Concealed Insanity: Protestant Conceptions of Mental Maladies

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Heather Hartung Vacek

Date:_______________________

Approved:

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Grant Wacker, Supervisor

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Mark Chaves

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Mary McClintock Fulkerson

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Bonnie Miller-McLemore

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Allen Verhey

Dissertation submitted in partial fulfillment of
the requirements for the degree of Doctor of Theology
in the Divinity School of Duke University

2012
ABSTRACT

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Abstract

From the colonial era to the twentieth century American Protestants professed to care for the well-being of bodies, minds, and souls, but those living with mental illnesses often received minimal attention. Through a focus on five paradigmatic figures (Cotton Mather, Benjamin Rush, Dorothea Dix, Anton Boisen, and Karl Menninger), this dissertation first explores the history of the Protestant church and mental maladies in America. While leaders like those profiled proved engaged attending to mental illness, I argue that, developing over three centuries, two analytically distinct forces combined to inhibit broader Protestant attention to their stated mission to care for the whole person. First, the social stigma surrounding mental illness deepened and linked mental maladies with weakness and deviance in ways that prompted concealment and avoidance. Stigma resulted both from rising confidence in humankind’s ability to solve problems and the persistence of theological notions that linked mental maladies with sin. Second, shifting professionalization sequestered clergy authority in the private, spiritual sphere, leaving healing as the responsibility of secular medical professionals. After tracing how social stigma and shifting professionalization inhibited Protestant responses to mental illness, I reflect theologically and explore Christian hospitality as an antidote to stymied reactions. I assert that the practice of hospitality—through acts of welcome, compassion, incorporation, and patience—counts stigma and clears the way for more faithful and attentive care for the suffering that results from mental maladies.
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Introduction

Of all the forbidden subjects in the church, mental illness may be the surest conversation stopper, even though evidence suggests that it may be as pervasive in the church as it is in the broader society...When was the last time you read an announcement in the church bulletin that there will be a meeting of the support group for those who have experienced clinical depression? Or heard from the pulpit a prayer like “Lord, help brother Howard with his clinical depression?”

“Pained Silence” and the “Nervous Glance”

Writing pseudonymously in 1968, an ordained Presbyterian elder wondered, “how should the church handle mental illness?” “Jim Bryan” wrote as part of the “Life’s Hard Questions” feature in Presbyterian Life, and divulged his experiences with the church and his wife’s mental illness. Jim, his wife, and their children had belonged to six different Presbyterian congregations as they moved around the country. His wife’s repeated bouts of severe depression made life difficult in each church. Every time illness struck, word of the cause of her hospitalization spread and Jim encountered what he named the “Nervous Glance” followed by “Pained Silence” from other parishioners. “The news of mental illness—depression, nervous breakdown, or psychosis of any kind,” he recalled, swept “through the grapevine overnight.”

“Faithful churchgoers,” Jim observed with a dose of sarcasm, “who, I’m sure always take the log out of their own eyes before looking for specks in the eyes of their brothers, tend to close both eyes tightly and pretend that mental illness just doesn’t exist.” Jim reported that in some congregations, “four or five hospitalizations because of mental illness have gone unreported in church literature, unmentioned from church pulpits, and

unprayed for during worship services.” In contrast, he observed, “you quickly qualify for each of these if you happen to be injured in an automobile accident.” As his family suffered, they usually failed to receive support or acknowledgement from fellow congregants. Even their minister struggled to offer more than a hesitant, “Jim...how are things?”

Stigma and fear, Jim realized, prompted silence and avoidance. They also inhibited the care the family desired. In the face of mental illness, Jim lamented that not just the congregations they joined, but the larger church, had “failed in her educational and healing ministry.” Some Christians, he noticed, were “still under the unfortunate illusion, a remnant of the Dark Ages, that mental illness is the sign of divine judgment for past sin.” Other illnesses escaped similar theological diagnosis.

Eventually, Jim and his wife talked more openly, taking an active role to combat stigma and facilitate the physical and spiritual care they longed for. The concerned husband hoped that sharing their experiences and providing education about mental health and illness would bring change. To their surprise, as Jim and his wife began to be more forthright, they learned that despite hushed conversations, “nearly everyone we talked to either has had similar experiences or knows of other cases.”

