in fighting AIDS. If medical societies and federal agencies follow suit, there is room for hope that the gay community will not have to learn to love itself alone.☸

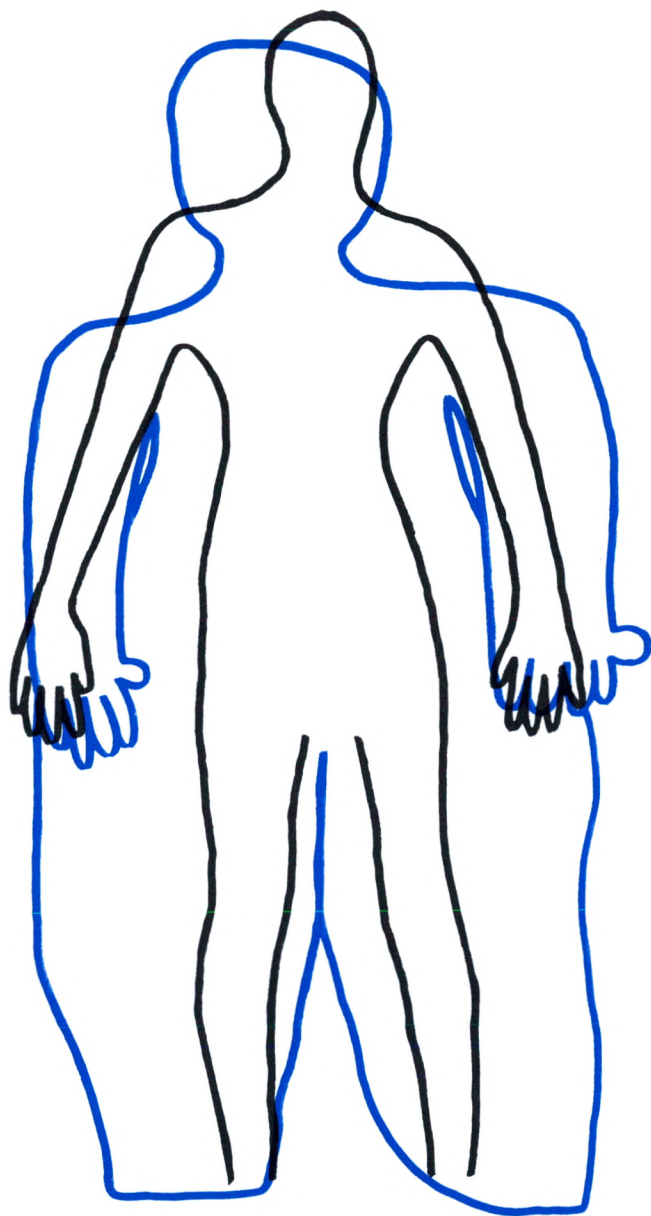
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# The Other Anorectics

MAKING ITS PRESENCE increasingly and disturbingly felt in the U.S. and other Western countries today is a disorder whose origins are almost as elusive as those of cancer, and whose prognosis for some individuals is equally as gloomy: anorexia nervosa and its related eating disorder, bulimia. Termed *anorexia* (from the Greek, "loss of appetite") *nervosa* by the Englishman Sir William Gull in 1874, the designation is actually a misnomer; there is no real loss of appetite among its victims. Indeed, while they are starving themselves, they are constantly obsessed with food. But because the appellation is in such widespread use, it is unlikely to change, and it is uniformly accepted by health care professionals.

Most experts affirm that at least one American female in two hundred develops some form of anorexia,



*The difference between perceived and actual body size graphically illustrates the anorexic patient's body image misperceptions (these drawings are reduced from life size). The outline in blue is a fifteen-year-old's drawing of the size she believed herself to be; the black outline is the result when she stood against a wall and had a fellow patient trace the outline of her body. Therapists report that photographs and mirrors aren't convincing to the anorexic patient—only when the outline is traced on paper can they recognize how thin they are.*



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generally between the ages of twelve and eighteen (National Institute of Child Health and Human Development 1983); others insist that the figure is much higher. All agree that the number is rising—as is media coverage of the condition. No month goes by without an anorexia article in a professional journal, a Sunday newspaper, a women's magazine, or a teenage fashion publication.

Despite this increase in incidence and coverage, however, anorexia is little understood either by laypeople or, for that matter, by specialists; it remains mysterious. People claim that they cannot bear to look at an eighty-pound anorectic, and yet there is a fascination, too, in regarding someone who clearly displays the potential for self-imposed death by starvation. Most specialists I talked with agree that some 5 percent of anorectics do in fact die in this way, or from such a cause as electrolyte imbalance leading to heart failure. This figure, however, is an improvement over the earlier one they cite of approximately 15 percent deaths, and indicates an advance in the ability to care for anorexia victims.

Anorexia is regularly portrayed as a condition of teenage girls or young women, and these do make up the vast majority of patients. Two significant anorexic minorities, however, are generally ignored in the literature and often by the health care profession; these subgroups are men and older women. The reason for lack of attention to these populations is the smallness of their size, which to many professionals renders them insignificant. In a number of ways, both emotional and circumstantial, the two groups depart from the majority, and some of their special needs are not consistently addressed in the available treatment programs. The purpose of this article is to draw attention to the problems of these atypical anorectics, thereby filling in some of the gaps that exist in the public's knowledge of anorex-

ia. Research for the project included interviews with ten eating-disorders victims, of various ages, and with some twenty-five professionals who deal with the problem—physicians, therapists, social workers, and administrators.



The number of female anorectics over twenty-five is estimated at between 14 and 30 percent (Eckert 1985:14). (Canadian researchers David Garner and Paul Garfinkel report that in their ongoing examination of anorectics since 1976, besides an increase in the number of victims there have been noticeable increases in age of onset

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***Two significant anorectic minorities are generally ignored in the literature and often by the health care profession: men and older women.***

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[Garner, Garfinkel, and Olmstead 1983:67].) The number of males is calculated to be about 5 percent of the entire anorexic population, although some practitioners guess that there are far more. Arnold Andersen, head of the eating disorders program at the Johns Hopkins University Medical Institutions in Baltimore, which has developed a reputation for its work with males, places the figure at approximately 10 percent. When the total number of anorectics is considered, these two groups add up to a significant number of individuals.

A number of quite specific factors are usually required for the diagnosis of anorexia, and these apply to the two subgroups as well. Anorexia can be precipitated either by almost total starvation (these victims are called "restricters" or "starvers") or by alternate denial and binging, usually on huge amounts of food, followed by

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purging through self-induced vomiting or the use of laxatives. The bingeing/purging behavior, bulimia (which can exist by itself without anorexia), often develops later than the original anorexic condition (and usually signals more difficult recovery). The traditional criteria for a diagnosis of anorexia nervosa are these:

- loss of at least 25 percent of body weight
- usual onset before age twenty-five
- distorted implacable attitude toward food, eating, and weight, accompanied by a totally unrealistic image of one's appearance (anorectics continue to think they are fat)
- no known medical illness that could account for the anorexia and weight loss
- at least two of the following manifestations: amenorrhoea (loss of menstrual periods), lanugo (fine downy hair over the body and face), and bradycardia (persistent resting pulse of 60 or less)
- periods of hyperactivity (often intense exercise)
- episodes of bulimic gorging
- vomiting

(Feighner et al. 1972:61)

The American Psychiatric Association has modified these long-accepted criteria to exclude a particular age of onset and to make the weight-loss percentage less specific, though some critics find the APA criteria still too restrictive (Eckert 1985:5). In addition to these traits, almost all anorectics have difficulty with some aspect of

their sexuality and generally lose interest in sexual activity.

Experts most often cite two categories of causes for this constellation of symptoms. First is a set of characteristics very commonly displayed by the families of anorectics; the individual realities, of course, vary from family to family. (Some specialists, for example, Elke Eckert, codirector of the eating disorders program at the University of Minnesota Medical School, argue that “there is no proof of family type” in contraction of the illness. Most patients may fit the standard criteria; some will not.) A family displaying some combination of the following features is labeled *anorectogenic*, that is, at least one member may become vulnerable to the illness. Most of these designations derive from the work of noted family therapist Salvador Minuchin, though others have added to or altered them:

- white; middle- or upper-class background (though both of these are changing). When food is scarce, psychological obsessions are rarely played out through its denial.
- perfectionistic goals communicated by at least one parent, with the child feeling that he or she is loved only for accomplishments, not for himself or herself.
- considerable family “enmeshment” (Minuchin’s term): closeness and interdependence to an excessive and unhealthy degree, yet without meaningful communication among members; as a result the child feels no sense of personal identity.



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- a particularly close and almost symbiotic relationship between mother and child. The mother is often an unfulfilled homemaker who has reluctantly given up a career to raise a family. As a result she is frequently hostile or depressed and looks to her children for an unusual degree of support; the anorexic child may see himself or herself as a caretaker responsible for the parents' happiness. The father, though he may be either domineering or passive, is typically removed from the family's main interactions.
  - some traumatic event affecting the family, such as the death of a close relative; the mother may "choose" for special attention the child who is, for whatever reason, most on her mind at the time of this event.
  - a family focus on food and eating, either condemning it or overconsuming.

Men and older women share both the symptoms and the family background characteristics with young females, although their manifestations may vary (for example, in men, certain hormonal changes take the place of amenorrhoea).

A second influential factor, one affecting primarily females (of all ages), is the current cultural focus on slenderness as the ideal feminine body type. This message is communicated constantly through advertising, diet articles, fashion displays, movies, and television. Through this virtually enslaving force, all women, not

just those developing eating disorders, are made to feel that their identity derives from their body's appearance: if they are not slender, and hence beautiful, they are failures. At least early in the illness, most anorexics like their emaciated condition; they do not believe they have

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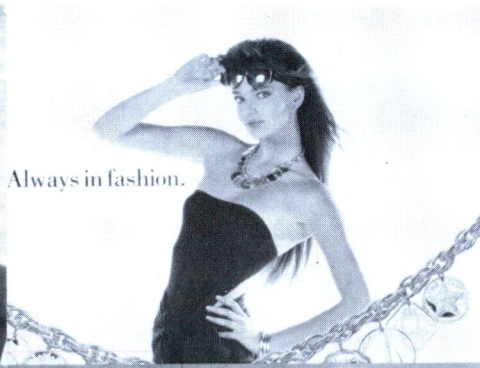
***Slenderness as the ideal feminine body type is constantly communicated through advertising, diet articles, fashion displays, movies, and television.***

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a problem; they get a "high" from dieting; and they think they look more and more attractive as they become thinner and thinner.

Men and older women share the behavior and traits of the dominant anorexic population, and the issues of the basic psychological disturbance are essentially the same for the subgroups as they are for the majority; it is the particular forms they assume that are different. Special concerns and anxieties also come into play. In the following narratives of two less typical anorexics, one older female and one male (also older), such concerns and anxieties will be obvious. In relating these brief biographies, I make no claim to depict the individuals as representative of even their own peer groups. Instead, they are described as persons whose life stories may be suggestive of the circumstances and difficulties encountered by others.





to-be-missed shades, not-to-be-missed shapes



Tight, whiteand, oh, so tight... the bodycon, opposite party. This one has a kaiser that snaps behind the neck, a provocative V back. To slide on over it is a fancy-bugging mini that snaps (and unsnaps) on one thigh. Bodycon, of cotton/Lycra, about \$65, and skirt, of cotton knit, about \$75, by Corinne Coleman. Sanford Hutton for Colors in Optics sunglasses. Go ahead and take the plunge! With its crisscross hair back and daring scoopneck front, the stretchy, saffron pink sundress, of cotton, is guaranteed to set his temperature soaring: Of cotton/vintage rib knit, by Iréna Grégory for Tehen, about \$68. Scooter, Paris earrings, about \$32. Hair, these pages, by Eyal for Bumble & Bumble; makeup by Joe McDevitt for Bumble & Bumble. For stores, see SHOP.

*This collage of models from an assortment of advertisements and fashion magazines is evidence of this society's preoccupation with thin as beautiful.*



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## ***Bernadette***

Having lost 12 pounds from her average of 78 this past summer during a visit with her family, thirty-six-year-old Bernadette is currently an inpatient in a clinic that treats both eating disorders and alcoholism, from which she has suffered for at least ten years (drug and alcohol abuse are not uncommon among anorexics). Her anorexia began when she was a very young teenager—around thirteen—and her first bulimic purge followed shortly thereafter.

A member of a military family that displayed many anorectogenic tendencies, Bernadette spent the first part of her childhood moving around in Europe; she returned to the U.S. when she was ten, only to resume the same itinerant lifestyle because of her father's job. Life in the States was traumatic and full of culture shock for the already somewhat withdrawn girl. Years before she had decided that the way best to please her parents was to be good and, above all, to remain quiet. Over the years she talked and related to others less and less, even though she was naturally inquisitive and highly intelligent.

Shortly after their return to the States, the father was sent to Korea. During that period Bernadette made her first of a number of suicide attempts—in this instance with kitchen gas. When asked now what prompted the action, she is not certain. Aside from being very lonely without her father (even though she actually saw very little of him because his work often took him away), she also felt that her action was somehow connected to a desire to ease her mother's unhappiness at the separation. When her mother returned home after Bernadette had been found on the floor and put to bed, she shook the girl awake demanding to know "how you could do this to me while your father's gone." Shortly after this incident Bernadette decided that, in addition to being too talkative, she was also too fat, although she had never had a weight problem. She began to throw food away or feed it to the dog.

The dieting may have been another means to win attention from her mother, a chronic dieter who was always

frustrated at being slightly overweight. Food was a tremendous focus in the family, with Bernadette and her sister never allowed snacks or "unhealthy" foods. Always the family disciplinarian, the mother was apparently loving, but demanding and firm; Bernadette was generally in awe of her. She did not work, and she seemed to enjoy the active social life of a colonel's wife.

The bright but unhappy teenager concentrated almost exclusively on her studies and did very well, winning a National Merit scholarship to the college of her choice. She selected one very close to home, although it is apparent that her life centered on school. During college Bernadette developed a relationship with "the only boyfriend I've ever really had." Never previously able to eat with other people, she found that she could do so with him, even in a restaurant. She was thrilled with the connection, so much so that she became quite possessive. As a result, the romance ended abruptly, and since then Bernadette has focused all her energy on work and avoiding food.

Although Bernadette had heard of anorexia, it was not until graduate school that she became aware she might have an illness. However, losing weight gave her such a needed sense of control that she never sought help. Indeed, it was fourteen years, a period including various hospitalizations and suicide attempts, before Bernadette's family would acknowledge her illness or discuss it. In the meantime, she had developed a pattern that has since characterized her life: not eating at all during the day, then after 8:00 p.m. preparing food which she eats ritually, always while reading, and then purges. This behavior is accompanied by increasingly heavy drinking. She maintained this pattern through the stresses of graduate school, closeting herself in her room and developing no relationships with other students. Once extremely athletic, as are many anorexics, she became so thin and weak that she could do only "head work." Even in this area her performance was not living up to her earlier accomplishments, presumably because the lack of nourishment affected her thinking and concentration.

Bernadette also began to steal food from grocery stores,



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even when she had the money to purchase it (another rather common compulsive behavior among anorectics). She has also stolen drugs—sometimes not knowing their identities—from other hospital patients on psychiatric wards. She was caught several times taking food, but a particularly humiliating experience drove her to seek out her pastor, whom she much admired, and to confess at least two of her problems: the stealing and the drinking. It was not difficult for him to perceive others; he suggested that she see a psychiatrist and helped her find one, whom she has been seeing for several years. During that time she has had tremendous ups and downs with her illness and has been in and out of the hospital for both physical and emotional treatment. She left graduate school after her last suicide attempt, which required several surgeries for stomach injuries resulting from gunshot wounds. Since then she has had severe problems digesting what little food she does eat.

After her physical recovery, Bernadette resumed her isolated life. In the evenings she carried out her purgation rituals, which sometimes occurred even between courses of her meal. Despite her renewed entrapment in anorexic behavior, she took a job. Her health extensively impaired, she was sometimes so weak that she could do little more than sit at her desk to work, occasionally fainting, and often experiencing acute stomach pains. Nevertheless, she struggled on until the crisis weight loss of this past summer.

Somehow frightened by this experience more than by any previous one, Bernadette entered an extended inpatient treatment program. She had some trouble with its more directive aspects, which made her feel less than adult. By the same token, she was not always able to adhere closely to the program rules, falling prey to some purging behavior as well as secreting away portions of her food instead of eating it. As a result, she gained very little weight in the center. Although the staff has advised continued long-term treatment, her next move is uncertain.



Several unique aspects of Bernadette's condition arise from the fact that she is older than the average anorectic. She has suffered from her illness for so long that neither her body nor her mind adapts easily to suggested changes in eating patterns. Because of all the stomach trouble she has had, it is difficult for her system to absorb nutrients. And she has now been weak for so many years that she cannot manage normal physical activities like carrying a small package for several blocks. Finally, her teeth are in very poor condition after years of acidic purging.

Bernadette is also limited by other circumstances common to older patients. For example, she pays rent for an apartment, though it is not being used while she is an inpatient. Though she is single, other older, married anorectics may have children and feel tremendous guilt at leaving them for long. An additional emotional burden is placed on older patients who are likely to feel that life is passing too quickly; they are often desperate to get well while they "still have a chance." Bernadette looks on her current treatment as her "last opportunity." This tension and impatience may actually make a patient less susceptible to therapeutic measures.


Bernadette finds being away from work and the few other dependable support structures in her life (such as church) to be terribly threatening. She cannot believe that her colleagues at work will want her back. And though her pastor has been very supportive and has provided valuable counseling, and though he stays in frequent contact, the church is not close to the treatment center, and Bernadette worries about being forgotten. She has an acute case of what Regina Casper, director of the Eating Disorders Research and Treatment Program at Chicago's Michael Reese Hospital, calls "rejection sensitivity"—which is very common among anorectics.

While Bernadette has been a chronic anorectic,

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others in her general age group suffer from *anorexia tardive*, or late-onset anorexia (see, for example, Dally 1984). British researchers J. Kellett, M. Trimble, and A. Thorley present a case of a fifty-four-year-old postmenopausal widow of eight years who became anorexic when her children began leaving home to marry. During a hospitalization the woman talked constantly about two topics: her dead husband and her fear of being too fat. It is clear that she had derived her identity and feelings of self-worth from her role as wife and mother. When the centrality of this role faded from her life, she began to feel a loss of control and, as most anorexics do, grasped desperately for the only other sort of discipline that seemed possible: command of her own body (1976:555–58).

One problem for women in their forties or fifties is that because they, like everyone else, assume that anorexia is a young girl's condition, they may be hesitant or unwilling to report their symptoms to anyone who could help. Considerably older women—and some in their sixties or seventies are known to develop the illness, though they must be distinguished from persons who stop eating for other reasons, as many elderly people do—may also be less aware of the publicity given the illness in recent years. Like those who suffered from anorexia before it was much studied, they may have no idea what they are experiencing, making their already fear-filled lives even more difficult to bear.



## **Martin**

Martin is a thirty-eight-year-old recent-onset anorectic. The eldest of four sons, he, like Bernadette, comes from a family that exhibits anorectogenic characteristics. His father, a quiet man, suffered from a serious lack of self-confidence. The mother, having grown up in a broken home, did not want her own marriage to be vulnerable to that possibility, so gave up a promising career to be a homemaker. She was always subject to bouts of depression, and the entire family, except for Martin, experienced continual problems with obesity. Food was of exaggerated concern, with, as Martin says, the “neurotic behavior of choice being to gorge oneself.” Martin became somewhat of a caretaker for his family, watching over his younger brothers as well as his parents. Like his father, he always had low self-esteem, but he fought the feeling by being extremely achievement oriented, an attitude that was particularly encouraged by his mother.

Martin's strong drive to care for people influenced his college and graduate studies and his choice of a career in church ministry. He soon developed a reputation as a creative preacher and church leader. He also married young and had two sons (now in high school). Martin's wife had dropped out of college to marry, and for most of the early years of their life together she did not work.

About five years ago, when Martin was thirty-three, a number of significant changes began taking place in his life. First, the members of his parish seemed to be taking less and less interest in his ideas for creative worship. At the same time, his wife decided to return to school, so while she attended classes he took on more of the household and childrearing responsibilities in addition to a punishingly heavy church schedule (50 to 60 hours weekly, some of it self-determined by his perfectionism). Upon completion of her degree, Martin's wife began working nights, which introduced a number of difficulties into their relationship. Near that time Martin applied for a job at one of the most prestigious churches in his denomination and was rejected.



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Feeling that he was burned out in his present situation, Martin decided to refocus his goals. He applied to a Ph.D. program at an eminent university in a distant state and was accepted. However, the family seemed to him opposed to the idea of being uprooted, and he dropped the idea with very little discussion. (Looking back, he now says the opposition may not have been so clear, and that it is possible he never expressed how much this program meant to him.)

Perhaps as a symbol of starting over together again where they were already located, Martin and his wife decided to buy a new house in the same area. They were having poor luck in their search, and one day Martin decided he would go looking alone—and that until he found a suitable house, he would not eat. This was the immediate precipitating event of his anorexia.

Because he was feeling under so much pressure at work and was still upset at the sequence of recent events, Martin decided to try a new release from his tensions: running. The first time he attempted it he could not even run around the

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***Male anorectics are often even more reluctant than are older women to seek treatment.***

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block, but before long he was running up to 100 miles a week. One unexpected result was that though he did not need to, and had not planned to, he began to lose weight. At 6'2" and 165 pounds, he was already fairly slim, but losing the weight started to feel as good to him as did the running. Soon the process of self-denial and intense self-exertion took on a life of its own, and, observes Martin, became "like a snowball rushing down a mountain," gathering both size and momentum.

Martin obviously felt that as other former certainties in his life began to unravel, he could regain his former control in at least this one area: his body and its behavior. Martin became a restrictor anorectic, and as he continued to run ever greater distances, he drastically curtailed his food intake, sometimes eating nothing for days. At the same time, he engaged in the

typical anorexic behavior of carefully preparing food for his family, but never consuming what he cooked.

Martin's social life became increasingly difficult; he could not eat with friends, except perhaps for a salad. His weight eventually dropped to 115 pounds. Family and those close to him were constantly worried, but they did not know what was wrong with him—nor did he. They pressed him to seek treatment, and finally he reluctantly arranged some appointments with a clinical pastoral counselor who, though holding a Ph.D. in psychology, did not recognize his symptoms. Martin found these visits unsatisfying and soon ended them.

Later he saw a behavioral therapist who helped him with projects like diet plans and specific weight goals. In their conversations, Martin reports, the therapist asked him inappropriate and discouraging questions such as "Why can't you just control these symptoms?" Finally, again at the insistent urging of his family, Martin entered the hospital, where he stayed for 3½ weeks—a very short period for anorexia treatment, which usually averages three to six months. Under staff supervision he gained some weight and was seeing a therapist several times a week. However, when he left the hospital, the planned after-treatment never materialized because the same hospital therapist, whom he was supposed to continue seeing, paradoxically had no outpatient appointments available. Martin tried to keep up on his own, but the Christmas season was approaching—the most tension-filled time of year for any minister. Under the stress of preparing sermons and special programs, he reverted to his former unhealthy behavior.

With his family, Martin later investigated other inpatient treatment possibilities, but the hospital he visited told him that a stay would have to last at least four to six months. This was a horrifying possibility to him, and he declined to enter. "Muddling through," as he puts it, Martin was not prepared some months later when his wife suddenly requested a separation, informing him that she simply could no longer deal with the stress his eating disorder was causing the family.

Though shocked at the time, Martin acceded to her wishes and found a nearby apartment. The trial separation lasted two months, during which he alternately experienced



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severe depressions and feelings of liberation, as some of the oppressive forces represented by his family—his compulsion to be a caretaker, for instance—were temporarily alleviated. When Martin and his wife decided to resume living together, they both agreed that she could no longer worry about “saving” him; he would have to save himself. This lifted some of the tension from their relationship, which was improving.

However, soon thereafter, Martin’s insurance ran out, and he does not see how he can afford the therapy bills on his own. He is hoping to find a clinic with a sliding scale.

Martin’s weight is still dangerously low. Some days he feels fairly successful in his efforts to fight his illness; other days are intensely dark, and at such times he feels totally alone, helpless, desperate, and suicidal. He is very aware of his compulsions, but because they are just that he has been able to do little to tame them. As he concludes his story he is very quiet, and then says, almost in a whisper: “I used to pray for a miracle cure. It’s been awhile since I’ve had that kind of prayer; my prayer lately has been just to live long enough to get better.”



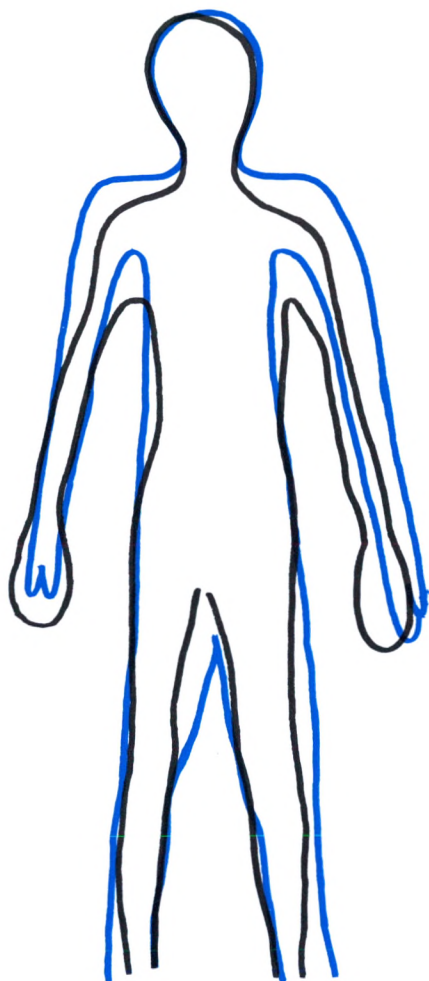
Male anorectics are often even more reluctant than are older women to seek treatment. Because society regards anorexia as a female condition, males who suffer from it report a feeling of overwhelming shame. In a study of ten male anorectics, researchers report that “no patient came on his own initiative to seek psychiatric help, and most consulted a doctor only under considerable family pressure” (Hasan and Tibbetts 1977). This is one reason some specialists believe there are far more male anorectics than have been documented; they exist, but they do not come forward. Others think the death rate may be higher among men than we know, for it may never be discovered that a heart attack, for instance, was actually anorexia-related.