Recent statistics support their findings. In the early twenty-first century, estimates indicate that every year one in four adults in the United States suffered from a diagnosable mental illness, and severe mental illnesses afflicted six percent of the population. Children suffered too—one in ten lived with a serious mental or emotional illness.

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disorder. Mental maladies struck persons of all ages, races, religions, incomes, educational levels, and upbringings.

While treatments were available, not all sought help, and some died as a result. In 2007, for example, nearly 35,000 Americans took their own lives, making suicide the tenth leading cause of death. While many died, even more came close—eleven attempted suicides occurred for every death. More than ninety percent of those committing suicide had experienced depression, other mental disorders, substance abuse, or some combination thereof. Yet, even four decades after Jim Bryan’s experience, public conversation about mental illness proved limited and causes remained as mysterious as cures. Despite their prevalence, those ailments continued to spark misunderstanding and fear. Sufferers faced stigmatization, and as a result, individuals and families often kept illness quiet and suffered in isolation, compounding the pain.

As the account of Jim Bryan and his wife displays, Christians proved no exception. Mental maladies in twentieth and twenty-first century congregations often remained out of sight, whether purposely hidden or silently ignored. That “sufferers, their families, and the community [were] more likely to interpret [mental illnesses] in moral and religious terms” than they would with physical ailments shaped that reality. Some questioned the use of secular, instead of spiritual, treatments for mental distress. Even homeless Americans—who constituted the nation’s largest population of mentally

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5 Donald Capps, Fragile Connections: Memoirs of Mental Illness for Pastoral Care Professionals (Atlanta: Chalice Press, 2005), 6.
ill individuals—received mostly physical care from Christian churches. Believers readily fed and clothed homeless men and women, but did so largely without attention to their mental health.

The Christian tradition has always included concern for health and healing. The biblical narrative recounted that Jesus Christ restored sight to the blind, enabled the lame to walk, and drove demons out of the possessed. His disciples carried on that work, and for thousands of years healing and wholeness for body, mind, and spirit have been embedded in Christian belief and practice. Followers of Christ focused on their own health, but also on caring for others. The historian Amanda Porterfield argued that Christianity is, at its core, a religion of healing. That healing, she asserted, involved both “relief of suffering and enhanced ability to cope with chronic ailments.”6 Christianity promised help in the face of distress, and in a variety of ways.

By the late twentieth century, researchers began to investigate connections between religion and mental health. Studies indicated that religious belief and participation might contribute to mental health. Wave III of the Baylor Religion Survey showed, for example, that those who “strongly believe that they have a warm relationship with God [reported] 31% fewer mental issues” and that those who “strongly believe that God knows when they need support [reported] 19% fewer mental health issues” than those without such beliefs.7 Yet, as Kathryn Greene-McCreight—a clergywoman, theologian, and sufferer—noted, studies like those often made the sick feel worse. Faced

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with the perception that Christians should feel happy and full of joy, the afflicted often felt “guilty on top of being depressed, because they [understood] their depression, their lack of thankfulness, their desperation, to be a betrayal of God.”

Human suffering concerned Christians, but not all shapes of distress earned the same response from those that professed Jesus as Lord. Mental maladies proved complex for medical, practical, and spiritual reasons. And that complexity—in assessing, living with, and attending to mental illness—appeared long before the late twentieth century.

**Statement of Problem and Argument**

From the colonial era to the twentieth century American Protestants professed to care for the well-being of bodies, minds, and souls, but those living with mental illnesses often received minimal attention. In this dissertation, I argue that, developing over three centuries, two analytically distinct forces combined to inhibit Protestants’ ability to fulfill their stated mission of caring for the whole person. First, the social stigma surrounding mental illness deepened and linked mental maladies with weakness and deviance in ways that prompted avoidance. That stigma resulted both from rising confidence in humankind’s ability to solve problems and the persistence of theological notions that linked mental maladies with sin. Second, shifting professionalization sequestered clergy (and lay Christian) authority in the private, spiritual sphere, leaving healing as the responsibility of secular medical professionals. Together, by the mid twentieth century, those forces hindered Protestant engagement with mental illness.

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Significance and Fit in the Field

My work serves two purposes. First, it explores the history of the church and mental maladies in America, filling a gap in American church, cultural, and medical history. It then uses that work to ground theological reflection about modern belief and practice. As a basis for theological reflection, my historical work provides what the anthropologist Clifford Geertz named as a “thick description” of three centuries of Christian practice.

My account draws from complementary narratives. Historians have addressed mental illness in America from the perspective of medical, institutional, legislative, and social narratives. Most significant are the historian Gerald Grob’s detailed accounts, especially *The Mad Among Us: A History of the Care of America’s Mentally Ill* (1994). Despite comprehensive treatment of mental illness, however, religion figures only nominally into Grob’s work.

Second, historians of religion have explored the history of physical healing in Christianity, with some attention to the history of pastoral care, but they have undertaken virtually no investigation of the history of specific Christian responses to mental maladies. Porterfield’s *Healing in the History of Christianity* surveyed twenty centuries

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of Christianity as a religion of healing. She argued, “healing has persisted over time and across cultural spaces as a defining element of Christianity and a major contributor to Christianity’s endurance, expansion, and success.” Yet, mental maladies appeared in her account only briefly, in discussion of the pre-modern era. In his *A History of Pastoral Care in America* (1983), the historian E. Brooks Holifield, through an exploration of the “private interchange” between clergy and “parishioners seeking counsel,” documented the theory and practice of pastoral care used by centuries of ministers in the United States. Undoubtedly, mental maladies prompted some parishioners to seek clergy counsel. Holifield’s account of the “cure of souls,” however, attended to a large set of causes for clerical and lay interaction and did not focus on mental maladies.

Third, other researchers have attended briefly to the historical intersection of faith and mental illness as part of more general investigations of mental health in America. Two examples show the placement of histories in those broader explorations. The psychiatrist Dr. Harold Koenig’s *Faith and Mental Health: Religious Resources for Healing* (2005) included a chapter-length account of historical vignettes about ecclesial care for the mentally ill in Europe and the United States. Koenig then explored both how

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11 Similar accounts, with a focus on the United States, include the Health/Medicine and the Faith Traditions series edited by Martin E. Marty and Kenneth L Vaux. Individual volumes addressed the practices of the Anglican, Catholic, Evangelical, Methodist, and Reformed traditions, among others. Also, Darrel W. Amundsen and Ronald L. Numbers, *Caring and Curing: Health and Medicine in the Western Religious Traditions* (Baltimore: Johns Hopkins University Press, 1998) offered a one-volume investigation. Mental maladies received limited attention in those volumes.

12 Porterfield, 19.

13 See, for example, her overview of demonic possession and exorcism in the Middle Ages and treatment of insanity and religious melancholy in seventeenth-century Europe. Ibid., 85-6, 102-3.

“religion affects mental health and well-being” and “the role that faith-based organizations play in delivering mental health and substances abuse services to those in need.”\(^\text{15}\) The theologian Rosemary Radford Ruether’s *Many Forms of Madness: A Family's Struggle With Mental Illness and the Mental Health System* (2010) offered some historical evidence as she shared her son’s thirty-year struggle with schizophrenia. Neither account, however, offered a detailed history of the American church and mental illness.

Fourth, akin to Ruether’s work, a spate of texts published in the last two decades deployed first-hand reflections about mental maladies to offer theological reflections and recommend productive connections between religion and mental health. A representative sample includes Stewart D. Govig’s *Souls are Made of Endurance: Surviving Mental Illness in the Family* (1994), Kathryn Greene-McCreight’s *Darkness is My Only Companion: A Christian Response to Mental Illness* (2006) and Nancy Kehoe’s *Wrestling with Our Inner Angels* (2009). An ordained Lutheran clergyman and professor of religion, Govig wove recollections of caring for a son with severe psychiatric distress with a scriptural framework for assessing suffering and hope. The Episcopal Rev. Dr. Greene-McCreight examined “the distress caused and the Christian theological questions raised by” her own clinical mental illness.\(^\text{16}\) Kehoe, a clinical psychologist and member of a Catholic religious order, found patients and fellow professionals resistant to overlap

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\(^{15}\) Koenig, ix.

\(^{16}\) Greene-McCreight was diagnosed with bipolar disorder. Among other theological issues, she explored “sin and grace, creation and redemption, God’s discipline of the soul, the hiddenness of God, and the dark night of the soul.” She also offered “practical advice for clergy and friends in dealing with mentally ill folk.” Greene-McCreight, 7.
between psychology and spirituality, a division Kehoe rejected. My work differs from all of these accounts in seeking broader historical and theological assessments.