Even if a male sufferer seeks aid, the correct diagnosis of his problem may be delayed. Because doctors do not look for anorexia in a male, he may be told that he is suffering from an ulcer or some other gastrointestinal trouble that is causing loss of appetite. The same phenomenon may hold true in efforts to trace the etiology of his illness; specialists, who often stress mother-daughter conflicts, may not know how to translate these principles to males. In addition, little case literature is available for the therapist to study, so he or she may have trouble finding paradigms that could be helpful in making treatment suggestions.

In addition, male anorectics may escape notice more readily than their female counterparts because thinness (like extra weight) seems somehow less noticeable in males. For one thing, their limbs are usually covered with shirt and slacks, which hide bones better than do skirts. Men’s coarser skin and beards can obscure some of the facial characteristics of anorexia—for example, translucent or dry skin, sunken eyes, and the growth of fine body hair. Even the short hairstyles men wear better disguise the dry and brittle, or lanky, hair that often accompanies the illness.

It is odd that on the one hand some practitioners say there are too few male anorectics to pay attention to, while on the other, different practitioners are pointing to male (and female) distance runners as almost the archetypal anorectic personality. And although all the experts argue that there is not the same emphasis in our society for men to be thin as there is for women, I would argue that there is at least some movement in that direction. In addition to the exercise craze and the emphasis on lighter foods, the prominence of tall, slender male models in such style-conscious publications as *Esquire* and *Gentleman’s Quarterly* illustrates the trend.





*Bernadette's outlines indicate that her perception of her body size (in blue, here reduced from life size) approximates her real size (in black). While there is still some disparity, particularly in the shoulder area, Bernadette has made great progress in perceiving her body image. Her original drawings were grossly distorted.*

Most experts agree that male anorectics, like females, have persistent problems with sex and sexuality; as noted, at the very least most anorexia sufferers lose their interest in sexual activity. (Many boys, like girls, begin to have anorectic symptoms at puberty; older men sometimes when they become fathers or when marital trouble arises.) Some years ago a number of specialists, even the highly regarded British researcher Arthur Crisp, suggested that most men with anorexia are homosexuals or at least have such tendencies (Crisp 1970:452). This generalization became common, though it was disputed by other experts and by male anorectics themselves. According to Daryll Pure, a psychologist in private practice and hospital consultation in Chicago, of the six male anorectics he has treated in recent years, two were gay, although all had unresolved confusion regarding sex or sexual identity or both. And Arnold Andersen of Johns Hopkins remarks that while his male patients are often unresolved over *general* sexual issues, only a minority have been homosexuals; this trait, he argues, is definitely "not an essential feature" of anorexia nervosa. Unfortunately, however, the early stereotype persists, giving rise to misleading generalizations. In addition, physicians or therapists with strong prejudices against gays may resist acknowledging or treating male anorectics if they presume them all to share this sexual orientation.



Bernadette and Martin are examples of atypical anorectics. With a view toward understanding how they feel about their relatively unusual circumstances and the treatment they have received, it will first be helpful to introduce a brief, hence necessarily simplistic, look at some of the more prevalent treatment models being

used today in hospitals and clinics or by individual practitioners. At the outset it is crucial to note that, while various therapists support one or another treatment mode, it is almost universally agreed that there is no one absolutely “right” or uniformly successful way of dealing with anorexia; in fact, most professionals, even if they defend a particular method, use an eclectic collection of principles and practices in their therapy procedures. Anorexia is a tremendously complex constellation of symptoms, and it is stubbornly unyielding to treatment. Most specialists are grateful for anything that seems to work.

For the most part, treatment for anorexia involves two aspects: attention to the patient’s physical health, especially if a dangerously low weight has been attained, and focus on his or her mental and emotional state and its possible causes. Some treatment methods ignore causes, while, conversely, some particularly conservative analytic models tend to ignore the physical conditions, on the hypothesis that these will improve as insight is forthcoming.

Most therapy with anorectics has a psychodynamic configuration; that is, it involves acknowledging mental and emotional forces developing during childhood and affecting later behavior. However, because of the illness’s unusual rigidity and resistance, relatively few specialists employ the most conservative analytic modes. At the time of her recent death, Hilde Bruch, then emeritus professor of psychiatry at Baylor University, was the dean of American experts on the condition. She rejected “outmoded concepts of psychoanalytic treatment” in which therapists “stress the symbolic meaning of the noneating and the underlying unconscious meaning to the patient.” According to Bruch, “giving interpretations” contradicts the proper goal of therapy because the therapist appears as a “non-receptive authority who

dispenses his or her own views” (1978:123). Bruch also advocated informing patients of treatment goals rather than keeping them in a state of anxiety and confusion about what to expect (many adult patients complain that their therapists do not so inform them).

According to Alan Goodsitt, a Chicago psychiatrist in private practice and on staff at Northwestern Memorial and Michael Reese hospitals, Bruch was “ahead of her time”—a “self psychologist before the field of self



*“Transcendent Self,” a drawing rendered by Bernadette in art therapy during one of her hospitalizations. Asked to illustrate her feelings about herself, she seems to indicate a sense of being trapped within her own body.*



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psychology was defined.” The concept of self psychology, developed largely by psychiatrist Heinz Kohut, posits that an illness like anorexia grows out of deficits in the experiences and identity of the patient. The task of the therapist is to help the individual fill in those deficits. As a practitioner of this theory, Goodsitt argues that the therapist must “take a position from within the patient,” becoming more involved and supportive than the traditional neutral therapist or analyst would do. He or she must avoid telling (or appearing to tell) the patient how to think; an anorectic is all too used to that.

Also influenced by self psychology is Steven Levenkron. In addition to his popular novel and television movie about a teenage anorectic, *The Best Little Girl in the World*, Levenkron, in private and hospital practice in New York City and Westchester County, has written *Treating and Overcoming Anorexia Nervosa*, in which he introduces a system called nurturant/authoritative therapy, designed to bypass the “neutral attitude on the part of the therapist.” The first goal of the method is to “regress” the patient—to “help [him or her] become younger and less mature,” hence paving the way for working through conflicts that arose early in life (1982:20–21). The nurturant aspect of this approach finds the therapist being much more directly supportive of the patient than in traditional psychotherapy, while at the same time the authoritative posture allows one firmly to direct and structure the course of treatment. An insecure patient needs both overt support and a strong, confident authority figure in whom to trust, remarks Levenkron, who is careful to point out that the nurturant and authoritative stances must always be balanced.

One method that many therapists use (in addition to whatever is their own basic technique) is family therapy, especially as developed by Salvador Minuchin

who, with his colleagues, produced the “family therapy Bible,” *Psychosomatic Families*. Although Minuchin is a family therapist, not an eating disorders specialist, this book, along with Bruch’s works, has influenced eating disorder treatment perhaps more than almost any other source. In Minuchin’s approach, “every human being’s identity depends, in large measure, on the validation of

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***Many specialists remark that anorectics are the most difficult cases they have ever worked with.***

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self by a reference group. . . . The family’s validation is vital for all family members but is particularly important for children who are undergoing the fluid process of identity formation” in their adolescent years (Minuchin, Rosman, and Baker 1978:52). Unfortunately, obstacles can arise when a family is confronted with its own unhealthy interactions; some members may balk at entering therapy, refusing to think they have a sick member, fearing confrontation with their own problems, or expressing our culture’s general bias against the idea of therapy.

Among other treatment models, behaviorism and pharmacological therapy are widely used though disputed by many in the field. Some clinicians use the behavioral approach exclusively; many others adapt elements of it in combination with additional perspectives. It seems to be most favored in the earlier stages of care for a hospitalized patient. Often a contract is made between staff and patient that he or she must gain a certain amount of weight per day. If the patient meets the goal, certain rewards are forthcoming, usually such privileges as watching television or making a phone call. By the same token, if he or she does not attain the target weight, the staff may use negative reinforcement—such



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as confinement to a certain area or prohibition of library or lounge use. In severe cases, if a patient has refused to eat at all (or has purged, hidden food, or drunk a great deal of water before weigh-in) a treatment team may decide to order intravenous or nasogastric tube feeding. The latter, especially, is an uncomfortable, humiliating process that will often convince a patient to eat—at least for awhile.

Some therapists do not believe such practices are successful in the long run. For example, Bruch cited cases of clients coming to her after disastrous failures with behavioral therapy, including the development of new, more serious symptoms. However, the main objec-

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***At least one American female in two hundred develops some form of anorexia, generally between the ages of twelve and eighteen.***

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tion of critics is usually the use of the technique *by itself*, with no accompanying attention to causes and development of the illness.

Some clinicians also question treatment by pharmacological therapy when it is used alone or with little back-up; they are skeptical about how the patient will fare once off the drug. However, supporters of the technique frequently hypothesize an organic component to the illness, which makes physical treatment seem more appropriate. Several drugs have been introduced as potentially beneficial in treating anorexia, but none has yet proven consistently reliable over time. Recently the greatest attention has been paid to the tricyclic antidepressants: amitriptyline, chloripramine, and imipramine—powerful psychotropic substances that must be prescribed with care and then monitored for such potential side effects as dizziness or disorienta-

tion. In any case, these drugs have been more successful with bulimics than with restrictor anorectics (see, for example, Pope and Hudson 1984).

Controversial, too, though more for its philosophical basis than for its results is the relatively new feminist approach advocated by a number of female therapists, among whom the best-known is British psychotherapist Susie Orbach, author of the popular *Fat Is a Feminist Issue I and II*. In her most recent book, *Hunger Strike* (1986), she spells out an exhaustive historical and theoretical rationale for a feminist interpretation and treatment of anorexia. She argues that our culture denies women the opportunity to develop personally in the ways that men do and that they are instead subjugated to seeking identity through their physical appearance.

Because anorectic women feel particularly oppressed, Orbach stresses letting them take as much responsibility in therapy as possible, and one aspect of her technique is direct, protracted discussion with the patient of her eating behavior and attitudes toward food. Together the therapist and the patient slowly “live through” eating and purging experiences to determine exactly how those events feel and what they mean to the patient.

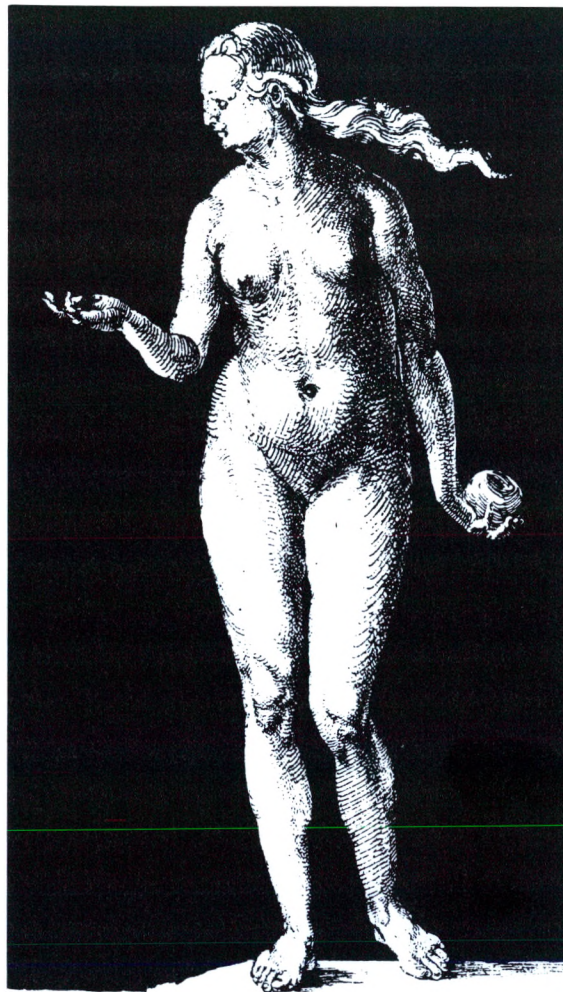
Orbach believes that hospital programs need not be coercive; she suggests involving recovered anorectics as advisors and conducting a self-examination by staff to determine their own attitudes toward food, slimness, and femininity. As she notes, many medical personnel themselves have a problem with food, just as does the population at large, and they need to be sure that they are neither secretly envying the patient’s thinness nor adopting a superior stance. (Mary Kay Kramer, coordinator of Chicago’s Loyola University Hospital eating disorders program, comments on the large number of medical students who come to her seeking counseling



for anorexia or bulimia.) In general, Orbach places such great emphasis on the societal subjugation of women, particularly the emphasis on body shape as identity, that the other factors leading to an eating disorder tend to disappear from her purview.

Yet another debated therapeutic technique, used rarely because of the special skill required of the therapist, is hypnosis. One practitioner of this method is Donald Keppner of Athens, Georgia. Most of Keppner's patients come to him from out of state, and what is most unusual about his plan is that they receive only three days of intensive treatment. In hypnotic trance they regress to stages of trauma and, with the therapist's guidance, attempt to work through them. Keppner also practices "in-vivo extinction" during the short period: eliciting the emotions and urges identified with food but not allowing the patient then to engage in the habitual maladaptive behavior. At home, the client builds on both experiences through the use of tapes and post-hypnotic suggestion, perhaps returning later for another brief period of treatment. Keppner also advises that simultaneous psychotherapy be conducted wherever the patient lives.

A small number of therapy centers use a model based on principles originating with the Alcoholics Anonymous and Overeaters Anonymous (AA/OA) organizations. Perhaps one of the most controversial programs of all, it insists that anorexia and other eating disorders are diseases like cancer or pneumonia and that they can be treated without resorting to underlying emotional sources. Gail Canning, program manager at Parkside Lutheran Hospital near Chicago (other centers are in Wisconsin, Florida, and California), describes the system, which treats eating disorders victims who are also either alcoholics or substance abusers. Through a variety of individual and group experiences (with a

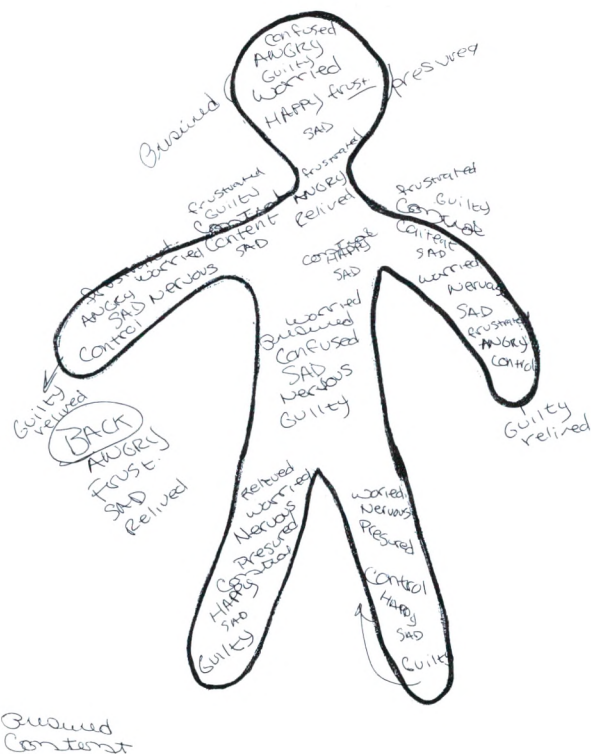


*Not every age and culture has admired slimness as a crucial element of ideal feminine beauty. For example, Dürer's preliminary drawing of an "idealistic female figure" for his engraving Adam and Eve (1504) depicts a more robust image of womanly beauty.*

stress on the latter), anorectics, bulimics, and others are educated in the “twelve steps” toward recovery. These include an emphasis on a “spiritual awakening” and a belief that “a Power greater than ourselves could restore us to sanity.” When possible, the family or the employer is brought into the program for participation, but the most effective aspect of the AA/OA system seems to be the group peer pressure and support of the other patients. After discharge, clients are urged to attend meetings of these groups (and to be part of other organized after-care events).

Many specialists, regardless of which therapeutic technique they favor, remark that anorectics are the most difficult cases they have ever worked with. However, most practitioners also claim to have helped clients, and they are often very protective of their particular method. John A. Atchley, president of the American Anorexia/Bulimia Association and a professor of psychiatry at Columbia University, remarks that even the nation’s several large service organizations for eating disorders have not been able successfully to merge their efforts. Presumably, as in any field, there is jealousy of “turf” and leadership, giving rise to separate, though often parallel, research and support activities.

Of the above-mentioned modes, Bernadette has at one time or another been treated in all but hypnosis and feminist therapy; Martin, in all but hypnosis, feminist therapy, and the AA/OA model. Both report ways in which their needs have been ignored by the emphases of their treatments. For example, they consistently voiced complaints about how hospital or clinic staff related to them. They criticized the standardization of care for all patients using a model based on the needs and traits of teenagers. Bernadette told of a leveling out of individuals on her inpatient unit, where she was considered overly intellectual and was admonished by staff members to simplify her speech. Martin agreed but also



*In this exercise, the therapist gives anorexic patients identical stylized body outlines and a list of words describing various feelings. Patients are asked to use those words to label the parts of the body where they experience particular feelings. According to the therapist, many anorectics tend to associate negative feelings with the particular body areas—especially the stomach and thighs—where they feel the fattest.*



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commented on the inability of some physicians to accept that a bright, accomplished, and articulate adult might be suffering emotional distress and need individualized attention. Becoming frustrated with this approach, he checked himself out of the hospital before the suggested time was up. One wonders, too, whether treatment teams might make this situation worse by unconsciously preferring to treat young, completely dependent patients who may be more easily directed than a highly verbal adult who has strong opinions despite his illness. Treating a thirty-eight-year-old requires more of a give-and-take relationship of equals than most therapists are used to initiating with their young patients.

If a program involves group therapy, as many do, an older patient may feel uncomfortable, points out Randall Flanery, director of the eating disorders program at Lutheran General Hospital in Park Ridge, Illinois; he or she will want to bring up concerns about spouse, children, or job. This is not to say that such persons cannot relate to teenage or college-age patients in groups; rather, it is to suggest that older patients may get less from the group than they could. In fact, says Flanery, such patients may need special attention to the “double whammy” they may be suffering: two families to deal with—their own parents and their marriage family. They may be caught in the desperate situation of feeling a need to make everyone in both families happy and not knowing how.

From a purely practical point of view, older persons may have more insurance worries than do dependent adolescents. Because the insurance of older persons is probably through the place of employment, their care will not be paid for if they leave their jobs, whereas a teenager’s coverage presumably comes through the family. The “halfway house” situations sometimes recommended for adults after inpatient treatment are

not covered by insurance. In fact, some insurance companies do not cover psychological treatment at all, and the many that do may limit strictly the amount of coverage. Stories have been recorded of families or individuals losing all their savings and even their homes in order to pay uncovered hospital bills. Equally tragic is the necessity for some patients to leave treatment early, as in Martin’s case, because their insurance has run out; the low self-esteem of anorexics often causes them to feel that their problems are not worth spending money on.

Another problem for older patients, whether in or out of the hospital, according to analyst Pieter de Vryer of Evanston, Illinois, is that if they have suffered from the illness for a considerable time, they run the risk of becoming “professional patients”—chronic anorexics. Their identity, according to de Vryer, is in their *being* an anorectic. Thus treatment may be particularly difficult as

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***Attention could be profitably given to the role of the basic concepts of grace and forgiveness, and to the ways in which anorexics may fail to apply these concepts to themselves.***

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both the therapist and the patient attempt to break through walls that have grown thick and strong through years of aberrant behavior.

Even as older patients are more entrenched in their illness, they are, remarks Steven Levenkron, ashamed to have had it for so long. Generally, if they experienced an early onset of illness, they are no longer in a stage of denying that anything is wrong. They know it full well, and they suffer all the more for the realization. And late-onset (tardive) adults experience just the opposite syndrome, nearly as devastating, asking themselves guiltily, How could I contract anything like this at my age?



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One particularly interesting frustration arose repeatedly among adult patients when I explained my project and the nature of this publication as a journal of “health, faith, and ethics”: their therapists’ lack of attention to their religious inclinations. For an individual who has a strong belief system, it will be important to discuss in therapy how that system has helped or not helped in the person’s illness. For one who is seeking to affirm faith, the therapist could assume an enabling role in helping the patient to sort out spiritual questions as they relate to the other concerns of therapy. Indeed, some of the important religious questions involve definitions of self in relation to family, neighbor, the world community, and the spirit of life—the very areas in which the anorectic has special difficulty. Attention could be profitably given to the role of the basic concepts of grace and forgiveness, and to the ways in which anorexics may fail to apply these concepts to themselves. Though the degree of religious understanding exhibited by Bernadette and Martin may be unusual, their religious concern and desire to incorporate it into therapy is not.

Concerning the relationship of anorexia and religion, Regina Casper relates an extremely interesting development. A collaborative study funded by the National Institute of Mental Health evaluated 105 anorexic patients, resulting in an unexpected finding: religious beliefs indicated a positive prognosis. Casper comments that if patients can believe in something beyond themselves, they have a better chance than does an anorectic caught totally in an interior, egocentric world. She also relates, however, that when she presents this finding to a group of colleagues, they tend to respond with laughter. Is this response an example of psychology’s bias against religion? Perhaps. Or it may be a more ingenuous ignorance and self-consciousness on the part of these therapists, simply expressing their discomfort or lack of familiarity with religious concepts.

Certainly patients with other emotional illnesses would express similar dissatisfaction if their religious faith were ignored in therapy.

In contrast, most of the therapists I spoke with avowed that they would not ignore religious concerns if they seemed important to the patient. Thus there seems to be both inconsistency among professionals and a lack of parallel perception between patients and therapists on this matter. Perhaps the subject, while not being sup-

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pressed by the therapist, does not come up unless the patient articulates it. Or the therapist may fail to recognize subtle references to faith that, unless picked up, the patient might not continue to express.

Some therapies do consciously explore religious themes in treatment. One such program is offered by the Foundation for Religion and Mental Health, a religiously sponsored interfaith agency with thirteen outpatient centers in New York, New Jersey, and Connecticut. As described by therapist Barbara S. Nadel, the organization does not proselytize; rather, the staff is trained to “respond to religious faith in the interest of healing.” If a client has no religious interest, the subject plays no role in therapy. In addition to the therapist’s being able to discern what may be crucial elements of a client’s personality, such a system has another advantage: some persons needing help might never seek it in another setting. Nadel relates the example of the anorectic daughter of a fundamentalist Christian woman who was highly skeptical of therapy. She acknowledged that she would never



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have taken her daughter for help if the religious agency had not been available.

A therapist in private practice who espouses similar principles is Andrew Canale of Boston, who refers to himself as an “incarnational psychologist.” Canale finds his approach particularly suited to a condition such as anorexia, in which deeply rooted impulses are expressed so dramatically through the body. As he observes, “the body expresses problems of the soul,” and when people abuse their bodies they are asking the religious questions, Where do I belong? Where do I fit in? Canale stresses that he is not anti-biology or anti-psychology, but he argues that these disciplines alone do not capture the total picture of an illness. At the same time he is careful to emphasize that one can also be spiritually reductionistic, a danger as much to be eschewed as the avoidance of religious themes. He is heedful to take account of all three personal dimensions in his stratagem for wholistic healing.

Other therapeutic schemes also embrace religious principles—some of them the objects of extensive skepticism. For example, when ministers of a very conservative church, who often do not have training in clinical pastoral counseling, dispense advice according to literal biblical statements, the results may be adverse (witness the recent California case in which a couple sued their fundamentalist church when their son committed suicide following counseling sessions with a pastor). Specialized training is imperative in counseling for an emotional disturbance, particularly one as serious as anorexia.

So far the discussion has been of religious elements in the practice of therapy, but it is also provocative to consider what, if any, role—positive or negative—religion may play in the *genesis* of anorexia. Arthur Crisp introduces his standard text, *Anorexia Nervosa: Let Me Be*, with references to various religious traditions, focus-

ing on the practice of fasting in diverse cultures and times: “Throughout history, fasting has been recognized in some cultures as a weapon of personal or public protest” (1980:8). Crisp also comments on possible connections between current eating disorders in Western society and fasting associated with Christianity. As a way of purifying oneself, of conquering temptation, or of punishing oneself for sins committed, fasting and asceticism may for some anorectics be background elements in the encounter with the illness, especially for those who have a keenly developed religious sensibility and whose personal ethics derive from that awareness.

In her last suicide attempt, in which she shot herself in the stomach, Bernadette performed the act in a religiously ritual setting and manner, donning a new long nightgown and calmly, deliberately making her preparations. Likewise, drawings that she created in art therapy while hospitalized are replete with religious imagery; Bernadette herself is often pictured as a nun or a Mary-like figure, and spiritual symbols are juxtaposed with those of death.