Fifth, a plethora of volumes aimed at clergy and pastoral counselors hoping to counsel men and women that live with mental maladies have appeared in the last century. While my work might aid in a more informed provision of care, it does not offer direct pastoral care methods and techniques.

Finally, a group of texts by academic theologians discusses illness and disability, with a focus on anthropology, ecclesiology, and suffering. While mental illness rarely forms the primary focus of these authors, their work serves as a guide in constructing a theology of mental illness.

17 See also Kathleen J. Greider, Much Madness is Divinest Sense: Wisdom in Memoirs of Soul-Suffering (Cleveland: Pilgrim Press, 2007). Greider’s assessed the “spiritual wisdom” found in a variety of firsthand experiences of mental distress. Christian theological assessments join other “lenses” (psychological, psychopharmacological, physiological, sociological, religious, and spiritual) for describing experiences of mental distress. Greider framed her effort with Anton Boisen’s assessment that “certain forms of mental disorder and certain forms of religious experience are closely interrelated. Mental disorder is, I hold, the price humanity has to pay for having the power of choice and the capacity for growth, and in some of its forms it is a manifestation of healing power analogous to fever or inflammation of the body.” Boisen in ibid., 24. See my chapter 4 for discussion of Boisen.


My exploration of the history of Christianity and mental maladies in America and theological reflections about illness complements both first-hand accounts of suffering and more general studies of Christian health and healing. Given the prevalence of mental maladies, the paucity of historical treatment, minimal theological attention, and limited prescriptive literature aimed at congregational practice, my study not only fills a void in current scholarship, but also makes connections between history and theology in an effort to inform ongoing Protestant practice.

**Definition of Terms**

**Protestants**
White, middle class, Protestants form the primary subject of my account. I use the term mainstream for these believers. By the 1950s and 1960s, these Christians were known as Mainline Protestants, but that label is anachronistic before the middle of the twentieth century. I use the term mainstream to capture the Protestant leaders and flocks that enjoyed culture-shaping authority. Those Christians, I argue, offered the dominant public voice of Protestantism through the middle of the twentieth century. Within this group, I focus on the work and thought of clerical and lay leaders, believers that had the resources to take action, in the face of mental illness, but also to communicate with a wider American public. When sources provided access, I also attend to the voices of Protestants not in leadership positions. Catholic, Pentecostal, Fundamentalist, and African American believers fall outside the scope of this project.

**Mental Maladies**
Distraction. Possession. Madness. Insanity. Mental illness. Over three centuries, Americans defined diseases of the mind in many ways and did so from
practical, spiritual, and medical perspectives. Often, terms that in one era were
descriptive (such as insanity) turned pejorative in the next. By the nineteenth century,
medical labels joined—and often supplanted—descriptive and spiritual assessments. The
most customary descriptions in each period indicated presumptions about the causes of
illness and the professional groups that claimed authority to define and treat mental
distress. “Possession,” for example, popular before the rise of scientific medicine,
reflected religious assessments of demonic forces at work in individuals. “Dementia
praecox” or the more modern “schizophrenia” displayed definition by a medical
establishment.20

I deploy a variety of names for the experience of human suffering that this
dissertation addresses. Those labels reflect culturally specific experiences of mental
ailments and include: madness, malady, insanity, distress, disorder, dysfunction, and
illness. Whenever possible, I use the terminology that was normative in the period under
study. I refer to all of those ailments as “mental maladies.” I use this phrase as an
umbrella term with spiritual, organic, medical, and sometimes moral components.
“Malady” reflects the experience of those that suffered—they first suffered with
symptoms (depression, mania, visions, anxiety). Only later did professionals classify
those symptoms as disorder or illness. The phrase mental maladies also makes room for
changes in medical diagnoses and classifications that evolved throughout the nineteenth
and twentieth centuries.