In *Holy Anorexia* (1985), a book that has received both praise and criticism for its unusual thesis, historian Rudolph Bell reasons that a number of female Catholic saints during the Italian Middle Ages were “holy anorexics” who starved themselves, either to do penance or to purify themselves for a mystical union with Jesus. Some of the author’s arguments are provocative and could be useful in the study of contemporary anorexia nervosa (the second term of which is not part of the condition he describes). However, while it is fascinating to speculate about precursor conditions to twentieth-century anorexia, as well as their possible causes, it is impossible to diagnose in retrospect. As Crisp suggests, there may be *implications* in Christian history for understanding the current conundrum, but actually to assume early cases of anorexia because certain women

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were not eating is risky; there were many other reasons religious people—saints, mystics, ascetics, hermits—did not eat. Also, Bell's contention that these women were attempting to rebel against and wrest control from the male church hierarchy does not seem well substantiated. In any case, the work exemplifies the necessity for further exploration of religiocultural elements in connection with anorexia.



One should not leave the topic of atypical anorexia without acknowledging that the position of the anorectic as victim is not without ambiguity—and more so for the member of a small subgroup. Individuals like Bernadette and Martin discover that they are unusual not only within the general population, but even within the cohort of their fellow patients. It is thus possible that despite their conscious desires, they may hold tightly to their unique position for whatever “status” or attention it affords them.

Family and friends witnessing such an attitude often

become less sympathetic, assuming that it is purposeful. However, the obstinacy and seeming selfishness are as much actual symptoms of the illness as is the non-eating itself. Although such an ironic situation may be terribly difficult to understand, it is vital that we do so. Otherwise we are liable to give up on such persons just when they need the most support—when their symptoms seem less those of a sick individual and more those of a willful egocentric. Certainly these anorectics need help in reality-testing to correct some of their perceptions in order that they contribute appropriately to their own healing. But it is also sadly true that, through none of their own doing, they do suffer painfully from the very fact of their uniqueness, regardless of the personal attitudes they project.

Anorexia nervosa is a dreadful illness under the best of circumstances. It is incumbent upon health care providers and upon the families and friends of atypical anorectics—ultimately, of course, upon society—to assure that these individuals suffer no more than the majority population of patients simply because they happen to be statistically less significant. ☸

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### ILLUSTRATIONS

P. 46, from Albert J. Stunkard, Thorkild Sorensen, and Fini Schulsinger, Use of the Danish Adoption Register for the Study of Obesity and Thinness, in Seymour S. Kety et al., eds., *The Genetics of Neurological and Psychiatric Disorders*, p. 119 (New York: Raven Press, 1983). Reprinted with permission.

# A Place for Madness?

## An Introductory Essay

*Poised over the motionless body of his patient, Dr. Martin Dysart stands with surgical pick in hand and momentous question in mind. He is about to put an end to Alan Strang's madness. But in doing so the psychiatrist finds himself unable to subdue his own torment. Dysart addresses his inert subject: "You won't gallop anymore Alan. Horses will be quite safe. You'll save your pennies every week, 'til you can change that scooter in for a car, and put the odd fifty P on the gee-gees, quite forgetting that they were ever anything more to you than bearers of little profits and little losses. You will, however, be without pain. Pause. But the huge question goes on vibrating. That voice of Equus out of the cave. 'Why Me? . . . Account for Me!'" (pp. 104–5).*

This scene, the creation of noted playwright Peter Shaffer, carries its viewers and readers into the presence of one of life's greatest riddles, madness. What is it? What causes it? How do we respond to it? The play from which this scene is taken, *Equus* (London: Andre Deutsch, 1973), lays bare a troublesome linkage—madness, religion, psychiatry, and human identity. In the story of an adolescent boy's agonizing and bloody experience with his transcendent horse-god and the parallel account of his therapist's anguished search for adequate responses, Shaffer has exposed a modern syndrome. In the nexus of the Strang-Dysart relationship, religious experience collides with scientific explanation at the same time that social expectations confront individual perceptions. From the center of that vortex comes one therapist's startling confession—is it on behalf of many?—"My profession is based on a total mystery! In an ultimate sense I cannot know what I do in this place—and yet I do ultimate things . . . I stand in the dark with a pick in my hand, striking at heads" (p. 105).



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The Strang-Dysart syndrome is not the invention of a playwright, even one as gifted as Shaffer. More than 100 years ago, the Millerites, an often overlooked religious group, provided a stunning case history of similar collision and conflict. This group, the central focus of the following feature article, believed that the world was about to end—and then lived accordingly. Their apocalyptic intensity unsettled many, inside and outside of their movement. As Ronald and Janet Numbers review the asylum records documenting the “religious insanity” of numerous Millerites, one example of how a society and its young psychiatric profession sought to account for the relationship between madness and religion comes into view.

Several implications of this small but salient episode in American religious and psychiatric history are developed by commentators Thomas Jobe, Patrick Staunton, and Bonnie Miller-McLemore. Jobe, for example, places the Millerite story in a much larger historical context, calling attention to some of the ebbs and flows in the course of discussion about the nature, etiology, and cure of madness as far back as fifth-century church father John Cassian. The place of religion in that discussion has been in flux, especially during the centuries that concern the Numberses and Shaffer. Patrick Staunton returns the reader’s attention to present psychiatric realities with reminders about the gap between estimates of mental illness by the National Institute of Mental Health (15–20 percent of the total population) and the number of people who actually receive treatment from mental health professionals (20 percent of those projected to be mentally ill). He speculates that this discrepancy between the number thought to be ill and the number seeking treatment may be due in part to a societal resistance to the current “mental illness” mode of dealing with madness. For many, the current relationships between madness, psychiatry, and human identity seem to be less than satisfactory. Bonnie Miller-McLemore’s comment calls attention to the fluidity of the religious dimensions of the Strang-Dysart syndrome. The new specialties of clinical pastoral care and pastoral psychotherapy signal that the search for a proper relationship between madness, religion, and therapy continues.

After the dramatist, historians, theorists, and commentators have all taken their verbal turn with the mystery of madness, what is left to be said?

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Why not ask those our society identifies as patients? Neurologist Oliver Sacks, recounting the stories of some of his most perplexing patients, brings us close to clinical reality and its mostly latent but occasionally manifest mystery (*The Man Who Mistook His Wife for a Hat* (New York: Summit Books, 1985)). Twins John and Michael, for instance, who have at various times in their lives been diagnosed as autistic, psychotic, or severely retarded, spoke a numerical language few could begin to fathom. Ask them for the date of Easter at any time in an eighty thousand-year time span and they could answer. Drop a box of kitchen matches on the floor and listen to them respond instantly with “111” (the number of matches it contained) and “37” (the trisection of the first answer). Speak an eight-figure prime number to them and watch a smile of appreciation appear on their faces followed by a new nine-figure prime number. After a lifetime together they were separated and placed in therapy regimens intended to enable them to become “quasi-independent” and “socially acceptable” (p. 199). In the process their amazing ability to communicate numerically, to see numbers and speak their language, disappeared.

Or there's José the autistic artist, whose severe temporal-lobe disorder caused twenty to thirty major convulsions a day. José would rock back and forth and could at most mutter unintelligible sounds. Yet give him pen and paper and a subject to sketch and he could communicate with amazing dexterity, creativity, and accuracy. Patients like José pose the fundamental mystery that gives rise to humanity's relentless efforts to categorize, explain, define, and therefore control the unexplainable. Let Sacks pose the nagging question: “is there any ‘place’ in the world for a man who is like an island, who cannot be acculturated, made part of the main? Can ‘the main’ accommodate, make room for, the singular? . . . Specifically: what does the future hold for José? Is there some ‘place’ for him in the world which will *employ* his autonomy, but leave it intact?” (p. 221). So great was José's talent that Sacks wondered if he might illustrate botanical textbooks, accompanying scientific expeditions and sketching their discoveries, if only others had the imagination to see his potential. But, the doctor-narrator admits with resignation, “he will probably do nothing, and spend a useless, fruitless life, as so many other autistic people do, overlooked, unconsidered, in the back



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ward of a state hospital” (p. 222). The riddle which is madness, whether confronted in the heat of destructive varieties of religious fantasies or the cool silence of autism, confronts us with the greater mystery—who is this complex being we so summarily call human? 🌐

*Hugh W. Diamond's photograph of a woman with religious melancholy, Surrey County Lunatic Asylum, ca. 1856. Diamond, superintendent of the women's department of the asylum, was one of the first to use photography in the study of the insane. Diamond's work was based on the belief that there was an exact parallel between a person's appearance and his or her mental state.*





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# RELIGIOUS INSANITY



## — History of a Diagnosis —

IN THE WORLD OF MODERN PSYCHIATRY, religion seems to have little place. Psychotherapists still treat religiously deluded patients, such as the institutionalized schizophrenics made famous as *The Three Christs of Ypsilanti*, and researchers in epidemiology continue to report that certain religious groups tend to attract members with considerable psychopathology (Rokeach 1964; Galanter 1982). But extended analyses of the relationship between religion and mental health rarely appear in the psychiatric literature, and one searches in vain for any reference to religion in the index to the current *Diagnostic and Statistical Manual of Mental Disorders*, the bible of mental health professionals (American Psychiatric Association 1980).<sup>1</sup> Such neglect was not always the case. Scarcely a century and a half ago, religious enthusiasm ranked among the leading

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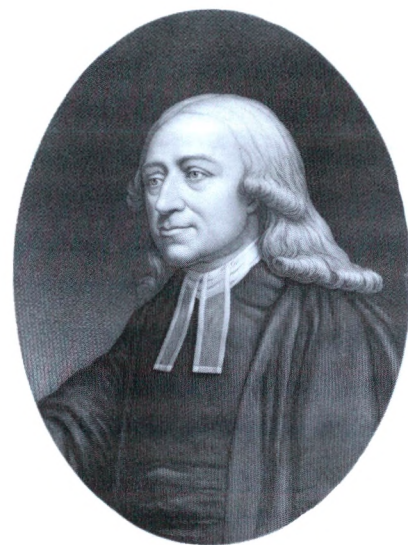
causes of insanity in the asylums of America, and the psychiatric publications of the day were filled with discussions of madness induced by the religious excitement of the times. Indeed, for a number of decades the diagnosis of “religious insanity” went virtually unquestioned.



Since antiquity some observers had regarded excessive religious enthusiasm as a species of madness, but it was not until the seventeenth century that it acquired definition as a distinct disease. In 1621 in *The Anatomy of Melancholy* the Anglican vicar Robert Burton coined the term *religious melancholy* to describe the often intense religious experiences of Puritans and other sectarians. As the medical historian George Rosen observed in a pioneering essay on religious enthusiasm, “it is quite likely that the sectarian ranks included individuals whose mental and emotional balance was at the least precarious,” but it seems equally probable, as Michael MacDonald has recently argued, that the “ruling elite” at times used the concept of religious insanity to discredit socially disruptive religious dissidents such as the Puritans (Rosen 1968:417; MacDonald 1981a; MacDonald 1982; see also MacDonald 1981b; Sena 1973; Skultans 1979:22–25).

With the rise of Methodism in the eighteenth century, talk of religious insanity in the English-speaking world shifted from the Puritans to the even more enthusiastic followers of John Wesley. Under the influence of Wesley’s preaching, anxious listeners would sometimes drop “as dead,” experience temporary blindness, tremble violently, tear their clothes, or groan and shout loudly. Wesley himself reported numerous cases of insanity associated with his ministry, and between 1772 and 1795 the Hospital of St. Mary of Bethlehem in London (better known as Bedlam) admitted 90 patients alleged to be suffering from “religion and Methodism.” By the middle of the eighteenth century, writes MacDonald, “the idea that religious zeal was a mental disease had become a ruling-class shibboleth,” widely acknowledged by both medical and lay opinion (Dimond 1926; MacDonald 1982:120, 124). By the nineteenth century medical authorities commonly used the term *religious insanity* to connote an etiologically distinct mental disease.<sup>2</sup>

In the first major American work devoted to the subject of insanity, *Medical Inquiries and Observations upon the Diseases of the Mind* (1812),



*John Wesley, who reported numerous cases of insanity associated with his ministry.*



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Benjamin Rush, probably the most influential physician in the United States in the early nineteenth century, noted that 10 percent of the 50 “maniacs” then residing in the Pennsylvania Hospital owed their misfortune to “erroneous opinions in religion,” especially ones that burdened the pious with unbearable guilt. He expressed particular concern about the baleful effects that often accompanied “researches into the meaning of certain prophecies in the Old and New Testaments,” noting that madness associated with such activity arose “most frequently from an attempt to fix the precise time in which those prophecies were to be fulfilled, or from a disappointment in that time, after it had passed.”<sup>3</sup>

The wave of revivals that passed over the United States in the early nineteenth century, characterized by protracted meetings that involved days of nearly constant preaching and praying, seemed only to confirm the connection between religious enthusiasm and insanity. The evangelist Charles Finney, for example, who rose to prominence in the mid-1820s, sometimes reduced whole congregations to wailing and writhing, ostensible manifestations of the Holy Spirit. When, on occasion, the excitement and fear generated by his sermons pushed a poor soul over the brink of sanity, Finney blamed the victim, saying that he had “made himself deranged by resisting” the Spirit. Such goings-on naturally attracted the attention of physicians who cared for the insane—and prompted one of them, Amariah Brigham, to write a controversial book on religion and mental health, in which he attributed the “outward signs” associated with revivals to overstimulation of the nervous system rather than to the “*special outpouring of the Spirit of God.*” In New England and New York alone, for the period 1815 to 1825, he knew of more than 90 instances where “religious melancholy” had led to suicide and an additional 30 cases where it had resulted in attempted murder.<sup>4</sup> The implication that clergy could not distinguish between “the ravings of the insane or semi-insane and the operations of the Holy Spirit” did not go unchallenged. As Frederick A. Packard explained in the 1850 *Princeton Review*, “An enthusiast preaching wildly would at once pass among us for an insane man, and his influence would extend but little if at all beyond those who are predisposed to the same class of mental aberrations or already under their power.”<sup>5</sup>

The religious revivals of the early nineteenth century coincided with—and indirectly encouraged—a boom in asylum building that saw the



*Christoph S., diagnosed as suffering from “religious melancholia.” Lithograph from the first illustrated psychiatric textbook, Elements of Psychiatry, by Dietrich Georg Kieser, 1855.*

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Because asylum physicians usually relied on information supplied by a patient's friends or relatives to ascertain the exciting cause of a breakdown, most of them readily conceded the possibility of error and the likelihood of confusing cause with effect, especially when religion was involved. "In such cases," wrote the superintendent of the Western Lunatic Asylum in Staunton, Virginia, "the brain has no doubt frequently been acting morbidly for some time, without its being discovered, and at length when influenced by religious feeling, its manifestations upon this subject indicate mental disorder—this the *effect*, is hastily seized upon and assigned as the *cause* of the malady." There also existed the danger, pointed out by the English physician Burrows, that those treating the insane might "impugn opinions, merely because they differed from their own."<sup>9</sup>

Some superintendents, such as Luther V. Bell of the McLean Asylum, held the "statistics" of insanity in such low esteem that they refused to append the expected tables of supposed causes to their annual reports.<sup>10</sup> But even the most skeptical among them—including William H. Stokes of the Mount Hope Institution in Baltimore, who claimed never to have "succeeded in tracing any one case unequivocally and directly" to the influence of religious hopes and fears—stopped short of denying that religious anxiety, acting as "a whip of scorpions lacerating and torturing to the utmost limit of endurance," as Isaac Ray described it, could, and did, derange persons predisposed to insanity.<sup>11</sup> Thus most superintendents continued to compile their tables—while at the same time warning against placing too much confidence in them.

## The Case of the Millerites

The late 1830s and early 1840s witnessed one of the greatest millenarian revivals in American history, the Millerite movement, which arose in response to the prediction of William Miller, a Baptist farmer and lay minister from upstate New York, that Christ would soon return to earth. On the basis of the biblical prophecy found in Daniel 8:14—"Unto two thousand and three hundred days; then shall the sanctuary be cleansed"—Miller calculated that the end would come "about the year 1843," 2,300 years after Artaxerxes of Persia issued a decree to rebuild Jerusalem. At the peak of the movement, about two hundred ministers and five hundred public lecturers were



spreading the Millerite message, and thousands of believers (a necessarily imprecise figure because of the amorphous nature of the movement) were waiting expectantly for their Savior's return. After a series of failed time-settings, the Millerites fixed their hopes for the Second Advent on 22 October 1844. The Great Disappointment that resulted from this miscalculation splintered the movement into several factions, one of which evolved into the present Seventh-day Adventist church (see Numbers and Butler 1987).

In the early 1840s, as Millerite enthusiasm approached its zenith, asylum superintendents in the Northeast began reacting with alarm to the influx of patients seemingly deranged by "the Miller excitement." Samuel B. Woodward, superintendent of the Worcester State Lunatic Hospital and soon to become the first president of the Association of Medical Superintendents of American Institutions for the Insane (the present-day American Psychiatric Association), noted in his annual report for 1843 that nearly 7 percent of all admissions during the previous year—and over half of all cases resulting from religious causes (15 of 28)—could be charged to Millerism. He believed that in the other asylums of New England, Millerites constituted an even larger percentage of the patient population. Although he regarded it as unusual for a "popular religious error" to have "produced so much excitement in the community and rendered so many insane," he professed to understand why so many minds were unsettled by Millerism: "the subject is momentous, the time fixed for the final consummation of all things so near at hand, and the truth of all sustained by unerring mathematics." At Worcester the Millerite cases fell into two categories: the true believers so "full of ecstasy [*sic*]" that some refused even to eat and drink, and the unconverted who feared that Miller's prophecy might be correct, "who have distracted their minds by puzzling over it, thinking about it, and dreading its approach, who have sunk into deep and hapless melancholy."<sup>12</sup>

Amariah Brigham, the distinguished head of the Utica State Lunatic Asylum in upstate New York and, as mentioned above, author of a book on religion and insanity, also addressed the Millerite problem in his annual report for 1843—and devoted an entire article to the subject in the first volume of the *American Journal of Insanity*, which he founded and edited. In Brigham's opinion, the insidious effects of Millerism stemmed less from its peculiar teachings than from its tendency to deprive "excitable and nervous persons" of needed sleep while they attended protracted meetings. To



*William Miller, Baptist farmer and lay minister; predicted the end of the world would come around 1843.*

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illustrate his point, he related the history of one of his own patients:

S. H. attended from idle curiosity a religious meeting, and heard for the first time the doctrine of the immediate destruction of the world. His attention was awakened and he attended similar meetings several evenings in succession; commenced studying the bible on the subject; passed several nights in the investigation; had but little or no sleep for above a week; then had contests with devils; determined not to eat until the end of the world, and became decidedly deranged.

Brigham acknowledged that “for the most part” Millerites were “sincere and pious people.” However, he believed that their teachings threatened the mental health not only of the present population but of generations yet to come, who, because of their ancestors’ errors, would enter the world predisposed to insanity. Such prospects prompted him to rank Millerism above even yellow fever and cholera as a threat to the public’s health.<sup>13</sup>

During the middle third of the nineteenth century American asylums admitted no fewer than 170 patients for causes related to Millerism. Of this number, about 70 percent entered institutions in New England; over 20 percent went to asylums in New York, especially the state hospital in Utica, which apparently treated the largest number of Millerites in the country; the remaining 10 percent were scattered throughout a region stretching south to Virginia and west to Indiana.<sup>14</sup> An analysis of the clinical records of 98 “Millerite” patients (56 men, 42 women) from three asylums—the New Hampshire Asylum for the Insane, the Worcester State Lunatic Hospital in Massachusetts, and the New York State Lunatic Asylum at Utica—allows us to say with reasonable certainty that asylum physicians rarely, if ever, diagnosed a patient insane merely because of his or her Millerite beliefs; in virtually every case pathological behavior was the deciding factor. The largest number of diagnosable Millerite patients (80.5 percent) were psychotic: manic-depressive with psychotic features, schizophrenic, or schizoaffective. The others (19.5 percent) suffered from such nonpsychotic disorders as depression or dementia without psychotic features.

By the late 1840s Millerism had come to occupy a prominent place in the literature of American psychiatry as the very stereotype of epidemic “religious insanity.” Far after the disintegration of the Millerite movement asylum superintendents and students of insanity continued to draw lessons



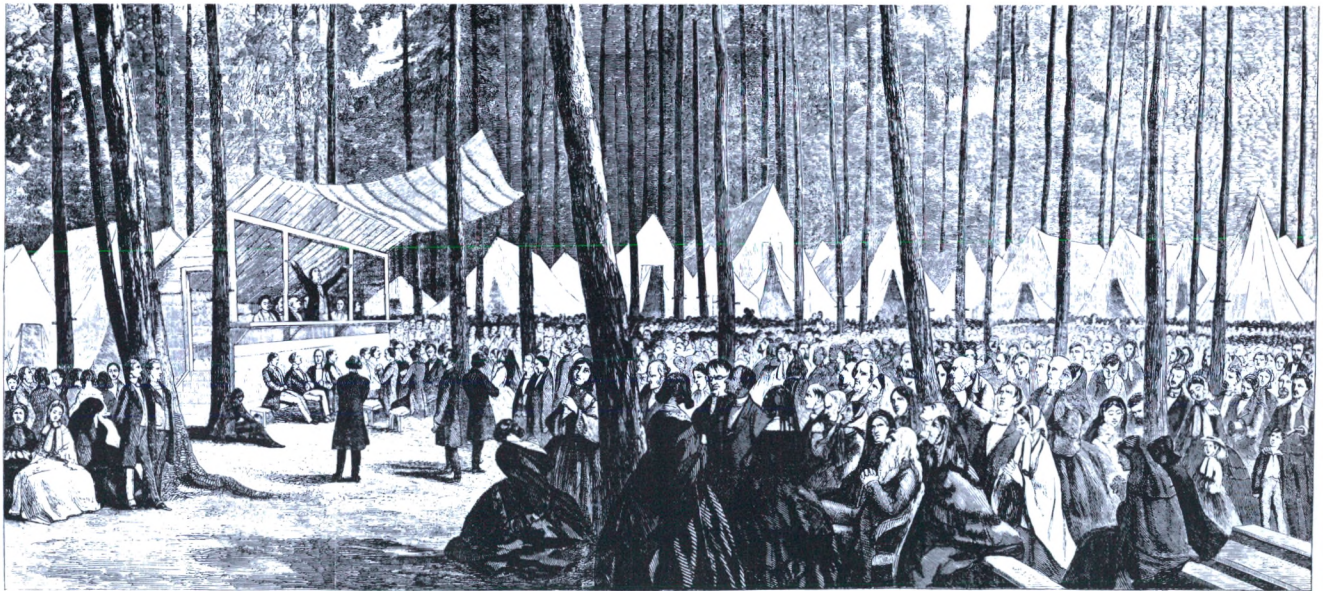
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from the Millerite experience, and as late as 1858 Dorothea L. Dix cited the unfortunate victims of the “Millerite delusions” in her appeals to provide better care for the insane.<sup>15</sup>

## **The Millerite Response to Charges of Insanity**

In a recent book on popular millenarianism, including Millerism, the British historian J. F. C. Harrison urged historians to spend less time worrying “whether millenarians were mad or sane” and more time exploring “how they perceived themselves and their needs.” Millenarians, he suggested, “did not accept the culturally dominant conception of reality, but inhabited a distinctive world of their own. In this (largely traditional) world madness was explained in terms of supernatural intervention, not as due to natural psycho-medical causes” (1979:215, 218). A study of Millerite attitudes toward insanity shows this assessment to be only partially true. Although Miller’s followers did commonly explain the various manifestations of religious enthusiasm (visions, hallucinations, fainting fits) in terms of divine or diabolical

*Depiction of an outdoor religious revival in Sing Sing, New York, 1859.*



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influence, to a surprising degree they adopted the prevailing medical model of insanity, even in cases involving religion.

For the most part, Millerites viewed the alleged insanity in their midst as a public-relations, rather than a medical or humanitarian, problem. Thus, although they did not flatly deny its presence, they minimized its incidence. As Miller's lieutenant Joshua V. Himes put it, reports of insanity, suicide, and other supposed "fruits of Millerism" were "most of them, unfounded: and, those which have any semblance of truth, are greatly distorted and exaggerated."<sup>16</sup>

On the one hand, Himes regarded the allegations of Millerite insanity as validating the righteousness of his cause and demonstrating the "want of good argument and scriptural reasons to meet us." He took comfort from the fact that the devil always opposes "the truth" and that infidels had long claimed that gospel preaching "makes people *crazy*."<sup>17</sup> On the other hand, he greatly resented the seemingly universal tendency among critics to attribute every crime and calamity to Millerism. Thus when one newspaper in 1841 implied that "the Miller humbug" had driven a crazed man to murder his wife and children to save them from the impending end of the world, the *Signs of the Times*, which Himes coedited, responded sarcastically with a piece headed "Is There Any Evil in the Land, and Miller Not Done It?" "This sagacious editor ought to have known, that no murders, or any dreadful evils could take place without Mr. Miller's aid," wrote the editors of the *Signs*, adding that no doubt the recent failure of the United States bank was also "a legitimate fruit of the Miller humbug." In a similar vein, the *Signs* ended a report on widespread insanity abroad with the quip: "What is the cause of insanity in Europe? It surely cannot be Millerism."<sup>18</sup>

Although the Millerite press regarded one minister's claim that William Miller himself was "probably mad, and ought to be put under the care of Dr. Woodward, at the State Lunatic Hospital" as too ludicrous to warrant a refutation, Millerite editors went to great lengths to refute other charges of insanity, sometimes securing and printing affidavits showing that the person involved was not a Millerite, that the Advent doctrine had not precipitated the breakdown, or that the wrong person had been identified.<sup>19</sup> On one occasion a delegation of Millerite brethren called on the superintendent of the New York City Lunatic Asylum at Blackwell's Island to check a rumor that eleven Millerites had recently been admitted. The correct





*Sketch of converts at the altar during a religious revival at the Jane Street Methodist Episcopal Church, New York City.*

number, they learned from the superintendent, was only four. Further investigation revealed that one of the four was a Baptist partially insane before he read a Second Advent paper; the second was an Episcopalian with a history of insanity who had never attended a Millerite meeting; the third was a chronically insane person whose connection with Millerism could not be determined; the fourth, the only undisputed Millerite, had lost his mind as a result of “domestic affliction,” not religious excitement. In such manner was the cause vindicated.<sup>20</sup>

At times Millerite leaders took the offensive and invited critics to submit “*proof* that the preaching of the immediate coming of Christ has been signalized in any place, as a cause of insanity”—fully knowing that, given the uncertain state of medical knowledge about the etiology of insanity, no evidence, not even the testimony of attending physicians, would suffice.<sup>21</sup> Mere presence in an asylum for the insane was also insufficient because, as



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the editors of the *Signs* pointed out in an article titled “The Doctrine of the Advent Not a Cause of Insanity,” virtually anyone could be committed for any reason:

It should be remembered that to be found within an Asylum of the Insane, is no proof of insanity. Friends have only to report a friend insane, and get the opinion of a physician to that effect, and they have power *vi et armis* to incarcerate them according to their own pleasure in any insane hospital and for any length of time they please.

Only a difference of opinion is often called insanity, and when ones [*sic*] opinions are so obnoxious, as is a belief in the immediate coming of Christ, to those who do not love his appearing . . . it is not strange that they should be regarded as beside themselves, and that their friends should take this method to get rid of the annoyance which the fear of the truth will necessarily produce on an unwilling conscience. When we consider how the doctrine is hated by the friends of many, it is surprising that so few have been denounced by them as insane.

Although Millerite leaders rarely complained about their followers’ being committed to mental institutions, the editors on this occasion went on to relate “an anecdote” about a man who, upon converting to Adventism, was denounced by his friends as insane and tricked into entering an asylum. “Could the tales of misery that individuals have suffered under a *suspicion* of insanity, be told, it would reveal many a scene of wrong and suffering that would cause humanity to shudder.”<sup>22</sup>

In view of the Millerites’ strict demands for proof—and their concern about the image of their movement—it is little wonder that, to our knowledge, no Millerite paper ever confirmed an instance in which a believer had become deranged for any reason connected with Millerism. In fact, Millerite writers repeatedly implied just the opposite. “We have become extensively acquainted with the operations of the Advent cause, particularly in the New England and middle States,” wrote one Millerite leader, “and we have never fallen in with a *single case* of insanity, which even our enemies, when their candor has been appealed to, in view of all the facts in the case, could attribute to a belief in the Advent doctrine.”<sup>23</sup>

But despite the numerous attempts by the Millerites to show that their message did not cause insanity, a considerable body of evidence indicates



that they, like asylum superintendents and other physicians, believed that an intimate relationship existed between mental health and religious belief, even Millerism. Of course, whenever possible, they stressed the positive aspects of believing in the Advent doctrine, which according to the editors of the *Signs* “seems wonderfully adapted to restore to sanity the monomania [sic], &c, by its glorious promises and hopes.” Relying on hearsay testimony they would never have allowed as evidence that Millerism *caused* insanity, they readily published accounts of how Millerism *cured* insanity. As illustrative of an “instance of recovery from insanity, by the preaching of the immediate coming of Christ,” the *Signs* printed a letter from a man certifying that his insane mother, formerly a patient at the private asylum in Pepperell, Massachusetts, had been “fully restored to her reason” by having the prospect of Christ’s return kept constantly on her mind. In another case, a man “so deranged as to render it necessary to keep him constantly lashed to the floor” had supposedly regained his sanity by reading Millerite papers,

*Utica State Lunatic Asylum, founded in 1843. The Utica asylum listed “religious anxiety” as the leading cause of insanity.*





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attending meetings, and finally embracing the Advent cause.<sup>24</sup>

Millerites also liked to contrast their own relatively benign teachings with the “terror” preached by their evangelical critics. “[W]hen they can produce *one* made insane by us,” charged Himes, “*many* might be produced who have become insane by their terrific descriptions of the judgment!”<sup>25</sup> Ellen Harmon White, who converted to Millerism as a youth and later led the schismatic movement that resulted in the Seventh-day Adventist church, graphically described the terror to which Himes alluded. Her autobiographical writings reveal how as a teenager she suffered intense anxiety about her chances for salvation. While listening to sermons describing hell, her “imagination would be so wrought upon that the perspiration would start, and it was difficult to suppress a cry of anguish.” Sometimes she spent entire nights agonizing about her spiritual condition and once slipped into “a melancholy state” for several weeks, during which “not one ray of light pierced the thick clouds of darkness around me.” Her own history led her to suspect that

many inmates of insane asylums were brought there by experiences similar to my own. Their consciences were stricken with a sense of sin, and their trembling faith dared not claim the promised pardon of God. They listened to descriptions of the orthodox hell until it seemed to curdle the very blood in their veins, and burned an impression upon the tablets of their memory. Waking or sleeping, the frightful picture was ever before them, until reality became lost in imagination, and they saw only the wreathing flames of a fabulous hell, and heard only the shrieking of the doomed. Reason became dethroned, and the brain was filled with the wild phantasy of a terrible dream.<sup>26</sup>

If the Advent message did cause insanity, Millerites wanted to believe that it resulted not from anticipating the Second Coming of Christ but from failing to prepare for that event. To corroborate this view, the *Signs* quoted the superintendent of the New Hampshire Asylum as saying that “*No one, as far as I have seen, of those who truly believed in the speedy coming of Christ, has been made sad or melancholy.* Some patients who have been disturbed and perplexed by these startling theories, and yet have doubts and fears of their reality, come to us sad and desponding.”<sup>27</sup>

According to Ellen White, the uncertainty and turmoil that followed the Great Disappointment of 22 October 1844 proved particularly unsettling to some minds. Years later she recalled that



*Ellen White (1827–1915), founder of the Seventh-day Adventist Church, had converted to Millerism as a young woman.*



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after the passing of the time in 1844, fanaticism in various forms arose. . . . I went into their meetings. There was much excitement, with noise and confusion. . . . Some appeared to be in vision, and fell to the floor. . . . As the result of fanatical movements such as I have described, persons in no way responsible for them have in some cases lost their reason. They could not harmonize the scenes of excitement and tumult with their own past precious experience; they were pressed beyond measure to receive the message of error; it was represented to them that unless they did they would be lost; and as the result their mind was unbalanced, and some became insane.<sup>28</sup>

How much this account paralleled her own experience, we cannot be sure. We do know, however, that during this same period she had visions and fell to the floor and became so mentally distraught that for two weeks her “mind wandered,” an episode she described as her “extreme sickness”—and which her enemies used in an attempt to discredit her ministry.<sup>29</sup>

Recollections such as White’s reinforce the suspicion that Millerite leaders in their public statements deliberately underplayed the incidence of madness among their motley group of followers. Such accounts also provide persuasive evidence of the extent to which even Millerites themselves adopted the prevailing view that undue religious excitement might be harmful to a person’s mental health.

## **The End of an Era**

In the 1850s, as admissions of Millerites dwindled, asylum superintendents began noting with alarm that spiritualism was playing the same role in the 1850s that Millerism had played in the previous decade. “ ‘Millerism,’ in its day, sent many victims to most of our hospitals,” noted Thomas S. Kirkbride of the Pennsylvania Hospital for the Insane in a typical statement, “and what is now called ‘spiritual investigations,’ is a not less prolific cause of the disease.” Indeed, clinical records identify at least two Millerite patients who deserted Millerism for spiritualism. One of them, a woman admitted to the New Hampshire Asylum in 1860, was described as being “always inclined to radicalism. First carried away by Birchard’s [*sic*] preaching. Next Millerism. Last spiritualism.” Another patient, admitted to the same institution in 1843

after having “suddenly taken crazy” following attendance at Millerite meetings, was readmitted in 1865 because of spiritualism. In the 1870s psychiatrists shifted their concern again, this time to the evangelistic campaigns of Dwight L. Moody and Ira Sankey, whose emphasis on “conviction of sin” and a “sense of divine wrath” seemed to be upsetting the “mental equilibrium of many a youth, at least temporarily.”<sup>32</sup>

Meanwhile, skepticism regarding the usefulness of identifying the supposed causes of insanity, such as religious excitement, continued to grow. As early as 1863 Isaac Ray, described by one historian as “probably the most influential nineteenth-century American psychiatrist” and a person long suspicious of the value of statistical tables of causes, noted that “the proportion of cases attributed, in our hospital reports, to ‘Causes unknown,’ has been steadily rising from zero to half or more of the whole number,” thus destroying, “at a blow, a great deal of fancied knowledge.”<sup>33</sup> That same year John P. Gray, who had succeeded Brigham as superintendent of the Utica asylum and as editor of the *American Journal of Insanity*, noted an



Woodcut of “last day tokens,” for example, darkened sun, falling stars, earthquakes—Millerite illustration of events preceding the Second Coming of Christ.



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apparent “decrease of religious anxiety, as an attributed cause of insanity,” owing, he thought, to the “steady progress of medical knowledge,” which was beginning to emphasize the organic, rather than moral, causes of mental illness. His own opinion, undoubtedly still a minority view, was that “religious anxiety is rarely, if ever, a cause of insanity.”<sup>34</sup>

Despite such sentiments, many American psychiatrists continued to subscribe to the notion that religious excitement produced insanity. A survey of about sixty American asylums in 1876 revealed that religious excitement was thought to be the probable cause of insanity for 5.79 percent of all patients; it ranked among the top four or five causes in a list of more than thirty.<sup>35</sup> Statistics from the Pennsylvania Hospital for the Insane giving the average number of admissions per year attributed to religious excitement suggest that significant change may not have come until the 1880s.

For the years 1841–1849, the average number of yearly admissions was 6.8; for 1850–1859, it was 6.6; for 1860–1869, 4.5; for 1870–1878, 6.4; and for 1879–1885, 2.1. After the death of long-time superintendent Kirkbride in 1883, religious excitement disappeared entirely from lists of supposed causes at the Pennsylvania Hospital, and his successors attributed only one new case to religion during the late 1880s.<sup>36</sup> This pattern lends credence to Barbara Sicherman’s observation that “the older view that religious revivals themselves caused insanity had generally declined by 1880” (Sicherman 1980:88). However, some asylums continued for years to list religious excitement among the alleged causes of insanity, and well into the twentieth century psychiatric texts commonly mentioned religious excitement as a possible, but overrated, cause of mental illness.<sup>37</sup>

Contemporary explanations for the decline of religious insanity varied widely. We have already noted that Ray attributed it to a growing agnosticism about the etiology of insanity, and Gray thought it resulted from increased knowledge about the somatic origins of mental disorders. Other writers credited the decline to the secularization of the modern mind, which dwelled less and less on religious subjects, while Theodore W. Fisher, a Boston psychiatrist, attributed it to changing theological fashions. “The number of persons actually made insane by religious excitement has probably diminished with the gradual softening of the rigors of orthodox belief,” he wrote in 1877. “Those nowadays who, ‘like Sir Harry Vane, have caught gleams of the beatific vision or awaked screaming from dreams of everlasting



*John P. Gray, editor of the American Journal of Insanity, expressed the opinion that “religious anxiety is rarely, if ever, a cause of insanity.” In 1854 he became medical superintendent of the Utica State Lunatic Asylum, where he greatly improved modes of treatment.*

fire,' are apt to be accounted insane and treated accordingly."<sup>38</sup> At any rate, with the appearance of new classification systems for disease toward the end of the century, psychiatric authorities tended increasingly to view religious agitation as a *symptom* of dementia praecox (schizophrenia) or some other disease, and the term religious insanity slowly disappeared from the vocabulary of medicine.<sup>39</sup> 🌐



*Recent photograph of William Miller's chapel, near Miller's farmhouse in Low Hampton, N.Y.*

#### NOTES

This essay is a condensed, revised version of "Millerism and Madness: A Study of 'Religious Insanity' in Nineteenth-Century America," *Bulletin of the Menninger Clinic* 49 (1985): 289–320, and is reprinted with the kind permission of the editor, Paul W. Pruyser.

1. The text does, however, recognize a "special relationship to a deity" as one of the hallmarks of the delusional system of manic depression and schizophrenia (p. 209).

2. See, e.g., Nathaniel Bingham, *Observations on the Religious Delusions of Insane Persons* (London, 1841), pp. 117–23.

3. Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind* (Philadelphia, 1812), pp. 36–37, 44–47.

4. Amariah Brigham, *Observations on the Influence of Religion upon the Health and Physical Welfare of Mankind* (Boston, 1835), pp. 260, 284–85, 291, 312. Regarding Finney's revivals, see McLoughlin 1959:27–29, 90–93; Rubin 1979:81–82.

5. [Frederick A. Packard], "The Relations of Religion to What Are Called Diseases of the Mind," *Princeton Review* 22 (1850): 1–41. After reading Packard's essay, the editor of the *American Journal of Insanity* (7 [1851]: 286–87) suggested substituting the term "ir-religious insanity" for religious insanity. For a general discussion of religion and insanity in the early nineteenth century, see Dain 1964:183–93.



6. *Annual Report*, New Hampshire Asylum for the Insane, 1843; *Annual Report*, New York State Lunatic Asylum at Utica, 1843. (Hereafter, *Annual Report* will be abbreviated as *AR*.) On the growth of asylums, see Grob 1973.

7. These figures are based on data for the two asylums provided by Barbara G. Rosenkrantz, who has coded the records of these institutions preserved in the Countway Library of Medicine, Harvard University. During the first eight years of operation at Worcester, 1833–1840, the percentage of cases assigned to religious causes varied from a low of 4.7 (1840) to a high of 9.0 (1838); *AR*, State Lunatic Hospital at Worcester, 1840, p. 61. The little comparative evidence we have found suggests that American asylums tended to admit—or diagnose—a slightly higher percentage of religion-related cases than did British institutions; see, e.g., the figures for ten U.S. and nine British asylums, *ibid.*, 1843, pp. 50–51.

8. “Masturbation (and vegetable diet)” appeared in *AR*, McLean Asylum for the Insane, 1835, p. 8; “Insufficient nutrition (Grahamism)” was listed in *AR*, Hartford Retreat for the Insane, 1846, p. 20.

Mesmerism was a form of hypnosis popularized by the Austrian physician Franz Anton Mesmer; Swedenborgianism, a mystical religious movement founded by the Swedish scientist and theologian Emanuel Swedenborg; Fourierism, a system of communal social reform advocated by the French socialist Charles Fourier; Grahamism, a health-reform regimen promoted by the American vegetarian Sylvester Graham. Millerism is discussed below.

9. *AR*, Western Lunatic Asylum, Staunton, Va., 1841, p. 23. See also *AR*, Hartford Retreat for the Insane, 1846, p. 20; and *AR*, Ohio Lunatic Asylum, Columbus, 1842, pp. 51–52. On the statistics of insanity, see Cassedy 1984:chap. 7. George Man Burrows, *Commentaries on the Causes, Forms, Symptoms, and Treatment, Moral and Medical, of Insanity* (London, 1828), p. 25.

10. *AR*, McLean Asylum for the Insane, 1843, pp. 28–29. See also the views of Isaac Ray in *AR*, Maine Insane Hospital, 1842, pp. 14–19.

11. *AR*, Mount Hope Institution, Baltimore, 1849, p. 19; *AR*, Butler Hospital for the Insane, 1856, p. 29.

12. *AR*, State Lunatic Hospital at Worcester, 1843, pp. 52–53. See also Woodward’s comments in the *AR* for 1844, p. 52.

13. *AR*, New York State Lunatic Asylum at Utica, 1843, pp. 22–23; [Amariah Brigham], “Millerism,” *American Journal of Insanity* (1844–45): 249–53. For another early case history related to Millerism, see *AR*, Western Lunatic Asylum, Staunton, Va., 1843, pp. 32–33. Some critics expressed concern about the economic cost of caring for the deranged disciples of Miller: “Scoffers Shall Arise,” *Signs of the Times* 4 (1843): 179.

14. These figures are based on an examination of the annual reports of two dozen asylums and other documents.

15. “Memorial of D. L. Dix, Praying a Grant of Land for the Relief and Support of the Indigent Curable and Incurable Insane in the United States,” *Journal of Mental Science* 4 (1858): 131. See also, e.g., *AR*, Eastern Lunatic Asylum, Williamsburg, Va., 1848, p. 14; “The Nervous Epidemic Connected with the Religious Revival in Ireland,” *American Journal of Insanity* 16 (1860): 357; *Biennial Report*, Illinois State Hospital for the Insane, Jacksonville, 1862, p. 27.

16. “To the Public: The Second Advent—Mr. Himes’ Statement,” *Advent Herald* 8 (1844): 100.

17. Joshua V. Himes, “Letter to Charles Fitch,” *Signs of the Times* 5 (1843): 53.

18. “Is There Any Evil in the Land, and Miller Not Done It?” *Signs of the Times* 2 (1841): 40; “Foreign,” *Signs of the Times* 5 (1843): 64.

19. See, e.g., “To the Public,” p. 101; “Calumnies Refuted,” *Advent Herald* 8 (1844): 123; “Case of Mr. Walker, of Belchertown,” *Advent Herald* 11 (1846): 29–30. The reference to Miller’s insanity appeared in Rev. T. F. Norris, “Millerism,” *Signs of the Times* 3 (1842): 8.

20. “Insanity,” *Midnight Cry* 4 (1843): 21–22.

21. Editorial statement accompanying “Letter from Rev. N. Colver,” *Signs of the Times* 4 (1842): 110. See “Case of Mr. Walker,” pp. 29–30, for an example of rejecting medical testimony.

22. “The Doctrine of the Advent Not a Cause of Insanity,” *Signs of the Times* 5 (1843): 173.

23. “Insanity,” *Advent Herald* and *Signs of the Times Reporter* 7 (1844): 100.

24. “Insanity,” *Signs of the Times* 5 (1843): 69; Letter from George A. Reed in “Letter from Rev. N. Colver,” p. 110; “A Fact for Our Opponents,” *Signs of the Times* 6 (1843): 111.

25. Himes, “Letter to Charles Fitch,” p. 53. A similar statement, apparently by Himes, appeared in “Letter from Rev. N. Colver,” p. 110.

26. *Life Sketches of Ellen G. White* (Mountain View, Calif.: Pacific Press, 1915), pp. 29–31; Ellen G. White, *Spiritual Gifts: My Christian Experience, Views and Labors* (Battle Creek, Mich.: James White, 1860), pp. 16–18; Ellen G. White, *Testimonies for the Church*, 9 vols. (Mountain View, Calif.: Pacific Press, n.d.), 1:25–26. On Ellen White, see also Numbers 1976; Numbers and Numbers 1983.

27. “The Doctrine of the Advent Not a Cause of Insanity,” pp. 172–73. See also “Insanity from Millerism,” *Signs of the Times* 6 (1843): 72.

28. *Selected Messages from the Writings of Ellen G. White*, 2 vols. (Washington, D.C.: Review and Herald Pub. Assn., 1958), 2:34–35, from a statement made in 1901.

29. White, *Spiritual Gifts*, pp. 51, 69.



30. AR, Pennsylvania Hospital for the Insane, 1856, p. 25. For similar statements, see also AR, Eastern Lunatic Asylum, Williamsburg, Va., 1853–54 and 1854–55 (1 vol.), p. 20; and AR, New York State Lunatic Asylum at Utica, 1858, p. 30. For discussions about the extent to which spiritualism was causing insanity, see Review of “Spiritualistic Madness,” by L. S. Forbes Winslow, *American Journal of Insanity* 33 (1877): 441–42; “Insanity and Spiritualism,” *ibid.*, pp. 593–94; and Eugene Crowell, “Spiritualism and Insanity,” in *Psychic Facts: A Selection from the Writings of Various Authors on Psychical Phenomena*, ed. W. H. Harrison (London: W. H. Harrison, 1880), pp. 111–29. We are indebted to Roy DeCarvalho for this last citation.
31. Cases 1789 and 58, 1843–50, Records of the New Hampshire Asylum for the Insane, 1842–1861, Division of Records, Management, and Archives, State of New Hampshire, Concord. Jedediah Burchard was a flamboyant revivalist in the 1830s.
32. Theodore W. Fisher, “Insanity and the Revival,” *Boston Medical and Surgical Journal* 97 (1877): 59–62. See also George H. Savage, “Religious Insanity and Religious Revivals: Effects of the ‘Moody and Sankey Services,’” *The Lancet*, 28 Aug. 1875, pp. 303–4.
33. AR, Butler Hospital for the Insane, 1863, p. 22; Grob 1973:146.
34. AR, New York State Lunatic Asylum at Utica, 1863, pp. 38–40. See also [John P. Gray], “Religious Insanity,” *American Journal of Insanity* 33 (1876): 126–31.
35. Fisher, “Insanity and the Revival,” p. 62. The breakdown by region was New England, 4.97 percent; Middle States, 2.78 percent; Southern States, 7.43 percent; Western States, 8.37 percent. Fisher attributed the low percentage in the Middle States to the fact that New York and Philadelphia furnished so few cases of religious insanity.
36. AR, Pennsylvania Hospital for the Insane, 1841–1900.
37. See, e.g., Daniel R. Brower and Henry M. Bannister, *A Practical Manual of Insanity for the Medical Student and General Practitioner* (Philadelphia: W. B. Saunders, 1902), p. 30; and H. I. Schou, *Religion and Morbid Mental States*, trans. W. Worster (New York: Century, 1926), pp. 116–33.
38. Fisher, “Insanity and the Revival,” p. 62. See also J. G. Havelock, “An Epidemic of Religious Mania Originating from a Case of Spurious Pregnancy,” *Edinburgh Medical Journal* 11 (1894–95): 261–63; and Leonardo Bianchi, *A Text-Book of Psychiatry for Physicians and Students*, trans. James. H. MacDonald (London: Bailliere, Tindall and Cox, 1906), p. 599.
39. See, e.g., T. W. Fisher, *Plain Talk about Insanity: Its Causes, Forms, Symptoms, and the Treatment of Mental Diseases* (Boston: Alexander Moore, 1872), p. 24; George H. Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London: Cassell, 1884), pp. 50–53; and R. von Krafft-Ebing, *Text-Book of Insanity Based on Clinical Observations for Practitioners and Students of Medicine*, trans. Charles Gilbert Chaddock (Philadelphia: F. A. Davis, 1905), p. 143.

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P. 58, Historical Pictures Service, Chicago; p. 62, courtesy of Aurora University, Aurora, Ill.; pp. 65, 67, Historical Pictures Service, Chicago; p. 69, National Library of Medicine, Bethesda, Md.; p. 72, courtesy of Aurora University, Aurora, Ill.; p. 73, Historical Pictures Service, Chicago; p. 74, courtesy of LeAnn Schoepflin.

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## Comment: Thomas H. Jobe



The view that religious enthusiasm, not religion per se, can be the exciting cause of insanity has been a continuous theme of European medical and psychiatric thought since at least the works of the fifth-century church father John Cassian. In his important treatise *De institutis coenobiorum et de octo principalium vitiorum remediis libri XII*, he described mental disorders attributable either to an excess of religious ardor or to a lack of ardor. He also introduced a term for these disorders, *acedia* (from the Greek *akedia*, “not caring”), and described a syndrome that sounds today like an anxious or agitated depression. In his discussion of the *acedia* concept, Noel Braun (1979) distinguishes the Cassianic version, which did not include *tristitia*, or sadness, from the Gregorian-Thomistic version, which did. Different humors were invoked to provide the medical explanation for the severity of these conditions. The Cassianic version of *acedia* identified the underlying cause of the syndrome as an excess of phlegm. The Gregorian-Thomistic version conceived of a merger between *acedia* and the traditional Galenic view of *melancholia* and so identified the offending humor as black bile.

The study of religious melancholy and of delusions that have a religious cast became a highly cultivated field by the second half of the sixteenth century. This is partly due to the great religious controversies of that century but also to the necessity for traditional religion sharply to define devotional and doctrinal concepts. In his 1586 *Treatise of melancholie*, Timothy Bright (1551–1615) clearly distinguished between “conscience of sinne” and melancholy due to an excess of the humor in which delusions regarding religion are present. Similar problems in distinguishing religious doctrines from the delusions of *melancholy* erupted in the debates about witchcraft and demons in the sixteenth and seventeenth centuries. The witchcraft debates provide an interesting analogy with the Melancholia controversy. The concept of the black bile was used by many physicians to explain away belief in witchcraft and the devil’s role on earth (Jobe, 1981).



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Religious polemicists of the sixteenth and seventeenth centuries also used the black bile to explain away sectarian religious beliefs. Both physicians and clergy discredited religious views that were widely divergent or antithetical to their own by positing an excess of black bile in those holding such views (Ben-Yehuda 1985).

The Millerite experience differed significantly from these earlier phases in the history of the belief that religious enthusiasm caused insanity. Now persons could be involuntarily confined for long periods “for their beliefs.” Physicians dealing with insanity were in a position of power over their “patients.” The peak years for admission of Millerite patients (the 1830s and 1840s) coincided with the peak of moral therapy in American psychiatry. Moral therapy involved a theory of the origin of insanity that strongly favored a psychological stress factor. Indeed, enthusiasm of any sort was thought to lead to insanity. Esquirol, student of Pinel and leader of moral therapy in France, put political enthusiasm at the top of his list, and American psychiatrists listed personal financial ambition as the chief culprit among the enthusiasms thought to be perverting Federalist America. Clearly the pendulum had shifted from psychological to organic explanations by the time John P. Gray provided his admonition against interpreting religious enthusiasm as a cause of insanity.