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20 The historian Ann Taves described such differences in terms of “experiencing religion” or
“explaining experience.” Labels, she found, “reflect[ed] the…historical and explanatory commitments” of
those making assessments: “Psychiatrists most commonly refer to dissociation (or more distantly hysteria);
anthropologists to trance, spirit possession, and altered states of consciousness; and religionists to vision,
inspiration, mysticism, and ecstasy.” Ann Taves, Fits, Trances, & Visions: Experiencing Religion and
Attentive to how historical figures discussed mental dysfunction, in my research, I sought mention of “conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning.” Using current medical terminology, the range of ailments I incorporated include those cohering with modern diagnoses of “major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder.” I also took note of less severe instances of mental distress, assuming that diagnoses and cures applied to both chronic and episodic mental distress. Where possible, I have differentiated between mental illness and mental disability and excluded the latter (which is characterized by permanent cognitive deficits).

**Stigma**

As my argument indicates, the changing nature of social stigma associated with mental illness, and inflicted on those that suffered, played a role in shaping Protestant reactions to mental maladies. Throughout the historical narrative, I attend to how stigma formed and affixed to mental illness. As a framework, I rely on the work of the sociologist Erving Goffman.

In his 1963 *Stigma: Notes on the Management of Spoiled Identity*, the seminal work on social stigma, Erving Goffman explored how stigma infuses human social interactions. Humans living in societies develop ways to understand themselves and others, and the construction of social identities enables this process. When meeting someone new, “normative expectations” of identity help decipher and categorize who and

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what a person is. For example, a woman wearing a suit? She must be a *professional*. A young white man with dreadlocks? He must be a *free spirit*. A disheveled older man sleeping on a city park bench? He must be a *bum*.

Stigma surfaces in human relationships when the attributes of an individual vary from what social norms tell us one “should” be, based on culturally shaped expectations. Goffman argued, “while the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind….He is thus reduced in our minds from a whole and usual person to a tainted, discounted one.”22 A human attribute triggers stigma when it is, in some way, “deeply discrediting” as the result of a preexisting stereotype held by others. Some might presume, for example, that a woman previously incarcerated would not make a trustworthy employee, regardless of her crime or of changes she may have made to her life after release.

Goffman named three origins of stigma. The first, rooted in “abominaions of the body,” included attributes like missing limbs, facial deformities and other very visible characteristics. Second were “blemishes of the individual character” including a “weak will” or “dishonesty” that might be inferred from “a known record of, for example, mental disorder, imprisonment, [or] addiction.” The final source included “race, nation and religion.”23 Regardless of its origin and visibility, Goffman saw stigma defined in contrast to “normal.” Stigma marks normalcy and its alternative, “deviancy.”

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23 Ibid., 4. I return to stigma generated by religion in the final chapter and highlight how awareness of such stigma might serve productively for Christian communities hoping to counter the effects of mental illness-related stigma.
For the stigmatized, including those living with mental health problems, the perceived division between normal and deviant creates distance in social relationships and defines those that suffer as “other” and “not like us.” The dynamics of stigma shaped responses to mental illness, both outside and inside of Protestant congregations.

Summary of Chapters

Historical Assessment

In America, care for the mentally ill changed dramatically from colonial times through the twentieth century, and not always for the better. Over time, the sick, their families, municipalities, medical professionals, clergy, and fellow citizens interacted to shape the provision of care. Three centuries of American Christian practice displayed varied reactions to mental distress because their understandings of mental maladies evolved as the world around them changed. Chapters one through five offer a history of the reactions to mental illness of white, mainstream Protestants in the years between 1680 and 1980. Those chapters highlight the roles that individual Christians played by focusing on five paradigmatic figures that professed interest in mental health: Cotton Mather, Benjamin Rush, Dorothea Dix, Anton Boisen, and Karl Menninger. The stories of those figures illustrate, rather than exhaust, the subject. They show a number of paths Christians took.

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24 Some physical ailments generate stigma, although of a different sort. HIV/AIDS and instances of lung and skin cancer—all ailments with presumed (although not certain) links to willing human action or inaction serve as examples. Those living with physical disabilities face stigma, but less frequently face blame for causing—or failing to prevent—their illness. In addition, the 1990 Americans with Disability Act (ADA), and years of advocacy work that preceded it, opened access and reduced significantly the stigma associated with physical disability. Stigma and mental disability are more often connected, with parents of those living with mental disabilities often being the targets of stigma, disapproval, and shunning. Because of cognitive limitations, however, those living with mental disabilities are sometimes less disposed than the mentally ill to experience shame and perceive the effects of stigma.
During the country’s progression from a colonial outpost in the late 1600s to an emerging world power in the 1910s—a period otherwise marked by tremendous ecclesial growth and institution building—the church, and particularly clergy, struggled to compete with outside authorities for the provision of care for mental illness. As urbanization, advances in science, the professionalization of medicine, population growth, the creation of institutions for the insane, and Enlightenment optimism about the possibility of a cure converged, Protestant clergy lost their position as sole providers of care and lone experts in the definition of mental ailments. Despite those changes, individual Christians, lay and ordained alike, continued to stake a claim to the solution.

The first four chapters cover the pre-World War I period. The earliest American colonists made connections between illness and Christianity. In chapter one, the Puritan clergyman Cotton Mather’s (1663-1728) story offers a case study of early pastoral authority on health and healing and presents theological assessments of illness during the colonial era. In chapter two, the work of Benjamin Rush (1746-1813), a trained physician with Calvinist roots, highlights the professionalization of medicine in newly independent America, and displays attempts to define and systematize the diagnosis and treatment of mental maladies as medical concerns. Those chapters show the slow, although incomplete, transfer of authority from clergy to medical professionals.

In spite of this shift, Protestants continued to fight for a care-giving role. Following the creation of the first American institutions offering dedicated care for the mentally ill, the public advocacy of the Unitarian Dorothea Dix (1802-1887) during the middle nineteenth century showed outrage over inhumane treatment of the insane, particularly the indigent insane. By the turn of the twentieth century, Anton Boisen
(1876-1965), a Presbyterian clergyman and seminary professor who spent time institutionalized as the result of mental illness, presented a plea to churches to train clergy to offer better care for those living with mental maladies. That move marked Protestant attempts to reclaim lost authority. The advocacy of Dix and Boisen appears in chapters three and four.

After World War I, Karl Menninger (1893-1990), the most revered American psychiatrist of the twentieth century, and a life-long Presbyterian, appeared as the central figure at the intersection of medicine, the church, and mental illness. The Kansas physician’s medical practice and public presence spanned nearly seventy years. For the betterment of the world, Menninger drew together scientific knowledge, deep compassion, his Calvinist sense of vocation, and a dose of Christian realism. Tireless, he offered an active Christian witness in the face of mental maladies. Few other twentieth-century Protestants, though, achieved Menninger’s level of involvement. His life and work form the focus of chapter five.

The first five chapters place the work of those five persons in a larger context that included: 1) prevailing understandings of madness, 2) the state of medicine, 3) commonly prescribed treatments for mental illness, 4) the availability of institutional care, and 5) social factors that shaped understandings of mental maladies. Sources of stigma and its role in impeding Protestant reactions appear in each chapter. With that historical account, I demonstrate that while the church lost its place as the primary authority in diagnosing the nature of suffering caused by insanity, some Christians refused to abdicate the provision of care for mental maladies to secular sources.
Though Protestant leaders addressed suffering in many ways, patterns emerged. Early American Protestants like Mather reasoned that sin caused suffering and responded with theological counsel about God, faith, and illness. With the rise of formalized medicine, Christians like Rush increasingly shared the scientific assessment that suffering stemmed from disease and sought medical innovations to alleviate distress. When adequate treatments remained unavailable to many, Dix worked for more far-reaching care through the establishment of asylums. By the turn of the twentieth century, Protestants shared lessons learned from their afflictions. For those like patient and pastor Boisen, mental maladies called the church to step up and train clergy to claim a role in providing care alongside medical professionals. Later in the century, Menninger brought modern medical expertise to bear and proved willing to collaborate with clergy to do so. Together those figures demonstrate both the range and the progression of Protestant responses amidst a rapidly shifting medical, social, and religious landscape.

Despite differences, Mather, Rush, Dix, Boisen, and Menninger each responded to mental affliction as a moral obligation and a Christian duty, and all, implicitly or explicitly, claimed theological authority as they defined and addressed suffering. They also appealed to a mix of medical, scientific, moral, and clerical authority depending on their professions and experiences. As those five Protestants reacted, they assumed that their assessments and solutions should apply to all individuals and in all cases; they considered their claims normative.