Both the shift toward a psychological understanding of mental disorders in the early nineteenth century and some of the features of the earlier preoccupations with religious enthusiasm by medical and religious elites have a bearing on the intensity of medical and psychiatric involvement with the Millerites. The medical psychologists who founded American moral therapy and the mental hospital movement were conservative or, at the least, traditional religionists (McGovern 1985). Even in an age of religious toleration, the Millerites appeared to be a dangerous force corrupting the lives of poorer and less educated persons. By pronouncing their beliefs atheistic, the medical superintendents of asylums served their traditional religious creeds as well as their new clinical science of psychiatry. Here was a place where the scientific opinion and private religious commitment of the psychiatrist reinforced each other. Once the pendulum shifted toward an organic explanation, these two interests no longer coincided. The religious opinion of the patient became a secondary phenomenon, symptomatic of the underlying brain disease.



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These observations lead to a generalization that those who held psychogenic psychiatric theories (that insanity originates in the mind or in mental and emotional conflict), such as the advocates of moral therapy, found themselves in the position of having to critique religion at least at the level of what constitutes mental health, while those holding strongly organic orientations, such as that of Gray, could abstain from this commentary. There is one important exception to this generalization. Strongly reductionistic organic theories, such as those holding that religious sentiment is localized in a particular brain region, must also dialogue with religious opinion. An interesting historical example of this is phreno-mesmerism which was in vogue in the second half of the nineteenth century. According to this school, religious enthusiasm was localized in a specific area of the cortex (the parietal lobe) which could be magnetized, causing the subject to drop to his or her knees and undergo the writhing and gyrations universally attributed to the sectarians—the Ranters, Diggers, Quakers, and so on.



Finally, a more fundamental problem casts the Millerite experience in a different perspective. This is the issue raised by the Millerites themselves in defense of their beliefs. They argued that some instances of madness were directly caused by divine or diabolical influence. The degree to which madness, whatever its current definition, has been secularized at a given historical period depends, in part, upon a dialogue between religion and psychiatry. That dialogue is informed by the pendulum swings in etiological theory in psychiatry but also by the role of religion within the state and society. The separation of church and state, religious toleration, and religious pluralism within the United States have probably contributed to a diminution in the importance of religious ideas within psychiatric nomenclatures. In social systems where religion is directly supported or directly suppressed by the state, religious as well as political ideas carry psychiatric significance. Thus the Roman and Spanish Inquisitions of the sixteenth and seventeenth centuries were anxious to distinguish heretical ideas from insane delusions. By contrast, in the Soviet Union, where religion has been suppressed by the state, religious and political ideas alone could qualify a person for a psychiatric diagnosis. Two factors influenced such interactions between psychiatry and religion. There is the selection factor by which persons experiencing prepsychotic psychological fragmentation select out the more dramatic, contradictory, sectarian religious ideas and develop grandiose per-



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sonalized interpretations of these. A second factor is the degree of imposed consensus, both in the political and in the religious arenas. The greater the imposed consensus, the more deviant and “disturbed” nonconforming ideas appear to the majority, and the less tolerance there is for these minority views. The abuse of psychiatric concepts is always more likely in such societies whether they be theocracies or secular totalitarian states. Interestingly, the Millerite experience occurred just at the time the Federalist consensus had broken down under the influence of a seemingly chaotic Jacksonian democracy (Rothman 1971). Perhaps the degree of enforced consensus with its sharp delineation of deviance plays a greater role in the dialogue between religion and psychiatry than either field is prepared to admit. 🌐

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## Comment: Patrick Staunton

My interest in madness began a number of years ago when I served as a psychiatrist in a policy-making capacity with the Illinois Department of Mental Health. In contrast to private hospitals, the public mental hospital system is always looking for ways to “deflect” or in some way to “get out from under” the enormous burden of patients; the limited resources supplied by state government were never sufficient to provide an acceptable quality of patient care. I discovered that other state agencies—welfare, corrections, courts, public education—were also experiencing demands for services that

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exceeded their ability to comply. Unfortunately for the Department of Mental Health, the other agencies could transfer part of their burden to us if they could show that a client suffered from mental illness. It was then that I discovered how elastic the concept of mental illness was—it could be stretched considerably depending on who was making the determination and for what purpose. My training in psychiatry, where diagnosis of mental illness was for the purpose of facilitating appropriate treatment services for those so diagnosed, had not prepared me for this. The great potential for this use or misuse of psychiatric diagnosis was forcefully brought home. Our response was that not all undesirable clients or patients were suffering from mental illness and that we needed to differentiate more precisely between those mentally ill who might benefit from treatment in a mental hospital and those persons suffering from madness who might be more appropriately cared for in nursing homes, in prisons, in special schools, or by the welfare system. We were supported in our position by advocates of civil liberties, who had a hard time accepting that there was justification for detaining any adult against his or her wishes in a mental hospital even if benefit might be gained from the treatment services.



As an example, in 1970 approximately one hundred patients a month were admitted to Chicago Residential State Mental Hospital who were age sixty-five or older and had not previously been in a mental hospital. Some could have been described as mentally ill, and others were suffering from a variety of chronically disabling physical conditions, but all were in need of food, shelter, and a caring environment. Subsequent attempts to place these patients in community nursing homes were rendered more difficult because they were now perceived to be mentally ill as well as sick and poor. The use of the label *mentally ill* is primarily justified by its ability to provide access to beneficial services for those so labeled. As this example illustrates, the labeling process can also have harmful consequences. Subsequent changes in the Illinois mental health code were largely responsible for correcting this problem.

Madness, like evil, is part of the human condition, and no concept of the person is likely to be complete that does not take it into consideration. The term has been variously used to describe some sort of evil (loss of one's rational facilities), unappreciated creativity (religious ecstasy), and a sickness of the mind, or mental illness. Madness is something recognizable in others



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especially if they are strangers and not related to us; it is difficult to recognize in our friends or family and perhaps impossible in ourselves. A precise definition of madness that we could all agree on proves elusive. The *Encyclopaedia Britannica* does not list *madness* in its index. It seems we have attempted to neutralize the term by using it colloquially to describe a state of anger, or we have substituted the term *mental illness*, which stimulates the hope that madness can be treated in the same way that we treat any other illness. Yet the term *madness* with all its primitive impact refuses to disappear and indeed seems to be making a comeback.

Kant defined madness as “the most profound degradation of humanity which seems to originate from nature” (1978:112). The Harvard psychiatrist Alan Stone commented that “having put madness to one side and isolated it, as though it had nothing to do with his understanding of the normal, Kant’s analysis of the situation of the rest of humanity is somehow haunted by the analogy to madness” (1984:219). Ronald and Janet Numbers take us back to a time in mid-nineteenth-century America when a large number of mental hospitals were built to care for the mentally ill, while at the same time a number of new religious offshoots of mainline Protestantism were evolving into separate religions. They also forcefully remind us that the conflict between psychiatry and religion existed before Freud. Even the primitive medical model of mental illness of mid-nineteenth-century psychiatry brought it into conflict with at least some religious groups. Western psychiatric medicine has attempted during the past two hundred years to provide an explanatory model for madness with the introduction of the concepts of mental illness. Thus the medical profession in general and psychiatric medicine in particular assumed (or were assigned) some responsibility for the mentally ill. Society increasingly looked to psychiatrists as the experts in determining what was the nature of mental illness, who was suffering from this illness, and how best to care for and treat those persons so affected. Yet as the Numberses’ article tells us, not everyone agreed with the mental illness explanatory model for madness. Furthermore, the privilege or authority to determine who is or is not mentally ill was a two-edged sword, with psychiatry being cast in the role of arbiter of some of society’s most difficult moral problems. The frequent attempts in this country before 1973 to obtain psychiatric justification for abortion provide a modern example. Such requests have now disappeared.



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Organized religions have had a long tradition of attempting both to regulate and to co-opt madness in its many varied forms. Many societies and their religious institutions also have often found it easier to deal with madness as if it did not belong in the human community, as if the excising of madness as a foreign body was justifiable. Somehow those afflicted with madness no longer had any rights as members of the human community. While the ships of fools, witch hunts, and Bedlam come to mind in this regard, the plight of the homeless in modern American cities reminds us that this approach to madness is still with us.

Even today this medical model continues to have difficulty in delineating the boundaries between mental illness and normality, aggravating the fear that psychiatrists will misuse the authority of deciding who is and who is not mentally ill. While the medical model in the nineteenth century was crude and primitive from a biological perspective, its commitment to caring for suffering human beings was strong. Yet it represented a conceptual model of the person that was new and difficult (because the moral responsibility of the individual for his behavior was diminished) and to some extent in conflict with the guardians and arbiters of morality in society. To quote Alan Stone, “psychiatrists have been engaged in an enterprise that involves concealed positions on human values, moral postures and even politics” (1984:219).

Psychiatric models of mental illness (even the narrow biological ones) compete with traditional morality. As the English jurist Lord Devlin said in 1949, “Everywhere the concept of sickness expands at the expense of the concept of moral responsibility” (1959:17). Once again Stone clearly states the issue: “The problem is and has always been for psychiatry—is it only a theory of madness or is it also a more general theory of human nature or is it possible in principle to make such a distinction? Can one explain madness without explaining human nature?” (1984:221).

In medicine our interest in history often arises from a desire to demonstrate how much smarter and more knowledgeable we are than our poor ancestors with their quaint practices. We fail to notice that there are lessons in history for us, though seldom easy or obvious ones. This study of the interaction between the Millerites and the psychiatrists should stimulate us to evaluate more closely our present understanding of madness and how the mental illness model and other approaches to deal with it have evolved over the past century and a half.





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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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## Comment: Bonnie J. Miller-McLemore

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

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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.”





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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-

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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



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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



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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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# Bringing Ethics to the Bedside





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# An Interview with Dr. Mark Siegler

Convinced that medicine has entered an age of bureaucracy and parsimony, Dr. Mark Siegler, director of the Center for Clinical Medical Ethics at the University of Chicago Pritzker School of Medicine, has called for a new model of the patient-physician encounter that balances the rights of patients and the responsibilities of physicians. Accepting neither the long-held tradition of medical paternalism nor the claims of the much more recent patient sovereignty movement, Siegler has proposed accommodation, a serious process of negotiation, between patients and their doctors. In his many articles, Siegler has examined aspects of the patient-physician relationship, asking questions like why doctors “hang crepe” and how a patient’s age affects treatment decisions.

In this interview with *Second Opinion* Siegler discusses the emerging field of “clinical ethics,” which seeks to bridge the gap between formal, philosophical bioethics and the scientific particularity of clinical medicine. As part of Siegler’s program at the Center for Clinical Medical Ethics, several physician fellows, along with ethicists, philosophers, theologians, and clinicians, explore in weekly consultations the ethical dilemmas that arise in treating particular cases. Fellows are trained in state law, public policy, and philosophical ethics; this training, along with their medical expertise, enables them later to assist clinicians, ethics committees, and administrators in decision making.

As he has developed his model of patient-care consultations and the field of clinical ethics, Dr. Siegler has entered many of the current debates about medical care. In *Making Health Care Decisions* (1982), the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research accepted Siegler’s judgment that the role of the health care professional is in a “phase of incomplete redefinition.” It also endorsed his assertion that shaping a new pattern of interaction between professionals and their patients was “the critical challenge facing medicine in the coming decades.” These and many other topics were discussed in two interviews with Dr. Siegler in October 1986.

**Second Opinion:** On numerous occasions you have raised concerns about the current shape of the bioethics enterprise. What's wrong with the way bioethics has been done in the United States?

**Dr. Siegler:** Since the mid-1960s, when bioethics developed as a new field in this country, there has not been adequate representation in the field by physicians, nurses, other practicing health professionals, or even patients. Bioethics has focused primarily on policy issues and theoretical questions and has not been as helpful as it might have been to clinicians, medical students, and most important, patients.

**Second Opinion:** Why did the bioethics movement begin where it did? Why didn't clinicians rise up and shape this field themselves?

**Dr. Siegler:** Interestingly, in the early years of the bioethics movement, two kinds of clinicians—physicians and theologians—played very important roles. For example, physicians such as Dr. Henry Beecher in this country and Dr. Maurice Pappworth in England criticized what they regarded as unethical research activities involving human subjects. Subsequently, Dr. Beecher and his colleagues at Massachusetts General Hospital began developing clinical standards for determining brain death

and providing optimal care to critically ill patients. Theologians—many of whom had a “clinical” perspective from training in the ministry—also were among the developers of the American bioethics movement. I am thinking of individuals like James Gustafson, William May, Paul Ramsey, Father Richard McCormick, Joseph Fletcher, and then the group of students whom Professor Gustafson trained at Yale in the 1960s. This group included James Childress, Stanley Hauerwas, and Albert Jonsen. So at the beginning of the bioethics renewal in America, clinicians were involved. But for some reason, they soon were replaced by theoreticians from nonclinical disciplines such as philosophy, the humanities, and the social sciences. I can only speculate on why the sociology of bioethics encouraged this shift.

As a result of the shift, however, the questions addressed by bioethicists became increasingly more theoretical and less practical, and physicians and medical students, who are very practical and goal oriented, were increasingly alienated from the field. One other development in the 1970s which drove a wedge between the ethics movement and clinicians was the emphasis on medical humanities in the curriculum. Medical humanities was of great interest to a small number of medical educators and a larger

***“As the bioethical questions became increasingly theoretical, physicians and medical students, who are very practical and goal oriented, were increasingly alienated from the field.”***





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number of academic humanists who saw medical students as a potential new audience to be taught (rather the way academic moral philosophers looked on medical students and physicians). Unfortunately, medical humanities generally was perceived as too soft and peripheral to be of much interest to practicing clinicians. So I think that the two directions that ethics took in the 1970s—one toward philosophy and public policy and the other toward the humanities—proved not to be very interesting or relevant for students, clinicians, or clinical investigators. Clinicians withdrew from the field and allowed philosophers and humanists to write for and talk to their own colleagues; clinicians felt they didn't have to take much account of either dialogue.

**Second Opinion:** And what have been the consequences?

**Dr. Siegler:** Biomedical ethics did not contribute as much to medicine as it might have done. The original “clinicians”—physicians and theologians—soon were replaced by analytic philosophers, legal scholars, humanists, and social scientists. Many, though surely not all, of the bioethicist-leaders in the 1970s actually expressed disdain for the traditional patient- and physician-centered bedside ethic that had existed in medicine from the time of Hippocrates, and

recommended that it be replaced by a more social and political perspective. Many bioethicists tended to be reformers rather than teachers; they wanted to reform medicine from the outside through legal and political approaches rather than to improve medicine from the inside by training students and physicians.

Two unfortunate results have followed: first, clinicians and students were alienated from the field of bioethics; and second, the legal reform movement, through legislation and judicial opinions regarding death and dying issues, has not contributed as much as one would have hoped to the humane care of dying patients. Why has this been the case? Clinicians and medical students saw medical ethics as an add-on to the curriculum, a required course offered as a concession to the softies on a curriculum committee who thought students needed to know a little bit about medical ethics, just the way they needed to know a bit about medical humanities, something about behavioral science, something about medical anthropology, and so on. Medical ethics teaching was not highly regarded by students or practitioners because there weren't many role-model clinicians who practiced what they taught and who were able to apply ethical analysis to clinical decisions. Regarding the failures of legal reform, many of the laws and

regulations and many court decisions were formulated with an inadequate understanding of the nature of the health care system itself, of the highly complex human interactions that lie at the center of medicine, and most important, with inadequate attention to the fundamental wishes and values of sick people. It may be that courts and legislatures, which probably are not the best places to deal with personal matters such as childrearing, are also not the best places to work out such delicate matters as the humane care of dying patients.

**Second Opinion:** Your remedy for this situation is what you call clinical ethics. What is the difference between clinical ethics and bioethics?

**Dr. Siegler:** Clinical ethics refers to an analytic and descriptive approach to the practice of medicine—particularly to the process and outcomes of clinical decisions—and focuses on the doctor-patient relationship and on the doctor-patient-institution relationship. Since medicine is a practical moral profession, its practitioners require both technical expertise in the profession and sensitivity to its moral character. Nonclinical bioethicists may possess the sensitivity, but they lack the expertise. At the University of Chicago, the Center for Clinical

Medical Ethics seeks to train people who have technical knowledge and experience and who are sensitive to medicine's moral character to also become knowledgeable and experienced in ethics, philosophy, and law. For several reasons, we think that practicing clinicians must be at the core of a clinical medical ethics program: first, they are in the best position to recognize the important clinical-ethical problems which nonclinicians may miss; second, clinicians will analyze these issues in the context of the clinical situation and not regard them simply as isolated philosophical or legal quandaries unrelated to clinical practice; and finally, clinicians will be more successful than bioethicists have been in the past in teaching this important subject to medical students, nursing students, and practitioners. I am convinced that clinical ethics will become an integrated part of deci-

sion making only when it is taught at the bedside and in other clinical settings by practitioners as an inseparable part of the teaching of clinical medicine. I would go so far as to suggest that clinical ethics, in contrast to biomedical ethics, should be regarded as an inseparable aspect of medical practice rather than as a subdiscipline of philosophy, theology, or legal studies.

**Second Opinion:** What do you hope clinical ethics will accomplish?

**Dr. Siegler:** Eventually, I hope that we can "democratize" clinical ethics so that every clinician will be sufficiently prepared in the elements of clinical ethics decision making to know how to analyze a case in order to reach a reasonable and morally permissible decision that can be justified to patients,

colleagues, and society. Further, I hope clinicians will learn when they need additional help or guidance. Just as good clinicians should know when they can treat a patient's urinary tract infection and when the clinical situation is so complex that they need help from expert consultants, we must also teach clinicians when guidance in ethical matters is required. In time, I would like to see responsibility for ethical decisions in medical practice taken away from all experts—including bioethicists, institutional ethics committees, and even clinical ethicists—and returned to the proper locus of medical decision making: the interaction between patient and doctor. My goal is to train enough physicians, nurses, and patients so that ethical experts will no longer be needed or will be called on only in the most unusual circumstances.

***"I would like to see responsibility for ethical decisions in medical practice taken away from all experts and returned to the proper locus of medical decision making: the interaction between patient and doctor."***





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**Second Opinion:** What can a clinical ethics program contribute to a medical center?

**Dr. Siegler:** A well-organized clinical ethics program, particularly one with strong medical leadership and with support from senior physicians and administrators, can strengthen the work of a medical center in several ways: by direct improvements in patient care, by improvements in teaching, and by research. First, clinical ethicists can contribute to patient care by developing an effective ethics consultation service and by working closely with other departments in the medical center (for example, pastoral care services, the nursing department, the administration and the board of trustees) to develop ethically sound institutional policies. Regarding teaching activities, clinical ethicists can develop educational programs for clinical staff (physicians, nurses, and others), house staff, and medical students that focus on the varied problems facing clinicians in a modern hospital. This teaching should be done through normal modes of medical training, which include bedside teaching, ward rounds, grand rounds and seminars, as well as lectures. Finally, clinical ethicists should develop research projects on topics relating to clinical activities. Our experience at the University of Chicago has shown how

integrating the moral and technical aspects of patient care helps to identify many practical clinical problems which demand empirical and analytic investigation. These problems relate to the most fundamental of all interactions in medicine—the patient-professional relationship—and to the most basic aspect of medical practice—decision making.

**Second Opinion:** How will you accomplish all this?

**Dr. Siegler:** The Center for Clinical Medical Ethics at the University of Chicago hopes to train a core of physicians to become leaders of clinical ethics programs in major academic institutions so that these leaders can, in turn, develop teaching programs, research programs, and patient care programs at their own institutions. These physician-ethicists not only will advance the field of clinical ethics intellectually but will be able to translate for doctors, medical students, nurses, and patients the rich information that has already been developed by bioethicists, clinical ethicists, government commissions, legislatures, and court decisions. I hope these physician-leaders also will contribute to discussions of clinical ethics in such important medical organizations as the American Association of Medical Colleges, the American Medical Association,

the American College of Physicians, the American College of Surgeons, the American Board of Internal Medicine, and the American Academy of Pediatrics. My ultimate goal for clinical medical ethics is to train a generation of doctors and patients and nurses in a tradition of clinical ethics decision making that can be applied to benefit patients even under the current exigencies of cost containment and all the other bureaucratic changes that we are witnessing. Ultimately, I would like to see a much smaller number of ethicists—clinical and theoretical—who would be available to do empirical and analytic research, to assist institutions to develop policy guidelines or to provide in-service education, or to consult with national organizations, but not to be required any longer to serve primarily as clinical experts.

In place of ethics experts, or institutional ethics committees, I have encouraged that we adequately prepare all health care decision makers regardless of their specialty. In addition, on clinical units that are regarded as “high-risk ethical areas,” I have urged the formation of many small advisory groups that possess great clinical expertise and moral discernment in their special clinical areas. These groups would be composed of individual clinicians and appropriate nonclinical participants. The aim would be to keep decision making as close to



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the involved parties—patients and clinicians—as possible.

**Second Opinion:** What are you doing at the University of Chicago to prepare this strategic group of clinical ethicists?

**Dr. Siegler:** Our Center for Clinical Medical Ethics has developed a set of circumstances and experiences which may make us unique among American ethics programs. First, for the last eight or ten years, we've emphasized practical bedside ethics. This contrasts with most bioethics programs in the country. Second, the center was established at the University of Chicago, where both the medical school and the central university have encouraged our activities. We also have developed great clinical support, as our center is endorsed enthusiastically by the major academic chairpersons at our medical school as well as by the leading clinicians in the medical center. I am not aware of another major medical ethics program in the country that has a comparable level of support within their own institution from clinicians and academic leaders. Third, the University of Chicago has a rich tradition in interdisciplinary studies. Because the campus and medical center are adjacent, easy and free interaction between the clinical setting and the rest of the university is possible. This geographic proximity en-

courages scholars from the divinity school, the law school, and departments in the social sciences and the humanities to participate in our teaching and research programs and to attend our weekly conferences including the patient care review conference. Finally, we have developed, so far as I know, the first formal clinical ethics fellowship program in the country that is aimed at providing training for academic physician leaders. We are now entering the third year of this fellowship program. We receive more than a hundred applications annually for four fellowship positions. This year, our four fellows are all dedicated clinicians—three internists and one pediatrician—and each had received at least five years of training after medical school before beginning our ethics fellowship program.

**Second Opinion:** On the one hand you're arguing for the irreplaceable role of clinician at the bedside, but on the other for this wide interdisciplinary context. How do these two fit together?

**Dr. Siegler:** They fit together easily. Many ethics programs around the country have similar interdisciplinary activities. The special focus at Chicago is that we begin with the clinical and academic core before involving the nonclinical interdisciplinary faculty. We believe that this is the

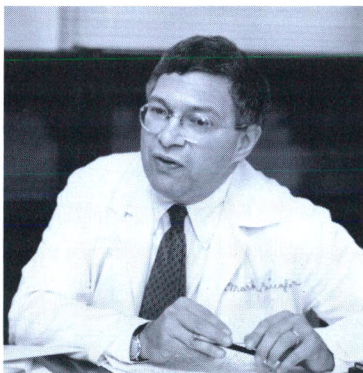
way nonclinicians can make the most substantial contributions. In contrast to many other programs, we have insisted that the clinical participants in the program be centrally involved and that nonclinicians be invited to contribute their perspectives to assist in the achievement of the central clinical mission. Let me give you an example. Earlier, I mentioned that we had developed an ethics consultation service. Currently, we receive more than three consultation requests each week. Not only do we see the patients and evaluate them and interact with the patient's family and the staff, but we also have a review conference each week which brings together clinicians, clinical ethicists, and legal scholars, theologians, philosophers, and social scientists. This latter group of nonclinical scholars participates in discussions and provides an outside review committee that comments on and criticizes consultation opinions that were reached in the previous week.

**Second Opinion:** Your model, then, involves a dialogue between physician and patient at the bedside and a larger public discourse with the clinician ethicists shuttling back and forth?

**Dr. Siegler:** It is even more complicated than that. Our clinical fellow goes to the bedside, and with the permission of the patient



***“The moral language of bioethics seems to me to have diverged from the language of those most affected by the decisions.”***



(or in cases where the patient is not competent, with the permission of the patient's best surrogate), interviews the patient, the patient's family, the patient's friends when appropriate, and interacts with all the clinicians involved in the case. This often includes discussions with the medical student, the resident, the attending physicians, the nurses, the social worker, and the hospital chaplain. After this data-gathering process is completed, the fellow presents the case formally to an attending physician, and a written note is left in the chart. The written consultation provides not only recommendations but reasons and justifications for them, and cites ethical, philosophical, and medical literature, along with legal guidelines when they are relevant. Our consultation team looks on itself both as serving a clinical role and as gathering resources for clinicians and patients who request our assistance. We try to clarify issues on which a moral, legal, or political consensus has emerged, and we frequently find ourselves addressing issues in which such a consensus has not yet developed. Frequently, these are situations in which a range of morally permissible actions might be taken by patients, families, and clinicians, but in which other decisions simply are proscribed.

This consulting activity often takes several days to complete for a single patient. Then we turn to the

weekly review conference. At times the scrutiny is critical, brutally critical; on some occasions it's thought that decisions made in haste at the bedside might not have been the best possible decisions or that relevant considerations were overlooked or that some people's views were not given sufficient weight in the decision process. At other times the reviewers are highly supportive of the decision that was made.