**Theological Reflections**

I close this dissertation with theological reflections about modern day Protestant congregations and mental illness. Having traced how social stigma inhibited Protestant
responses to mental distress, I explore Christian hospitality as an antidote to stymied reactions. I argue that the practice of Christian hospitality—through acts of welcome, compassion, incorporation, and patience—counters stigma and clears the way for more faithful and attentive care for the suffering stemming from mental maladies.

Closing

My work explores the past in order to shed light on the present; it engages history to strengthen theology. The theologian Kathryn Tanner advocated for this sort of “historically funded constructive theology” that “looks to the Christian past not for models for simple imitation” but for how to expand “one’s sense of the possibilities for present Christian expression and action.”25 I offer an investigation of Christian practices in the face of mental maladies, exploring a history that enables me to frame a theology of responding to mental illness. More broadly, this dissertation offers insight about what appeared (and failed to appear) on congregational agendas and how Christians engaged suffering, particularly seemingly intractable suffering, in the hope that my work will assist Christians in responding more faithfully to the suffering stemming from mental maladies.

1. Cotton Mather: *The Angel of Bethesda*

The Design of all this Essay, is to Lead the Reader unto HIM....The Cure of a Sin-Sick SOUL, is that all Invalids ought to reckon their Grand Concern....Adverse health, the threat to and death of members of the body is considered rather terrible. But of all things which can happen to man, the worst is illness or loss of the mind. If we seek so diligently for medication for the sick body, why not with greater care work hard to find what cures and revives the mind?

-- Cotton Mather

1.0 Introduction

The melancholy of his parishioners, the “distraction” of fellow clergymen, and his third wife’s madness all molded Cotton Mather’s (1663-1728) perceptions of mental maladies. Impressively educated, he read widely in both theological and scientific texts. A prolific writer, he published more than 450 works on a wide variety of subjects including a history of the colonies, an exploration of witchcraft, a reconciliation of theology and science, and medicine.

The third generation Puritan minister and theologian descended from one of the most prominent families in colonial New England. Biographer Kenneth Silverman asserted, “esteem, prestige, position, and respect belonged to Cotton Mather by birth, for his flesh and name united two of the most honored families in early New England, the

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1 Cotton Mather, *The Angel of Bethesda*, ed. Gordon W. Jones (Barre, MA: American Antiquarian Society: Barre Publishers, 1972), 326. Quotation is a translation of text provided in notes to Capsula I. Jones noted that Hendrick de Roy authored the quotation; Mather stated the translation from the Dutch was made by a Lorrichini, a text Jones was unable to identify. Jones transcribed Mather’s writing with the capitalization, punctuation, and spelling used by Mather. I have retained those elements in my citations to display Mather’s intended emphasis.

2 Biographical details are drawn from “Cotton Mather,” *Dictionary of Christianity in America*, ed. Robert Dean Linder et al. (Downers Grove, IL: InterVarsity Press, 1990), 715-6. Mather was the son of Increase Mather (1596-1669), grandson of John Cotton (1584-1652), and grandson of Richard Mather (1596-1669).
Cottons and the Mathers.”  After graduating from Harvard College, Mather served Second Church (Old North) in Boston, where he “preached weekly to the largest congregation in North America.”  In June of 1690, at age twenty-seven, he was the youngest man elected a Fellow of Harvard College.  Like his forbearers, Mather’s voice had a far reach.  While his fellow colonists did not agree with him on all subjects, he serves as an authoritative colonial voice in a number of areas, including on matters of faith and health.

Mather held a keen interest in the natural world that, alongside his Christian faith, shaped his interest in health and healing.  At Harvard, and on his own, vast reading in science fed Mather’s curiosity about natural processes and medicine.  His inquisitiveness about sickness and healing arose, in part, from his desire to rid himself of a physical ailment – a stammer.  Likely, his curiosity about medical matters also grew from a desire to understand suffering and evil in the world, and in the people he loved.  Thirteen of Mather’s fifteen children preceded him in death, illness took the lives of his first two