Let me give an example. A patient was brought to the emergency room by her husband in the middle of August. The patient was an alert, intelligent seventy-two-year-old woman, who complained of severe headaches for about two weeks. Abnormal neurological findings were detected, and the patient was referred the next day to a neurologist. The neurologist confirmed the headaches and the neurologic abnormalities and ordered a CT [computerized tomography] scan. The CT scan showed a large mass in the brain that had the appearance of a cancer, which either developed within the brain itself or had spread from another location. The neurologist advised the patient to see a neurosurgeon to decide whether this mass should be biopsied. The patient agreed and on the same day was referred to the neurosurgeon, who confirmed the CT findings, discussed the likelihood of cancer and the

***“How frequently we discover that we don’t really understand the beliefs, values, and traditions of our patients...”***



option of palliative radiation after biopsy, and recommended a surgical biopsy to determine the nature of the tumor and how best to treat it. The patient refused the surgery, saying that she had not had many dealings with doctors in the past, she was seventy-two, she had lived a full and rich life, and she really didn't want the brain biopsy or any treatment for the problem. The neurosurgeon pointed out that the treatment might depend on what was found, although it would likely be X-ray treatment. The patient said no, she didn't want the biopsy, and that she'd like to go home to think it over. When the neurosurgeon called her a week later, she was still reluctant to have the biopsy.

The neurosurgeon got a call over Labor Day weekend from the woman's husband, who said, "My wife and I have been talking about this and she's changed her mind.

She really wants the biopsy and would like to come to the hospital to be admitted tomorrow and have the biopsy done whenever you are available on Tuesday." The neurosurgeon agreed, and she was admitted on Labor Day. On Tuesday the neurosurgeon went to her bedside to talk to her at some length about her wishes. In a very short time at the bedside, he realized that the patient did not want surgery and was in the hospital under the mistaken impression that she was going to be given medicine to shrink her tumor. When the neurosurgeon referred to the conversation with her husband two days earlier, the woman insisted that she had not changed her mind and didn't know why her husband had said that. The neurosurgeon then went outside and found the husband in the waiting room—this was the day before surgery—and said, "Let me tell you what your wife has just

told me." The husband broke down and said, "It's true. She did not change her mind. I'm so upset that she's refusing to have the biopsy and refusing treatment. I love my wife and I don't want to lose her. I simply was hoping that if we got her to the hospital, you and I and the family could talk to her and change her mind. I thought it would give us leverage, but I see that my lie has not worked."

So the husband, patient, and doctor agreed the patient would go home. A follow-up appointment was scheduled a week later, but six days later the patient was brought to the emergency room, having experienced left-sided weakness and aphasia, an inability to express herself and to understand. The patient was awake but unable verbally, in writing, or by signaling to indicate that she understood anything we were saying to her or to express herself in any way.



The husband told the doctors to go ahead with the brain biopsy because, he said, the day before admission his wife had changed her mind. The husband realized that his earlier lie had damaged his credibility, but he maintained that her real feelings were to have the biopsy and to undergo any treatment the doctor thought right. The neurosurgeon, who had had three or four long encounters with the woman, could not bring himself to operate on her because through personal contact with the patient he thought he understood her wishes and because the husband had lied once before in an effort to “help” his wife. The legality of the situation, our lawyer-colleague assured us, was simple: the husband could be appointed guardian and could then legally consent to or reject surgery. Our legal colleague was troubled, however, with the ethical problems in the case:

would it be right for a legally appointed guardian to overrule the wishes of the now-incompetent wife in order to achieve his own goals? In fact, within two days, the husband became her legal guardian and the court gave him permission to consent to or reject surgery.

How would you proceed if you were the neurosurgeon who had been dealing with this woman and her husband in the past? That was the question the neurosurgeon came to us with. That seems to me to be a legitimate human and moral dilemma; it raises real questions about autonomy, fidelity, continuity of interest, about how you locate the truth in the real-world situation of ambiguity and uncertainty.

**Second Opinion:** How would you approach a case like this?

**Dr. Siegler:** The criteria that clinical ethicists would bring

to bear on a case like this may be somewhat different from the approach that might be applied from a distance by bioethicists. Clinical ethicists would focus, first and foremost, on the clinical indications in the case, particularly with regard to a patient who is now incompetent. In this case, the clinical indications were not open and shut; surgery was not the only way to proceed. Indeed, as we gathered the neurologists, radiation therapists, and medical oncologists, along with the neurosurgeon, a legitimate division of opinion emerged among the experts. Did the patient really require prior biopsy and then radiation treatment, or could one proceed directly to radiation therapy? Or in light of the size of this mass, might it not be the best thing to skip radiation therapy and to treat palliatively with steroids and comfort measures? Now those



***“...until situations become grim, sometimes until after the patient is no longer able to express them to us.”***

were three very different technical options. Among the three clinical groups that gathered on this case, (the ward team, the neurosurgeons, and the ethics consultation team) no one could decide what would constitute the best clinical care in this case.

Now, there is a second level: patient preferences for the incompetent person. The values, cultural beliefs, and traditions of the patient can be brought to bear on any clinical recommendation and can be asserted in the strongest possible way to indicate the patient's wishes regardless of the clinical recommendations or best standard of care. In this situation a number of people—the nurses, doctors, chaplains, and social workers who had seen the patient during her month's pilgrimage to the emergency room, the neurology clinic, the neurosurgery clinic, and the hospital—thought they knew what her wishes and values and preferences were. None of this was written in a living will; most of these things take place in the human encounters between patients and a variety of individuals, including the dramatic encounters with the husband, wife, and various health providers.

How does one balance that second level of interest? We thought we knew how to balance it; we knew what to do when she was competent; we would even have known what to do if the husband

had not asserted that she had changed her mind. I think we would have known what to do if he had asserted the claim that it was his wish now because he was the guardian and she couldn't speak. But he did not assert that. He advanced a much different claim when he said, "I'm telling you that she changed her mind and also, by the way, I am her legal guardian, and so I can free you of the legal worries."

The third level involves legal responsibilities. As this case indicates, having received legal sanction to perform the surgery may protect the physician legally and may even be a minimal standard of conduct, but it does not resolve the ethical dilemma faced by conscientious physicians or by the hospital lawyer.

I can't tell you how complex these discussions were—and they were a series of discussions among involved clinicians, family, family advisors, all of whom tried to come up with the most reasonable path to follow. Should we start X-ray treatment without the brain biopsy operation because we know that it is likely to shrink the tumor which has already caused the problems or should we biopsy or should we only palliate? Perhaps if the tumor can be shrunk by radiation, the patient will regain the ability to communicate and can tell us what her wishes are. I will leave the case at this point because the case is still going

on and a final resolution has not been reached.

**Second Opinion:** Cases like the one you've described must pose their own distinctive topics for research. Can you give some examples of the research projects pursued in clinical ethics?

**Dr. Siegler:** Let me mention a few of our many research projects. Most of the questions which generate our research originated out of clinical concerns expressed to us by our colleagues. For example, we started to study doctors and their understanding of DNR [do-not-resuscitate orders] and lo and behold, we found that although our hospital has had a policy for five years that's posted on every nursing unit, and the nurses understood it backward and forward, the doctors who were implementing it had very different interpretations of what DNR means. We discovered that when three doctors on a team—an intern, a resident, and an attending—decide among themselves that there ought to be a DNR on a patient case, the clinical implications of that order in the minds of those three clinicians often are different.

Another instance involved AIDS patients. "Half of my orthopedists," said the chief of orthopedics, "are ready to deal with AIDS patients, and half say they wouldn't touch an AIDS patient, or an antibody-





***“Over the last three hundred years we’ve witnessed a dramatic rise in the technical curing function of medicine and a decline in its humanitarian and caring role.”***

positive patient, with a ten-foot pole. Help me.” This led us to develop a national research survey of the attitudes of orthopedic surgeons toward caring for AIDS patients and toward doing preoperative antibody screening.

**Second Opinion:** On several occasions you have raised concerns that theologians are no longer central participants in the field of medical and clinical ethics. What contributions can theology make to this field?

**Dr. Siegler:** Theological understandings of medical ethics emphasize a sense of community, obligation, and the responsibilities of physicians both to individuals and to the community. Various theological understandings enunciate an ethic of giving and receiving, of caring and helping, which embodies a moral principle of responsibility. It seems to me that religion offers a very different perception of the moral order from that offered by philosophy and law. As my colleague Dr. Steven Miles notes, religion speaks allegorically, lyrically, emotionally, but it often speaks about what’s most real. And these modes of expression are sometimes at odds with modes of expression used by lawyers and by professional ethicists, many of whom seem to have developed a rather secular and coldly analytic mode of discourse. I agree with Dr.

Miles. We must be sensitive to the possibility that the religious modes may be the ones chosen by families and patients as they grapple with crucial life and death matters. The moral language of bioethics seems to me to have diverged from the language of those most affected by the decisions. I want to suggest that medical ethics and medical practice should be capable of employing, understanding, and feeling comfortable with modes of expression like the religious mode, alongside the rational and analytic mode.

**Second Opinion:** Does medicine need religion in order to be able to respond to certain dimensions of people’s experience? Or is something within the tradition of medicine itself already sympathetic toward these things?

**Dr. Siegler:** Traditionally there has been a very close association between religious thought and medical thought. It’s tempting to say that the separation between religion and medicine began with American bioethics, with the influx of lawyers, philosophers, and rational analytic modes of thinking, and was accelerated by what I’ve described elsewhere as the bureaucratization of medicine. Although the rift between religion and medicine has widened in the past forty or fifty years, the origins of that tension go back much further.

Over the last three hundred years we've witnessed a dramatic rise in the technical curing functions of medicine and a decline in its humanitarian and caring role. The factors contributing to this shift are complex, but surely the rise of science and technology, the image of the human body that has emerged in recent centuries—an image of a kind of physical-chemical machine—have been instrumental in leading to the division. For three thousand years medicine did very well as an art, even as a bit of a science, by offering primarily a caring function. Cure was elusive or unobtainable except when it occurred naturally or spontaneously.

The caring tradition in medicine, as opposed to the scientific and curative tradition, is more consonant with the religious tradition. Paul Ramsey and, more recently, William May stress the notion of the covenant between physician and patient. For Ramsey and for other theologians these covenant bonds involve justice and fairness, righteousness, faithfulness, loyalty, sanctity of life, and charity, concepts obviously derived from understandings of religious traditions. And indeed other possible models emphasize the caring function of physicians—the physician as friend, teacher, priest, healer, parent, or counselor.

Somewhere in the not too distant past, probably during the

Enlightenment, these roles began to change as physicians began to assume a curing rather than a caring function. The curative model was greatly reinforced in the nineteenth and twentieth centuries by revolutionary developments in the prevention and cure of infectious illnesses. In this model, the physician is viewed and sees himself or herself as scientist or fighter or technician, or more recently as contractor, cutting deals. The dominant model in today's health system is that of physician as curer. The health system, and our medical education system, perpetuate this image, and the control of infectious diseases (at least until the AIDS epidemic) and the extraordinary achievements of modern science and technology since World War II have reinforced the curing image.

An unintended side effect of this turn toward curing was a weakening of the caring tradition. Religion may not alone be sufficient to achieve a patient-centered medicine, but other traditions have been even less successful. Unfortunately, despite twenty-five years of pronouncements and efforts on the part of medical educators, conscientious physicians, medical humanists, and bioethicists, one does not really yet see a return to a patient-centered medicine in this country.

At issue is whether we will move toward a medicine of friends or a

***“At issue is whether we will move toward a medicine of friends or a medicine of strangers.”***





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medicine of strangers. If medicine is conceived as an enterprise among strangers or those who are estranged, if it arouses suspicion and distrust on the part of patients and physicians, it follows that it will be regulated in an effort to provide minimal standards for the kind of trust and confidence that formerly existed. It would be more desirable to bring back to medical ethics the theological model of a covenant and encourage the development of medical relationships that included elements of friendship, fidelity, trust, confidence, and promise keeping.

**Second Opinion:** We live in a culture that has many religions, and within any one there are many varieties of belief and opinion. How in this context can religion make a contribution in the clinical situation?

**Dr. Siegler:** The role that religion can play in clinical ethics is two-fold. First, an understanding of the religious aspects of life assists us in understanding the religious traditions both patients and physicians bring to their complex encounters. Second, the Judeo-Christian tradition remains a prevailing moral and religious underpinning of American society, despite the various factions within those groups and despite the fact that other religious traditions are represented. I think it would be wrong to ignore our

major ethical traditions, in light of both historical perspective and the context of our common morality. These traditions have played a central role in the political and legal evolution of this society. From the point of view of clinical ethics, religious pluralism should not be seen as a problem, so long as we do not use religious ideas as ontological imperatives for health policy design. If one seeks to understand the religious traditions of the participants in a medical encounter and not to use them as a rule to be applied to the next encounter, I think one could generate a much greater sensitivity to the need for a religious contribution to clinical ethics.

**Second Opinion:** What specific things can physicians do to be more responsive to religion in the clinical setting?

**Dr. Siegler:** One would be to add to the process of taking a medical history a series of questions that ask patients in a nonintrusive way to speak about their own beliefs and traditions. How frequently we discover that we don't really understand the beliefs, values, and traditions of our patients until situations become grim, sometimes until after the patient is no longer able to express them to us. Of course, it's not just religion. We lack knowledge about many aspects of individuals, about what identifies a

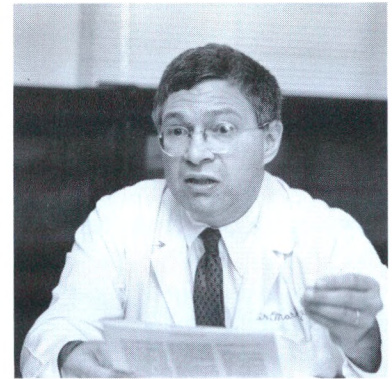
person as a person rather than a body. I must confess that, even with patients I've had for almost twenty years, it's often not until they've become sick and I begin to talk to them in new ways or to interact with their families, friends, or ministers that I first understand the rich religious traditions from which they've come.

We have a series of tasks here: to demonstrate that a patient-centered medicine is appropriate, to define the range of values that make up a full understanding of a patient as a person, and to show that for many patients religious beliefs, traditions, and values are an important component of the total picture. Then we have to devise strategies that enable our scientifically minded colleagues in medical education and medical practice to approach those values at the bedside.

**Second Opinion:** Why is raising religious questions difficult for you and your colleagues?

**Dr. Siegler:** I think there's a natural tendency not to complicate matters by infusing religious questions into the scientific and secular zones. A number of patients may be really reluctant to merge the two modes of interaction: the religious which they see as taking place in church and the scientific or medical which they see as taking place in a hospital. But many patients are not comfortable with that division;

***“How do people—doctors, patients, nurses, and other health care professionals—actually make moral choices?”***



they might prefer to integrate religion into many other activities, either tacitly or explicitly. I think with respect to medicine, scientific healing and humane caring should always be combined, and it's probably worthwhile to rethink the profound separation that now exists, to try to discover better ways to permit patients, if they wish, to allow the religious tradition to emerge in a clinical setting.

**Second Opinion:** What about hospital chaplains? What contribution do they make at the bedside?

**Dr. Siegler:** I've been impressed that for some patients a chaplain from their own religious tradition is the only one who can be of any service. These patients are concerned with questions about the dogma of the faith, and they need an expert. Frequently, however, patients are not seeking that degree

of specificity but rather an alternative way of being cared for in the clinical setting. Christians can cross over from one denomination to another and provide comfort, and for that matter Jews and Christians can cross over also. Often what is being sought is a new and larger view of the situation, an alternative context to the scientific paradigm.

**Second Opinion:** To what issues should bioethicists be addressing themselves today?

**Dr. Siegler:** First, I would hope the medical profession and medical educators will encourage the development of the field of clinical ethics. I believe it is essential to develop a wide range of morally knowledgeable clinicians who are prepared to take account of the ethical and values issues that are involved in every encounter with patients. And I want patients as

well to become sensitive to the complexity of human medicine, to the different forms of interactions that are possible in these professional relationships, and even to the mysteries of the encounter and its outcome.

Second, we need to shift from an ethic of rules appropriate to strangers to an ethic of character and virtue that seems closer to religious traditions and to the tradition of medicine that is ultimately a moral medical system. I really am eager, temporarily at least, to move from what I take to be the prescriptive ethics of the rule makers, the bioethicists and lawyers, to a richer descriptive ethic which will determine how people are currently behaving and why, what their attitudes are, and what justifications they provide for their behavior.

I've broken down this agenda into three specific questions. First, how do people—doctors, patients,



nurses, and other health care professionals—actually make moral choices? This would include attention to how they define the issues, what language and symbols they use, how they grapple with the questions, how they organize their priorities, how conflict is dealt with, how they avoid certain issues, and what kinds of decisions they are pleased with retrospectively. Second, how are moral choices actually made in the context of relationships? The first question has to do with how people might choose if left alone on a desert island, but the second has to do with making moral choices in the real world. How do the processes of relationships redefine problems, and how are agreements forged? How real and how important are constructs like individuality or autonomy in a world in which most decisions are made in a community of values and in a context of relationships? Third, how does the social and policy environment in a hospital, a nursing home, an emergency room, constrain and shape the process of moral action? Again, not how *should* the social environment constrain moral choice but how does it really work? Understanding the descriptive data may clarify questions, may redefine the questions, may even redefine some of the moral choices, while begging that ultimate question about how we know what we ought to do.

**Second Opinion:** You could have answered the question with a list of things like the American Medical Association's statement on nutrition and hydration, and other "hot topics," but instead you went in a very different direction. Are you saying that these fundamental issues are actually more important than how we deal with AIDS or whatever the current crisis might be?

**Dr. Siegler:** Absolutely. The hot topics (autonomy, informed consent, and death and dying questions) are likely to shift from those that have preoccupied ethicists for the last twenty years. They're likely to shift to questions about cost containment; ethical problems related to AIDS; some continuing questions about death and dying like withholding of fluid and hydration, and caring for patients with varying degrees of acquired and congenital brain damage; the limits of technology and the limits of treatment, and how we go about doing quality-of-life analysis. My fear is that we might permit the untested conclusions of the bioethicists and even some untested legal prescriptions of the last twenty years simply to be applied to the new questions as they emerge, as if we had already arrived at definitive conclusions. I would prefer to think that the fundamental clinical and ethical questions underlying those old dilemmas are not entirely

resolved and that the new dilemmas we must face will provide an opportunity to reexamine the fundamental questions in medicine and clinical ethics.

**Second Opinion:** What, then, would be your ideal for medicine today?

**Dr. Siegler:** I would like for our society the highest level of medicine that we are capable of delivering within our social and political system. To my mind that means a slight deviation from the old "do no harm" principle. In light of medicine's great achievements in the last fifty or hundred years we have to go further and say that we indeed can often do good. That means we have to develop a model of medicine that is outrightly beneficent in that it offers people who come to the health system asking for help things that our ancestors couldn't conceive of. I want to develop a broad system of medicine that is fully responsive to the patient as a sick or needy human being. The system of medicine I hope for would be one that responds in technical, in scientific, and in human ways, while remaining fully aware—more aware than perhaps we have been in the past or at least in the recent past—of the human dimensions which of course determine the moral dimensions of the medical encounter. ☺



# Body & Perspectives on Health Soul



*Ciencia y Caridad (Science and Charity)*, by Pablo Picasso, cover illustration for the book *Caring and Curing*.

*Caring and Curing: Health and Medicine in the Western Religious Traditions*, edited by Ronald L. Numbers and Darrel W. Amundsen (Macmillan, 601 pp., \$35.00).

It is the received wisdom of our age that while matters of religion are private, questions of health and medicine are public. Religion pertains to the soul, if there is a soul; health and medicine concern the body, the existence of which is testified to by many infallible proofs. Ministers, priests, and rabbis may freely preach, hear confessions, and even counsel, but persisting human difficulties call for the services of a “professional,”—the surgeon, psychiatrist, or social worker who has been trained to deal efficiently with the “realities” of life. Things proceed more smoothly—in government policy, in making research grants, in answering questions on medication and nutrition—if we assume that technique has the last word on the functions of life and that the best role for religion in these concerns is an invisible one. Only after experts have done all they can do with the body may the clergy reappear as central actors again, but even then they must defer to the requirements of morticians, the professionals of death.

Rarely is the received wisdom so obviously faulty. Almost all individuals who pass through crises of



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mental or physical health—believers as well as those who have lived without apparent use for religion—know the shortcomings of this view. They have experienced the ways in which “unprofessional,” nonscientific resources are tapped on such occasions. Whether it be prayers, anointings, readings from sacred texts, charms, incantations, conjure, folk remedies, or still other “unconventional” approaches to healing, it is all too obvious that man does not live by medical textbooks alone.

The difficulties with the received wisdom, moreover, multiply when we move outward from reflecting upon our own experience to examining the world more generally. Our intellectual conventions may reflect what Emil Brunner once described as the effects of the Fall: a “departmentalization of cultural life” and a “necessarily disconnected specialization” (1948:154). But in so doing they fail to describe our lived reality. The lines between religion, on the one hand, and questions of health and medicine in their widest implications, on the other, are everywhere blurred, indistinct; they zig where in a secular world we might expect them to zag.

Numerous examples of the interconnections occur in nearly every sphere. Even a rapid, nearly random, sampling suggests the artificiality of the conventional wisdom.

*Diet.* All self-respecting Americans eat prepackaged breakfast food, but not as many know that these native delicacies were invented by Seventh-day Adventists who, in their religiously motivated search for alternatives to red-meat diets, established Battle Creek, Michigan, as the cereal capital of the world. Americans who are at least middle-aged remember when restaurants

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***The lines between religion,  
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featured fish on Fridays to ensure the patronage of Roman Catholics. Until very recently Methodists would never “touch a drop” of alcohol, a practice shared with many Baptists, conservative evangelicals, fundamentalists, and not a few members of other Protestant bodies. Adventists and Mormons live longer than the rest of us in part, it seems, because they do not smoke or drink and also avoid coffee, tea, and sometimes the other caffeine-rich

beverages with which America has conquered the world.

*Sexuality.* Many of the most explosive issues in American public life are thoroughly beyond comprehension if links between faith and issues of sexuality, marriage, or reproduction are ignored. One of the first matters bringing the so-called New Christian Right into the public arena was its opposition to certain forms of sex education in American public schools. More recently, questions about the morality of abortion and about the use of government funds to pay for abortions have engendered intense public argument.

Within the religious traditions it is hard to find a more important event for Roman Catholics since the Second Vatican Council than the publication in 1968 of the encyclical *Humanae Vitae*, by Pope Paul VI, which reaffirmed traditional Catholic prohibitions against artificial forms of contraception. In another corner of the religious landscape, American Jews are increasingly worried about their overly effective practice of contraception and the resulting implications for the future of the Jewish population. And in the environs of Salt Lake the question of plural marriage is apparently not just a matter of historical curiosity for Mormons.

*Liturgy and ritual.* The worship resources of many religious traditions, including the Jewish tradition,



contain extensive forms relating to matters of health. Episcopalians have a special service for the "churching" of women who have given birth. The Anglican tradition has also made room for hymns directly addressing the situation of the sick, including one with the following prayer:

Still the weary, sick, and dying  
Need a brother's, sister's care.  
On thy higher help relying  
May we now their burden share,  
Bringing all our sufferings meet  
Supplicant at thy Mercy Seat.  
(*Hymns Ancient and Modern*:477)

**M**any Christian bodies anoint the sick or dying with oil because of the words found in the biblical book of James: "Is any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven." And almost all religious assemblies take note in some fashion of those from their number who are, as the phrase of my youth had it, "set aside on beds of illness."

*Health care delivery.* Hospital life reveals connections between religious traditions and medicine scarcely less prominent than the X-ray room or the hypodermic. Nurses

are still "sisters" to many people, and not just Roman Catholics, because of the early prominence of women's religious orders in the professionalization of institutional health care. Less well known is the extent to which Protestant "deaconesses," especially Lutherans, have fulfilled similar roles. The very names of hospitals often betray another bond between religion and health. In the Yellow Pages of my phone book from the Chicago suburbs, for example, twenty-two hospitals are listed. One is a member of the Adventist Health System, one is run by Evangelical Health Systems, one by the Alexian Brothers, one by the Franciscans, one is called Rush-Presbyterian-St. Luke's, and among the others are Loyola, Mercy, and St. Joseph's.

*Healing and medical care.* The explosive growth of Pentecostalism in the twentieth century has brought to almost everyone's attention the great popularity of "deliverance ministries" or faith healers. Among these Oral Roberts is especially intriguing, not only for his own ministry of healing, but also for his more recent efforts to establish a first-class teaching hospital in Tulsa. Many other Christian groups, as well as adherents of other religions, rely upon divine sources for healing, some as supplements to scientific medicine, some in opposition to it. Jehovah's Witnesses refuse blood

transfusions. Christian Science ministers are "practitioners" who, following the teaching of Mary Baker Eddy, treat the body through ministry to the mind. Black communities know well the healing powers of "root workers." Over three million people per year, most of them Roman Catholics, seek healing for myriad disorders of body and mind at Lourdes in France. That continuing flood of visitors is all the more remarkable in the face of rigorous standards imposed by Catholic officials themselves that have resulted in the certification of only sixty-four miraculous cures in the history of Lourdes. And these examples only begin to suggest the approaches to healing that lie beyond the orbit of "orthodox" medicine.

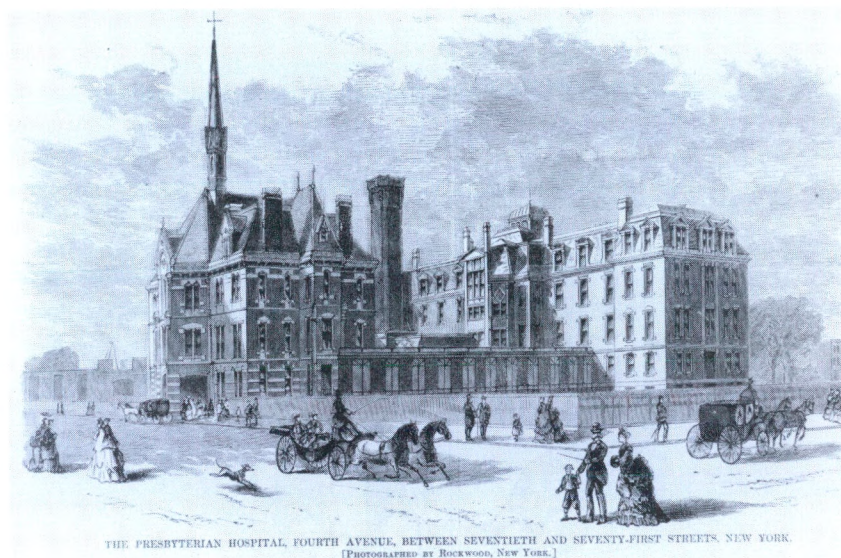
**T**he web of relationships between religion and medicine, between faith and bodily well-being, is thus extraordinarily dense. If these relationships are but survivals of primitive superstition, the world is not very modern after all. Were it not for the conventional wisdom that has divided the spheres of religion and health, one would expect their relationship to receive ongoing examination from professional organizations, annual colloquies, and learned journals.

Until recently, however, full-orbed, formal considerations of



these interconnections have been rare. Solid work abounds on the history of medicine and the history of religion in all its various streams. Abstract consideration of ethical questions enjoys a distinguished history nearly three thousand years old. Bioethics, as a specialized sub-discipline, has developed rapidly since World War II. Sociologists and epidemiologists have done considerable work on how religious “variables” affect mortality, longevity, and other actuarial matters. Books on pastoral care have become increasingly sophisticated. And casual references to the ways religion and well-being relate to each other surface in unimaginable variety and quantity.

Although artificial barriers are beginning to break down (Numbers 1982), the attention paid directly to the interconnections among ethics, religion, medicine, and well-being in its broadest aspect has been disappointingly meager. In my personal library I have three books on the history of American medicine which have served well as resources for intellectual history courses. Yet in the worthy books by Richard Harrison Shryock (1960), John Duffy (1976), and Susan Reverby and David Rosner (1979), the consideration of religious matters is limited to accounts of Cotton Mather, a clergyman in colonial Massachusetts who helped promote inoculation for



THE PRESBYTERIAN HOSPITAL, FOURTH AVENUE, BETWEEN SEVENTIETH AND SEVENTY-FIRST STREETS, NEW YORK.  
[PHOTOGRAPHED BY ROCKWOOD, NEW YORK.]

**A NEW HOSPITAL.**  
The magnificent structure pictured on this page is the "Presbyterian Hospital of New York," situated on the block bounded by

use of paint. All angles have been rounded off. The basins in wards, and where else required, are of porcelain. The wards are warmed by indirect radiation, the heat being supplied from the boiler-house through steam-pipes, and by open fire-

This hospital, as its name imports, is conducted under the auspices of the Presbyterian denomination. It is provided in the charter that the positions of superintendent and chaplain shall be held only by Presbyterians; while the object in

**BURNED AT SEA**  
A few days since a fast telegraph steamer, the *Manuel*, bound from New

*Columbia-Presbyterian Hospital, New York, 1872. The connection between religion and health care is clearly exemplified by the number of religious hospitals both early and modern.*



*The City of Faith Medical and Research Center, affiliated with Oral Roberts University, Tulsa, Oklahoma, is "dedicated to merging prayer and medicine for the healing of the whole person: spirit, mind, and body."*

smallpox, and very occasional passing references to Christian Science, the place of religion in Indian conceptions of health, and other ephemeral matters. My similarly small holdings on the history of pastoral practice do a little better, but not by much. Books by John T. McNeill (1951), H. Richard Niebuhr and Daniel D. Williams ([1956] 1983), and William A. Clebsch and Charles R. Jaekle ([1964] 1967) do illustrate the ways in which pastors have attended births, deaths, and other life passages, and the Clebsch-Jaekle volume describes one of the four primary functions of the minister as "healing" (1967:33-42). But here also the consideration of these matters is spotty at best.

Thankfully, something is now being done to cast the full light of disciplined inquiry onto these concerns. A pioneer in this effort has been The Park Ridge Center, an Institute for the Study of Health, Faith, and Ethics and sponsor of a coordinated series of efforts to explore relationships between religion and well-being (see Marty and Vaux 1982; Marty 1983; Vaux 1984; McCormick 1984; Feldman 1986; Holifield 1986; Smith 1986).

*Caring and Curing* provides a new dimension to this historical work. It is a remarkably good book and an immensely useful resource for all who are concerned about religion, health, faith, caring and



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curing, science and belief—in short, for anyone who cares about humanity and the way the most fundamental of human convictions interrelate with the most central of lived realities.

The editors' introduction sets the stage for twenty substantial essays on the major denominational groupings of the traditional Western faiths. Two of the essays are devoted to historical background, Darrel W. Amundsen and Gary B. Ferngren's account of the early Christian tradition and Amundsen's on the medieval Catholic tradition. Because of the importance of this material for the Christian tradition as a whole, these essays are of much more than antiquarian interest. They act rather as clarifying lenses through which to view the subsequent chapters. Three more essays treat generic groups whose roots lie in ancient cultures but which still enjoy great vitality today: Elliot N. Dorff on the Jews, Stanley Samuel Harakas on the Eastern Orthodox, and Albert J. Raboteau on Afro-Americans. Five essays treat Christian bodies which took definite shape in the sixteenth century: Roman Catholicism as defined by the Council of Trent (Marvin R. O'Connell); Lutheranism (Carter Lindberg); the Reformed, who are represented in America mostly by the Presbyterians (James H. Smylie); Anglicans or Episcopalians (John E. Booty); and the

Anabaptists, whose most visible modern representatives are the Mennonites and Amish (Walter Klaassen). Two essays then examine the Protestant bodies that emerged out of Reformation movements in Europe but which have had their greatest flourishing in America: "The Baptist Tradition" (Timothy P. Weber) and "The Wesleyan-Methodist Tradition" (Harold Y. Vanderpool).

Finally, eight authors address questions of health and medicine

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***While the faith traditions value  
freedom from bodily suffering,  
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comprehensively than merely  
the possession of good health.***

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among traditions that have arisen in America. Four of these groups are the product of developments within Protestantism: Unitarian and Universalists (Spencer Lavan and George Huntston Williams), Disciples of Christ and Church of Christ (David Edwin Harrell, Jr.), evangelicals and fundamentalists (Gary B. Ferngren), and Pentecostals (Grant Wacker). The other four are each connected

in some way with historical Protestantism, but also reflect the distinctive contribution of an American seer, prophet, or guiding voice. As a result these essays tend to have a dual focus, both on the founder and on the subsequent history of the movement: Ellen White and the Adventists (Ronald L. Numbers and David R. Larson), Mary Baker Eddy and the Christian Scientists (Rennie B. Schoepflin), Joseph Smith and the Mormons (Lester E. Bush, Jr.), and Charles Taze Russell and the Jehovah's Witnesses (William H. Cumberland).

Each essay covers roughly the same terrain: (1) an introduction to the distinctive events, persons, and convictions of the particular tradition (almost a short course in church history for the novice, or a ready review for someone who may have encountered this information long before); (2) an estimate of the number of adherents to the tradition, both in America and elsewhere; and (3) a complete consideration of the experiences and teaching of that tradition as they relate to the ten issues that are the focus of The Park Ridge Center: well-being, sexuality, passages (birth, adolescence, aging), morality, human dignity, madness, healing, caring, suffering, and dying.

The authors, for the most part members of the groups they describe, are well-versed in their sub-



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jects. Their work represents careful scholarship; treatment of the topics, given the limitations of length, is reasonably comprehensive. Each essay is also supported by extensive notes and a list of suggestions for further reading.

Unlike other works with such technical competence, moreover, the papers are a pleasure to read. Some are minor masterpieces. It is invidious to single out any from such a good collection, but the papers by Marvin O'Connell on the Roman Catholic tradition since 1545 and by Grant Wacker on the Pentecostal tradition struck me as models of lucidity, wit, scholarly comprehension, and interpretive depth.

As an introduction to an unduly neglected subject, this volume makes an unusually valuable contribution. It is successful on one level simply for the wealth of information and insight it presents in digestible form. On a second level it lays the groundwork for wider reflection on the subject.

**T**o begin with, this book suggests a number of new historical perspectives. One of these emerges from Marvin O'Connell's description of how decisions made at the Council of Trent in the mid-sixteenth century dominated Roman Catholic conceptions of well-being for over

four centuries. Trent's most important pronouncement defined Christianity as a spiritual life mediated through physical sacraments. Catholics therefore bestowed great spiritual significance on the material circumstances of life. In so doing, Roman Catholicism, at least from one angle of vision, more fully embodied the principle of Incarnation than did its Protestant contemporaries. At the same time, however, Trent's stress on the material realm, on the spirit-bearing capacities of nature, also opened the door to magic and superstition and gave an exalted status to *natural* law. The result was a religion which ministered powerfully, as if by course, to the physical, moral, and family lives of its adherents, but also a religion prone, in O'Connell's words, to "mesh its doctrine and practice, based upon the principle of divine immanence, with the acquired habits of country people" (p. 129). It was a religion which encouraged such peculiarities as the pilgrimage in eastern France "to a wooded shrine where mothers sought relief for their sick children from a saint who also happened to have been a dog" (p. 130). In the twentieth century, Catholic reliance on natural law has precipitated a veritable crisis of authority over the question of contraception, where the church's tradition collides with the potential for family planning created by an

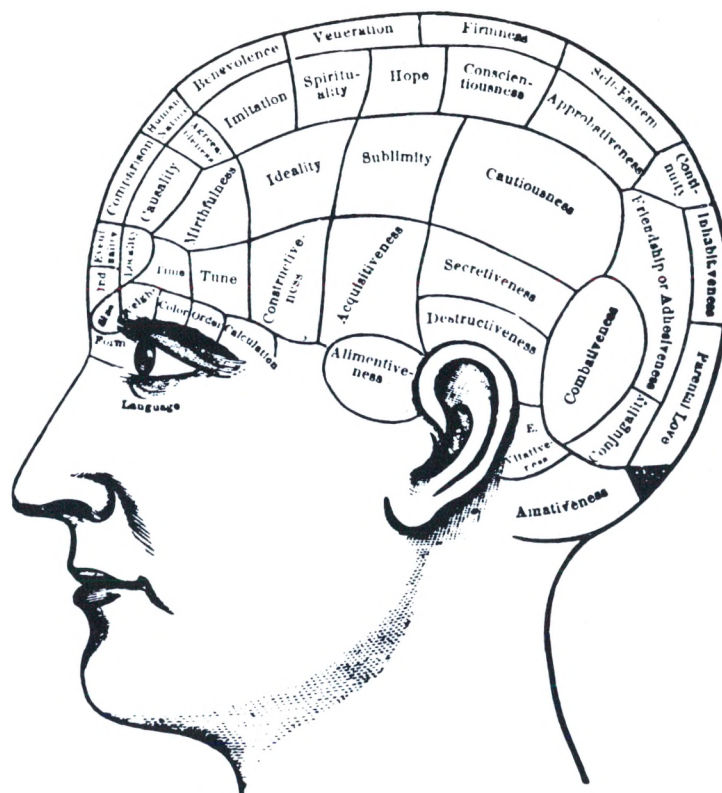
advancing scientific understanding of nature.

Another array of intriguing historical questions surfaces in the odd alliances revealed by these accounts of the denominations. The rational, modernistic faith of the Unitarian and Universalist Association seems worlds removed from the prophetic supernaturalism of the Mormons or the emphasis on the healing power of the mind among Christian Scientists. Yet these three groups, reflecting more the context of their times than the content of their distinct convictions, shared a predilection in the mid-nineteenth century for botanic medicine, Thomsonian cures (through heat and herbs), or homeopathic medicine (treatment by symptom-producing drugs) as opposed to more orthodox varieties. Similarly, leaders of the Church of Christ and of the Presbyterians have very little in common theologically except a reliance on the Bible and a rejection of the papacy. Yet these two groups, so different in other ways, were leaders in rejecting miraculous healing and championing a scientific approach to medical care. The historical commonality in this instance seems to lie in a shared commitment to scientific procedure, a commitment which has led to very different interpretations of Scripture but remarkably common attitudes toward medical practice.

Many of the essays raise a question



with even broader implications: What shift in expectation occurs when a group moves from prescientific to scientific assumptions about the care of the body? This question has a general historical significance for the older Christian bodies, and for Jews, since they in recent centuries have had to adjust ideas about divine providence, human duty, the nature of illness, and the like. Yet the question is much more than a historical one. Scientific medicine has come to have a nearly total sovereignty among a few denominations, such as the Unitarian and Universalists, and for the more liberal elements of many other traditions. At the same time older notions of divine, or demonic, control over the body persist with vigor in such groups, sometimes as a supplement to scientific views, sometimes as their antithesis. Moreover, many of the newer religious traditions rely almost as instinctively on unmediated spiritual influence as did Christians and Jews in the Middle Ages. For most Pentecostals, many evangelicals and fundamentalists, some Catholics, some members of black religious bodies, some Mormons, many Jehovah's Witnesses, and some charismatics in other denominations, the question of controlling paradigms for wellness and disease is anything but an abstract historical puzzle. It is rather a living reality that must be faced in count-



*A phrenological diagram. Phrenology, a study of the contours of the skull as indicative of character traits and mental abilities, was popular during the 1840s and 1850s. From O. S. and L. N. Fowler, New Illustrated Self-Instructor in Phrenology and Physiology (New York: Fowler and Wells, 1859).*

## MEDICAL ANECDOTES.



The Doctor takes the life to heal,  
The Butcher does the same to kill;  
The first designs the breath should stay,  
The next direct the other way.  
Should proof of this you wish to know,  
See *plate* above, and *scrip* below.

Now form your minds, which of the two,  
If sickness press, the work shall do.  
Ratsbane, zinc, and vitriol too,  
And mercury, to physic through;  
We know these poisons they do give,  
Are not their patients tough to live.

"What is the difference Doct?"

"The difference!! That is killing and this is healing."

"Doct our cures are similar. Suppose we consult."

A pro-Thomsonian cartoon on blood-letting from the Thomsonian Botanic Watchman (1834). Samuel Thomson, a farmer who founded the Thomsonian medical sect, used botanic remedies for healing rather than the drugs and blood-letting favored by doctors. He encouraged the public to buy his books and learn to heal themselves.

less daily situations, including the assignment of causes for illness, analysis of the reasons for not conceiving or for conceiving deformed children, attitudes in the face of death, and guidelines for the care of the elderly. For such individuals and groups the history of the older traditions as they passed through the scientific revolution may be instructive. From them the newer traditions can learn when conflict between orthodox scientific medicine and meaningful belief in God is counterproductive and when it is justifiable. And it may indicate the need for a more sophisticated conception of the relationship between the mechanisms of science and the convictions of faith.

Still other areas of fruitful inquiry open up from a consideration of prescientific versus scientific medicine. When, at the end of the twentieth century, members of religious groups persistently refuse to accept, at least without serious reservation, a technocratic view of physical well-being, they find themselves in curious company. With their "premodernism" they are arrayed alongside of "postmodernists" who, harkening to philosophers of science like Thomas Kuhn (1970) or any of the important contemporary theorists of meaning, have generally passed beyond the positivism of science. To be sure, some postmodernists are radically nihilistic



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and have no more use for a divinely ordered picture of the world than a scientific one. Others, however, are more kindly disposed to older alternatives to the scientific myths of our age. These are a resource for religious believers who affirm the fundamental meaningfulness of language that is not conducive to standard scientific verification. Although forms of discourse in religious communities of true believers and academic communities of post-positivists are very different indeed, there is a point of contact in the common rejection of the myth of sovereign science. A book like *Caring and Curing*, which displays so many possible alternatives to narrowly scientific conceptions of the body, the person, and the material world, thus makes an unexpectedly interesting contribution to wider considerations of the models we use to describe, define, and cope with the world.

One of many historical issues raised by the book is the distinctive contribution of the American setting for questions of religion and health. American culture has been marked by a tension concerning authority for both religion and health. On the one hand, Americans have been enamored of mechanics, science, technique, and the possibilities of efficiency. On the other, at least until the late nineteenth century, Americans have tended to be suspicious of

authority, to prefer the direction of charismatic lay leaders over the dictates of a hierarchy. In the twentieth century, that democratic propensity has been tempered by the rise of the specialist. But even modern Americans defer to the expert because he or she can get things done, can manipulate the world in a way that demonstrates competence. Traditional aristocracies, in other words, are rare.

This combination of American traits has exerted a significant influence on both religion and health care. Many of the country's strongest denominations have long histories of lay leadership or of self-trained and self-certified clerical leaders. Baptists and Methodists flourished in the nineteenth century partly because they were not dependent upon a clerical elite. Twentieth-century loyalties often cross denominational barriers to follow individuals who through the printed word or the air waves demonstrate the effectiveness of their message.

The analog in medicine is the lay-practitioner. John Wesley's book of folk medicine, *Primitive Physick*, enjoyed a long career on this side of the Atlantic. Almost all the major leaders of America's new religious groups pronounced authoritatively on matters of health. As a result, their followers in the late twentieth century must now explain some of their statements with unusual finesse

in order to demonstrate the continuing efficacy of the founder's pronouncements concerning the body. And yet because these lay leaders invited potential followers to put their words to the test, to subject them to the verdict of experience, they too contributed to the experimental, inductive style that eventually produced a new class of scientifically certified medical professionals.

A fault line, then, in American religion lies between reliance on nonhierarchical leadership and the predilection for pragmatic effectiveness. It is a virtue of many essays in this book to explain the agility with which so many American religious leaders have straddled that line. But the essays show as well the threat of earthquake brought on by the growing prestige of a demonstrably effective scientific medicine presided over by a hierarchy of professionals.

**C***aring and Curing* would be misrepresented, however, if it were considered here as only a repository of historical findings, however interesting. Not the least of the book's several other dimensions is its simple illumination of the human condition under God. The raw material it contributes toward a definition of well-being is especially important. The Western religious traditions



have exerted heroic efforts to alleviate physical and mental suffering. The recounting of these efforts reveals the great energy, faithful persistence, and liberality of means that have gone into the construction of hospitals and other institutions of healing, from the early Christian hospitals in the fourth century to the exemplary work of Roman Catholic, Lutheran, Presbyterian, Seventh-day Adventist, and others as medical missionaries in the modern world.

The other side of this picture is the patient endurance of suffering. Most of the traditions described in this book have given a high priority to sympathetic treatment of the ill and distressed. An even higher priority, however, has been the determination not to allow unalleviated suffering to detract from life's chief purpose—to know God and serve others. Thus Martin Luther, who esteemed the medical procedures of his day and was pleased when his son became a physician, was never permanently dismayed by his own continuing problems of bladder and bowel. For Luther it was enough to note that “one’s rear has its own rules” (p. 177). Mennonites, who especially in the twentieth century have distinguished themselves by practical assistance to those in need, still maintain a theology in which pain, suffering, and physical distress are bearable if experienced as part of

faithful service to God. Such examples, multiplied many times over in the book, suggest that while the faith traditions value freedom from bodily suffering, they define well-being more comprehensively than merely the possession of good health.

Such balanced conceptions of well-being prevail also in the face of death. Especially the older traditions—Judaism, Catholicism, Eastern Orthodoxy, and the different varieties of classical Protestantism—have made room in their theological firmament for the inevitability of death. They have internalized the truth that William Cowper, the eighteenth-century English hymn writer who was himself no stranger to mental trauma, once expressed as a commentary on the “Yearly Bill of Mortality of the Parish of All Souls, Northampton for the Year 1787”:

No present health can health  
ensure  
For yet an hour to come;  
No medicine, though it oft  
can cure,  
Can always balk the tomb.  
(Davie 1981:202)

**Y**et death, however vicious an enemy, is an enemy in its place. The resources which George Herbert could call upon in the seventeenth century have calmed many hearts at the approach of the end:

Death, thou wast once an  
uncouth, hideous thing,  
Nothing but bones. . . ,  
But since our saviour’s death  
did put some blood  
Into thy face,  
Thou art grown fair and full  
of grace.

(McNeill 1951:230)

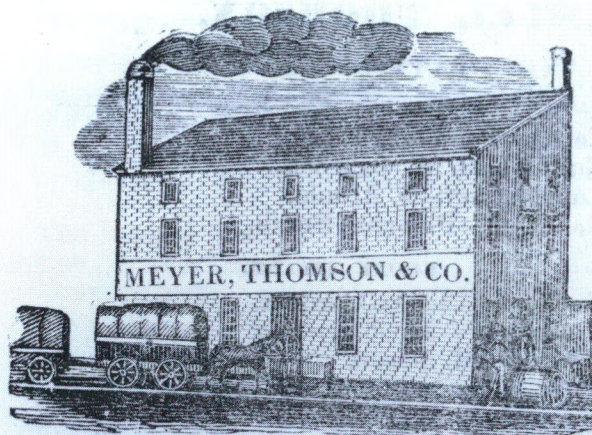
In sum, the mature religious traditions have sustained an ability to see both life in the midst of death and death in the midst of life. Catholics who stream to Lourdes do not, therefore, necessarily consider it incongruous that Bernadette Soubirous, whose vision of the Virgin established Lourdes as a healing place, died a painful death due to cancer at age thirty-five (p. 133).

One of the reasons the older traditions possess such resources for comforting the diseased and dying is that their leaders historically have attended to body as well as soul. Although today we think of physicians and ministers as the practitioners of two distinct professions, this book shows how often in the past the two offices were exercised by one person. Most of the older religions have long traditions of physician-priests or physician-ministers. Modern medical missionaries carry on this heritage, as do individuals like the twentieth-century Welsh evangelical, Martin Lloyd-Jones, who became a prominent preacher after training for medicine.



Besides discussing these healers, the book pays close attention to the role of religious orders, denominations, and pioneering men and women of faith in founding hospitals, providing nursing services, offering care for the mentally wounded, and creating medical systems. This rich legacy of comprehensive care, encompassing body and spirit, may encourage modern religious people to think that they can still exercise a more useful service to the infirm than modern fashions might suggest.

**C***aring and Curing* also stimulates consideration of what, under God, we ought to make of the body, disease, and modern scientific medicine. Again this is a byproduct of the book's major intentions, for nowhere do the authors pause to pontificate as theologians. Yet as the essays describe nearly every imaginable attitude by people of faith to questions of well-being, patterns emerge within that variety. Two attitudes contrast or counterpose the sacred and the secular, the divine and the human, the supernatural and the natural: one *rejects* the wisdom of man for the wisdom of God; the other defines the wisdom of God *as* the wisdom of man. The first resembles H. Richard Niebuhr's description (1951) of the "Christ against Culture" orientation to life in the world, the second his descrip-



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in the United States, comprising all the compounds and crude articles recommended by Dr. Samuel Thomson, part of which is as follows:

African Cayenne	Lobelia,—do. Seed
Balmony	Nerve Ointment
Barberry	Nerve Powder
Butter Nut Syrup	Pond Lily
Cancer Plaster	Poplar Bark, coarse and fine
Clivers	Prickly Ash
Composition	Raspberry Leaves
Conserve of Hollyhock	Slippery Elm
Cough Powder	Woman's Friend or Females'
Ginger	Bitters
Golden Seal	Unicorn Root
Gum Myrrh	Wake Robin, &c. &c. &c.

*Conserve of hollyhock and raspberry leaves were among the botanic remedies offered to people who were interested in self-healing.*





Visit from the Doctor—"A Serious Case," by Harry Roseland (1868-1950).  
*Alternate forms of healing were also important in the days when black doctors were rare.*

tion of the "Christ of Culture." Yet a third position seeks somehow to accommodate these two spheres of existence. All three stances appear in the spectrum of attitudes toward the body (especially its relation to the *summum bonum*), disease, and scientific medicine.

*The nature of the body.* Beginning in the fourth century Christians came more and more to consider the life of physical flesh as, at best, unrelated to life in the Spirit, or, at worse, detrimental to it. They agreed with Augustine that "wickedness" was a turn "toward lower things," including the body (Warner 1963:153). This dualism of matter and spirit owed something to resurgent Neoplatonism. It also reflected the challenge for serious-minded Christians to separate themselves from a world in which it was becoming fashionable to be a Christian. This early dualism has had remarkable staying power in Western religion, affecting in different ways and at different times Jews, Catholics, the Eastern Orthodox, Calvinists, Lutherans, fundamentalists, Episcopalians, Anabaptists, and others. It has encouraged the belief that the body is the prison of the spirit and life a burden to be borne until the mortal coil could be shuffled off for the immortal.

Just the reverse attitude prevails in some modern religions where sound physical health is equated



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with spiritual well-being. In some Pentecostal groups, for example, the failure to be healed can be explained, as Grant Wacker puts it, “in two ways: either one’s life was impure or one’s faith was shallow” (p. 522). Among Christian Scientists illness and disease are always functions of disordered mental conditions. Although other traditions lack the formal structures of these two groups, they also often encourage an attitude that links debility of body to debility of soul.

By far the most representative attitude toward the body, however, has been an attitude which values it as a very important good, but which does not equate illness or death with ultimate evil. Thus the rabbis could call the body “God’s masterpiece” (p. 9). Ancient rabbinic traditions prohibited Jews from living in cities without physicians because of the disrespect this showed for the body, and they held that Jews would one day have to reckon for the good food that their eyes saw but which they did not eat. At the same time, the rabbis enforced the dietary regulations of the Hebrew Scriptures, not so much for reasons of health as to curb an unregulated lust for food and the propensity to identify well-being with physical enjoyment. Similar attitudes are found in the Christian Scriptures and in the early church, both Western and Eastern. As John Booty put it for the Anglican

tradition, the Incarnation has led Christians generally to regard humanity in its bodily form as “flawed but nevertheless essentially of infinite worth” (p. 267). This attitude has been held by many other leaders and followers in the various Western religious traditions as well.

*The nature of disease.* Some have held that illness arises through the unmediated application of God’s

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***Ancient rabbinic traditions  
prohibited Jews from living in  
cities without physicians  
because of the disrespect this  
showed for the body.***

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will, the work of demons, or the control of spirits. In more modern times others have identified illness completely with natural causes—microbes, neurophysiological distress, or environmental conditioning. Still others, again perhaps a majority in the Western religious traditions, have sought to accommodate both natural and supernatural explanations for disease. The persistence of anointing the sick on the

model of James 5:13–14 in so many Christian denominations which have also embraced modern medicine illustrates a consistent effort to account for both the seen world and the unseen. Earlier figures like John Wesley, who taught his followers to pray for the sick, consult honorable physicians, and administer their own remedies, prepared for such a “middle way between natural and supernatural curing” (p. 329).

*The value of scientific medicine.* Within some religious traditions the practice of modern medicine remains suspect as an implicit assault on divine prerogatives. For an increasing number of others, modern medicine itself has become a religion for which no sacrifice in the ordering of daily life or the allocation of financial resources is too great. In most Western religious traditions throughout most of their history, however, the work of physicians has been honored, but honored in its place. To be sure, Christians and Jews have regularly suspected physicians, as illustrated by the medieval adage *Tres medici, duo athei* (Out of three physicians, two will be atheists) (p. 91). More typical, though, have been attitudes like those of the Franciscan sisters of Rochester, Minnesota, who helped the brothers Mayo start their famous clinic; or the words which Timothy Weber quotes from the Baptist theologian A. H. Strong: “Medicines



and physicians are the rope thrown to us by God; we cannot expect miraculous help while we neglect the help God has already given us" (p. 294).

*Caring and Curing* does not by itself provide a theology of the body, illness, or medical care. Its pages reveal more than the occasional willingness of believers to reject natural explanations in favor of the supernatural. They also describe the beliefs of the growing number of adherents to the opposite, contrasting predisposition. Most leaders in most traditions, however, have embraced the opinion that nature and providence can coexist peacefully. With its myriad variations on that theme the book confirms for theologians and ethicists that general explanations of well-being which account for both the spiritual and the material reflect the actual experience of all but the most sectarian and the most secularized of Western religious traditions.

**T**he volume does have some shortcomings. A few of the chapters, while never stuffy or obscure, drag on perhaps a little longer than necessary. In addition, there are a few simple errors of fact and interpretation. Marvin O'Connell, for instance, refers in passing to the "bleak attitude toward all things sexual routinely voiced by puritan preachers in New England" (p. 128),

even though Edmund S. Morgan ([1944] 1966:62–64 and *passim*) put such erroneous stereotypes to rest over forty years ago.

It is also possible to ask questions about the editors' choice concerning which religious traditions to include in the volume. The Quakers are missing, as is the United Church of Christ. Even more important, the essays on the Reformed tradition and on the Unitarian and Universalists, though fine pieces in themselves, make only the barest mention of the Puritan tradition in America. This is a significant lapse when one considers Puritanism's direct importance in the seventeenth and eighteenth centuries in shaping general attitudes toward life in the world and the lingering influence of the Puritans in American culture as a whole to this day.

Three other matters arise as questions for further investigation. First, it is possible at the end of the twentieth century to wonder if denominational subdivisions adequately reflect the reality of modern religious life. A denominational focus works well for the Eastern Orthodox and for several of the smaller, younger religious traditions like the Jehovah's Witnesses or Christian Science. But it is hard to imagine that simply being a Presbyterian, an Episcopalian, a Catholic, or even a Jew defines an attitude toward well-being. All Catholics probably do differ from all Presbyterians in some

particular questions of health and medicine, but it is hard to say what these would be. Increasingly clear in our day are connections which transcend traditional denominational boundaries. Those who march together to oppose abortion on demand are probably more likely to share a range of attitudes toward questions of health than the members of a denomination. The same may be said about those who sign petitions in support of *Roe v. Wade*. Similarly, religious divisions now seem more obvious as a result of contrasting answers to theological questions—for example, is the language of the resurrection literal or figurative?—than to membership in different denominations. The same sort of questions may be raised about geographical influence. Do the Conservative Baptists of Oregon share more in their attitudes toward well-being with Southern Baptists in Dallas or with Methodists in their own state? And similar questions may be posed from other interpretive angles. Marxists, for instance, quite rightly will want to know how attitudes toward well-being break down along socioeconomic axes. The editors have chosen a legitimate way of organizing their book, even if it is not the only possible one. And at any rate, they have established a standard of comparison for what others might do who would divide the religious pie into different pieces.

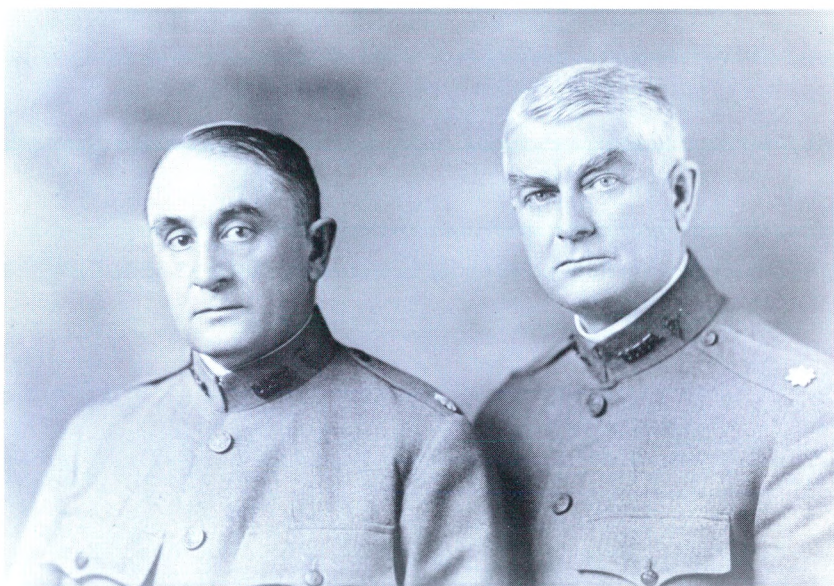
A second concern is methodo-



logical. Most of the material in most of the essays reflects the views of influential leaders. It is now a commonplace to ask whether such pronouncements are representative of religious bodies at large, and of course no easy means exists for bridging the historiographical gap between articulate leaders and less articulate parishioners. Nonetheless, the problem is not a minor one. One way to get a little closer to the person in the pew is to make full use of popular or colloquial literature. Published sermons or commentaries which enjoy a wide circulation—the more popular, the better—might be places to begin, especially for what they say about James 5:13–16 or about Jesus' promise to restore sight to the blind in Luke 4:18. Another such resource is hymns. William Cowper wrote in 1779,

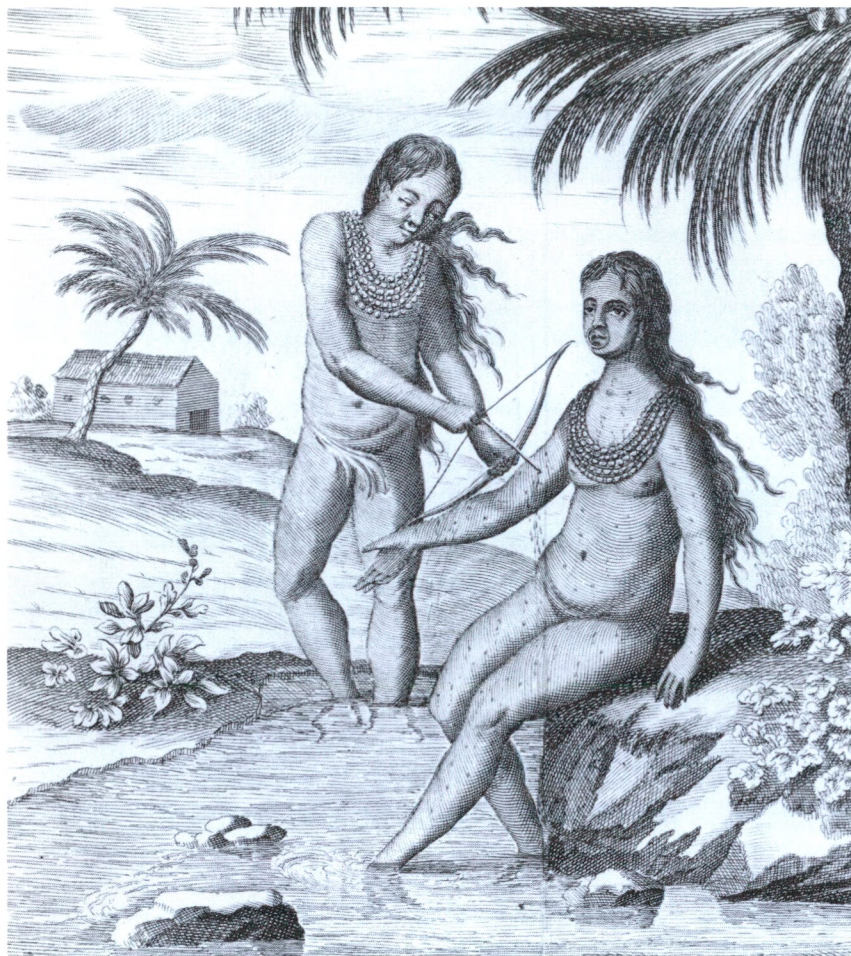
Sometimes a light surprises  
The Christian while he sings;  
It is the Lord who rises  
With healing in His wings.  
(Davie 1981:199)

**W**hether or not there is healing in singing itself, the hymns which remain in successive editions of a hymnbook, no less than those which drop out or come in, are able to get us somewhat closer to expressions of Christian faith that speak for, as well as to, the people. Where the hymns of Cowper, for example, are popular, we might expect something



*The Franciscan sisters of Rochester, Minnesota, played a pivotal part in helping Charles Horace Mayo and William James Mayo establish the Mayo Clinic (c. 1905).*





*One of the first portrayals by a westerner of blood-letting among American Indians. Engraved illustration from Wafer's New Voyage and Descr. of the Isthmus of America (1699).*

Illustrations: p. 108, in the Museo Picasso in Barcelona, Spain. © A.D.A.G.P., Paris/V.A.G.A., New York, 1986; p. 111, National Library of Medicine, Bethesda, Md.; p. 112, courtesy of City of Faith Medical and Research Center, Tulsa, Okla.; pp. 115, 116, 119, National Library of Medicine, Bethesda, Md.; p. 120, in the possession of Demosthenes D. Dasco, M.D., of Springfield, Mass., and reproduced here with his kind permission.

of his perception that suffering and the ills of the body provide a clearer understanding of God and are nearly means of grace. The popularity of other hymns with the same message, like the Lutheran Paul Gerhardt's "Why Should Cross and Trial Grieve Me," or the Anglican John Mason Neale's "Art Thou Weary," favorite hymn of the crippled Episcopal president, Franklin D. Roosevelt, could tell a similar story. Popular biblical commentaries and hymns will not succeed in revealing the mind of the people completely, but they may offer a start.

A third concern is the book's direct usefulness for clinical purposes. A few of its disclosures offer immediate aid to practitioners in the health professions. Counselors in family planning will find the discussion of modern Catholic debates on birth control helpful in work with faithful Catholics. Pharmaceutical salesmen will better know why they should not smoke when visiting an Adventist hospital. Physicians who see Jehovah's Witnesses will gain a fuller understanding of their resistance to transfusions. Those who minister to Christian Scientists at a death in the family will understand somewhat better the embarrassment (at the ultimate collapse of the mind's force) which accompanies the family's grief. And psychiatrists may be more secure when treating a Mennonite with manic-depressive symptoms because of the clear pic-



ture Walter Klaassen provides for the strain which some Mennonites feel because of their traditions's simultaneous stress on God's grace and the necessity to demonstrate faith in action.

Yet for the most part, the lessons of this book are not clinical ones, nor were they intended to be; rather the volume provides deep background. Although it does not supply sociological, demographic research sensitive to religious orientation, it illuminates the need for such work. Those who embark on such empirical investigations will yield much more impressive results if they pause

to digest thoroughly the material it presents.

**I**n sum, this book is a signal resource on its own terms. It amounts to nothing less than a pharmacopoeia of insight for matters of body, soul, and mind. But it is also more, for it provides historians with avenues for further research, ethicists with case studies for debated problems, and medical practitioners with nourishing food for thought as they go about their work. Most of all, however, the book illumines the human condition

under God. It breaks down artificial barriers between faith and science, religion and public life, the sacred and the secular. For these reasons it is to be hailed, not just because it helps professionals in working with their subjects, but because it encourages all of us, as subjects ourselves, to grasp the fuller implications of the ancient texts—"Let us make man in our image, after our likeness"; "you shall love your neighbor as yourself"—that still quicken the faith traditions of the West. ☸

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## Reflections on Aging

# Perspective

*This Perspective piece has been adapted from a speech Joseph Sittler delivered at the Human Values Institute conference, "How Does Our Society Today Value Aged Persons?" (Madison, Wisconsin, 12-14 May 1986).*

On the matter of aging, my credentials are existentially magnificent: I am eighty-two years old. I am also a professor of theology. Therefore, I wish to present some theological reflections on aging and to make a few comments on my role as a Christian theologian.

In the Jewish and Christian traditions, life is not regarded as by nature a demanding infinitude. Mortality, the bracketed character of our human life, isn't simply presupposed in either the Hebrew or the Christian Scriptures. In the psalms occurs an eloquent expression about the days of our years being "threescore and ten." I cannot help being astonished at how accurate, clinically accurate, this three-thousand-year-old statement is. Given all the so-called advances in pharmacology and biology, threescore years and ten is still just about right. The psalm continues, "and if by reason of strength they be fourscore years, yet is their strength labor and sorrow; for it is soon cut off, and we fly away" (Psalm 90:10). This agenda of ills may still be encountered today.

The Jewish and Christian Scriptures are thus extremely realistic about the nature of human life: life has a term, it unfolds its inward possibilities, and then it closes. This is not good news, however, for those who talk about life after death as if it were a biblical doctrine. Eternal life, in the Scriptures, occurs in the here-and-now as participation in the fountain of all life. Eternal life is quite different from the Elisabeth Kübler-Ross technicolor images of life after death which have attracted so many. To give us a theological perspective on life, the same psalm also sums up the matter this way: "teach us to number our days, that we may apply our



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hearts unto wisdom.” “To number our days” does not mean in Hebrew to know how many there are or to make fantastic calculations from the Book of Revelation about how many each of us may have. Rather, it means that although we don’t know what the number is, we know that there is a number. We therefore need to learn to live within the expectation of death; then we may gain wisdom from the process of confronting it. The Scripture says exactly what the Greek philosopher Anaximander said at about the same time the psalms were written: all wisdom is a contemplation of death. That is not a morbid statement but an extremely intelligent and wise one.

The extension of life expectancy made possible by biological and other scientific advances raises new issues for the aging. Certainly the whole tradition of ethics, either philosophical or Christian, finds itself in need of a new form of discourse which will somehow intersect the new realities of extended life. If by virtue of nutrition and good medical care my biological years are extended beyond my psychically responsive years, I am in a situation that only with ambivalence may be called good. I am, in a sense, preserved into idiocy. We do not have any ethical discourse able to deal with certain spin-offs from this expanded life span. For example, now that we live into an old age beset and bugged with various physical and mental illnesses, suicide among the very old has become a problem for which the older tradition of ethics has no clear discourse at all.

Suicide always, anywhere and in any form, is a mortal sin, according to the Roman Catholic tradition. This statement on ethics emerged early in Christian thought, was refined by St. Augustine, was brought to a magisterial solidity by St. Thomas Aquinas, and is now recognized by Catholic ethicists. It is, however, completely irrelevant to many of the realities of the current world. The increasing number of suicides among the old results from a combination of ineptitude, diminishing powers, growing irritation, and apprehension about which will come first: the exhaustion of the Social Security or the heart! With these problems the invitation to destroy oneself becomes clamant for many people. It is not likely that the clamor will be reduced in volume or in insistence. What kind of ethical discourse will open this situation to fresh theological reflection and sensitive human treatment?

Two years ago, I went every week for ten weeks to visit the wife of

a colleague. She had been told by her doctor that there was a complete occlusion of her colon. Because of the occlusion, she would not be able to take in any food, but she did have options. Either the medical staff could do an operation which would give her some relief for a few weeks, or she could simply desist from eating at all. She wanted to spend her last weeks seeing her children and friends, so she chose the latter option. She became weaker and weaker but remained clear right until the end. All of my previous notions about suicide were utterly exploded in that experience. She did not take her life; her life, in a sense, had already been taken. The number of her days had already been ordered. She didn't decide to die; her body decided to die. Her only choice was which way to do it. Any traditional notion of suicide would have been absurd in this situation. The usual assumption that suicidal acts result from despair, hopelessness, and an abysmal picture of one's future was totally absent in her case. She was grateful for the decently long life that she'd had. She had open and remarkably beautiful relationships with her husband, her children, and her grandchildren. Her spiritual relationship to the object of a lifelong devotion was beautiful to behold. It made me, as a kind of "professional Christian," feel that I wasn't even in her class in terms of spiritual solidity. For her death the Germans have a wonderful word: Heidegger speaks in his early work of the art of *Gelassenheit*—meaning "to let go of," to turn over, to withdraw from, to let be. She turned over her life. She didn't in anger throw it away, or in despair "curse God and die" as one character advises in the Book of Job. She simply turned it over, gave it back with a gracious gesture of gratitude, thankfulness, and praise. It was as if she said, "Thank you for a great gift; you may take it back now."

Such an action is becoming more common, and not only among those of the Jewish or Christian tradition. I know people who are not "religious" but who have lived lives of continual admiration, wonder, and praise for the variety of human experience. Those who have loved, enjoyed, and craved life die *with a gesture*. The current field of ethics is too limited to deal with this situation.

My son is a physician. I asked him if any set of norms guide his decisions about when, in what circumstances, and how long to "let be." He said, "You let it hang in a blessed ambiguity." He meant that any effort logically, theologically, or philosophically to systematize the interior



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drama of life, death, and letting go and to follow a rigid set of rules for action would do no service to his craft or to his patients. He said that we must feel our way through the inside of problems and count upon our sense of the circumstances to lead us to decisions. I find this to be of profound theological importance.

In *The Limits of Language*, edited by Walker Gibson, appears a two-page essay titled "Style," written by the late Robert Oppenheimer. It contains some memorable sentences, including this one that is well worth pondering: "Style is the deference that action pays to uncertainty." When we are in the midst of indeterminacy, where we must act and yet are without a norm, a guide, or any absolute, certifying authority for action, then the way in which we act is called style. Oppenheimer goes on to say that style is what permits us to act effectively, if not absolutely.

I offer this example of acting effectively, if not absolutely. A colleague of mine had asked me to see his wife who was *in extremis* from age. She had lived a life of sixty-seven years. As a child she had had rheumatic fever and was left with a weakened heart; she was fortunate, really, to have lived so long. When I went to see her in the hospital, she was hooked up to nearly every machine available. She said to me, "I can't say this to my husband, but I'm telling you. You see that they don't do any more of this stuff. I've had a good life, a long life, and I don't want any more things poked into me or attached to me." She made me virtually raise my right hand and say that I would do it. I repeated what I understood her to have said, and she said "That's exactly right. That's what I want." Then I spoke to her doctor, and she died two days later. But later I thought to myself, "By what authority do I do these things? How do I know that I did the right thing? I am a Christian theologian; I believe there is a God, that he has a will, but how do I know what the will of God is in the indeterminate actual situation?"

The fundamentalists might say, "Look it up in the Bible"; but the Bible has nothing to say about this. The Bible knew nothing about modern biology, anatomy, or modern science as a way of thinking and doing. I can't look at either the Old or the New Testament and find a chapter and verse that tells me what to do. In other words, in that situation, I had to act between absolutely given options: to tell the doctor or not to tell the doctor. I had to decide in the midst of absolute indeterminacy what the will of God was. Instead of making an ethical

judgment in the presence of certifiable facts, I had to make a judgment in the midst of indeterminacy. That is becoming the situation we all must face with the care of the aging.

Following the judgment, however, we must live with it. What is the nature of the interior climate whereby we live with these decisions? We can carry them as burdens on our consciences forever, and I have spoken with many people who carry these burdens of guilt from which they can find no means to set themselves free.

Because of this, I have pondered whether those of us who are members of communities of faith ought not try to create something which enables the problem to be let go, turned away, turned over to God. I have wondered how we might do that. I have wondered what kind of sensitive rhetoric is available to help us. I have not found such a rhetoric in the liturgies of the churches; but one could be created. We could call it literature for "Praise, Thanksgiving, and Departure." In it we could recognize, instead of sweeping under the ecclesiastical rug, the frailty of human life, the passing of time, the mutability of all things. We could create a liturgy wherein all the momentum of life before death could be honored in liturgical action. Some sources come to mind, including the wonderful benedictions of Simeon: "Lord, let now thy servant depart in peace from thine eyes." There are also lines in Scripture which are heavy with the faithfulness of time, destiny, and pathos. These could all be brought together to create a record for "Praise, Thanksgiving, and Departure."

Another disconcerting feature of the contemporary study of aging is the lack of attention paid to the views of the aging themselves. Some time ago, I participated in a conference on aging hosted by the National Council of Churches. In three days I heard twenty-two papers on aging—papers dealing with all conceivable, and several inconceivable, aspects of aging. We heard about the clinical description of aging, the theoretical aspects of aging, the sociology of aging, the pharmacology of aging, recreation for the aging, the shuffleboard school of aging. I was supposed to give a summary speech at the closing luncheon, but I became so angry that I set aside my speech to say the following: "I don't know any field that suffers more by the mindless transfer of methodologies appropriate



to one kind of inquiry without question to another.” The modern statistical and empirical school of sociology is now rampant in the field of gerontology and geriatrics; scholars are applying the very same methods used to make general sociological inquiries, without any self-criticism, to the issue of aging. Why is it that the people doing research on aging are not looking at what the *aging* are saying about aging? The aged have certainly not been silent or ineloquent on this matter. The aged have been talking about what it means to get old for a very long time! One can look at the works of Aeschylus, Dante, Cicero, and Shakespeare.

One of the most moving passages in all the literature of the West is a Shakespearean sonnet in which the speaker uses the image of a bare tree against an autumnal sky and remembers the same tree in the green, budding springtime. The same tree but now how different!

That time of year thou mayst in me behold  
When yellow leaves, or none, or few, do hang  
Upon those boughs which shake against the cold,  
Bare ruined choirs where late the sweet birds sang.

The terrifying plunge into the interior pathos of aging is all in that line, “Bare ruined choirs where late the sweet birds sang.” I know what this means; I am aging. I know what it means to forget, to be unable to recall with precision, alacrity, and fullness that which I’ve learned over the years. To be unable to call something to mind, to use it, so that one’s brain seems to have become a bare and ruined choir where late the sweet birds sang. The sweet birds of youth did sing once. My point is that the literature of the people is a profound confession of what they feel. I can think of several other examples in which men and women pour out their true feelings on aging. In E. M. Forster’s *Passage to India*, Mrs. Moore talks about getting old just before taking a ship home from India. These passages are some of the most moving I have ever encountered. Others may be found in Lord Halifax’s *Fulness of Days*; in Elisabeth Young-Bruehl’s biography of Hannah Arendt, *For Love of the World*; and in *Cannibals of the Heart*, a biography of Louise and John Adams by Jack Shepherd.

Finally, what might be the role of religious institutions in this era of extended life? How are the churches to address the many problems that

accompany that extension? Many people could tell you the obvious things: the provision of special care, the preparation of the church building for access, the sensitization of the pastor to the increasing numbers of the aging. All of these efforts are obvious and good. The less obvious but very important issue is our need to start talking about death earlier in life. It seems to me that the church has been simply supine before the mores of Western culture, according to which it is indecent to talk about death in polite society. Society sweeps the whole topic under the rug.

Jessica Mitford wrote a thumping book some years ago called *The American Way of Death*. In it she explicated the customs of the funeral industry, the burial plot, and all the rest. It was all, unhappily, pretty true. It is just not a part of our culture to make noises about death or to indicate that there will be an end of the Gross National Product and all of its goodies for us. The church has brought this practice up to its very height by calling every service a celebration. Some things are not to be "celebrated"; they are to be looked at straight, confronted, and put in order. Among these is death.

I faced death early in my life, not because of any wisdom of my own, but because I'm so confounded old that I was just a child at the time of the great influenza epidemic of 1916 and 1917. Three of my friends, with whom I played Saturday-morning baseball, died in that epidemic. So death hit me straight in the face when I was about ten years old. In my own ministry, I disobeyed the American way of silence about death. I did not make a big deal out of it, but when the text of the day indicated that the fullness of days had come or that the king was an old man and died, I preached on it. Death can be dealt with if it is confronted throughout our living days and not kept hidden as a mystery or a big surprise. For those with an interest in the issues of the aging I end with an admonition: See that you confront death and dying with clarity and boldness throughout your lives. See that you come to terms with death while living, and not with a shock when you are dying. ☸