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6 In addition to disagreeing with some of his contemporaries, historian Stout noted that Mather was also vilified “at the hands of historians.”  Despite Mather’s erudition and public service, “for two centuries, Mather survived in history annals as the Puritan hypocrite historians loved to hate.”  Stout credits work, after 1975, by David Levin, Richard Lovelace, Kenneth Silverman, and others with offering more “balanced” studies that “concede shortcoming in Mather’s character (notably his inflated ego and willful participation in the Salem witchcraft trials), but subordinate these to the unsurpassed contributions he made to Puritanism and his Native New England.”  Stout, 24.  As will be noted below, Mather’s role in the witchcraft trials is debated.
7 Mather had access to more volumes than nearly any other colonial American.  In addition to proximity to Harvard’s library, the Mather’s collection estimated as one of the largest, if not the largest, in the colonies.  Otho T. Beall, *Cotton Mather, First Significant Figure in American Medicine* (Baltimore: Johns Hopkins Press, 1954), 60n22, 23.  “Although much of his library was dispersed,” 849 titles survived.  Thomas E. Keys, "The Colonial Library and the Development of Sectional Differences in the American Colonies," *The Library Quarterly* 8, no. 3 (1938), 375.
8 Jones “Introduction: Part I,” in Mather, xiv.  Silverman, 15-17.  Silverman credits Mather’s prodigious publication record to his attempt to prove, that despite a stammer, he could produce worthy written material.
wives, and his third wife suffered debilitating mental torment that often manifested in “periods of violent hostility” toward him. Exploring sickness and investigating remedies connected Mather’s faith to existential hardships. Primarily though, as a Puritan, he investigated health and disease to understand better God’s good creation.

As the historian Winton Solberg observed, “Mather welcomed science as a handmaid of theology, a new instrument for discovering the mind of God.” Rather than viewing faith and reason as separate realms, Puritans like Mather were convinced of a “unity of knowledge” in which “sense and reason” were “God’s [works] as well as grace.” He worked hard to demonstrate those connections. Deeper comprehension of the natural world, he hoped, would bring closer communion with God, for himself and all New Englanders.

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9 Jones, “Introduction: Part I” in ibid., xv. Silverman noted the “prodigious Proxysms” his wife experienced and the hardship they caused Mather. Silverman characterized her as “vain, jealous, manipulative, and perhaps psychopathic.” Silverman, 309. Also Lovelace, 25.

The historian Virginia Bernhard affirmed the difficulty his wife’s behavior caused Mather. Bernhard, however, cast doubt on Mather’s, and later historical, claims of his wife’s chronic madness: “claims that Lydia Mather never recovered her sanity after falling ill in 1719 cannot be substantiated. In fact, given the existing evidence, it is impossible to determine whether [she] ever suffered from mental illness at all.” She speculates Mather interpreted Lydia’s anger (over finances and other matters) as madness. Regardless, Mather’s diary revealed that he worried about making his wife’s mental illness public: “I have lived a Year in continual Anguish of Expectation, that my poor Wife, by exposing her Madness, would bring a Ruine on my Ministry.” He did not comment further, but the confession displays the presence of stigma associated with mental maladies in the colonial era. Virginia Bernhard, “Cotton Mather’s ‘Most Unhappy Wife’: Reflections on the Uses of Historical Evidence,” The New England Quarterly 60, no. 3 (1987), 348, 342.


11 Perry Miller, The New England Mind: The Seventeenth Century (Cambridge, MA: Harvard University Press, 1954), 201. This “fusion” of faith and reason, Miller argued, required effort on the part of New England clergymen who needed to explain both God’s sovereignty and the order inherent in nature. Throughout his writings, Mather worked hard to justify both. Ibid., 208.

That “fusion” proved harder to maintain in later centuries, but Miller observed that seventeenth century Puritans like Mather “did not see the dangers ahead, the possibility that…descriptions of faith in the terms of reason…could give rise to a naturalistic morality and a belief that education would achieve everything usually ascribed to grace, because they were convinced that theology would remain forever the norm of reason.” While for Mather theological and scientific thought were one, the same would not be true a century later. That change influenced the loss of clerical authority over matters of health and healing. Ibid., 202.
Within the context of colonial health and healing, Mather’s story offers a telling example of thought about mental illness for several reasons. First, he viewed sickness and health in light of his Christian beliefs. In the final years of his life, Mather compiled a medical journal, *The Angel of Bethesda*. Written in 1724 and published posthumously, the text ranked as the “only comprehensive American medical work of the entire colonial period.”\(^{12}\) In it, the clergyman explored causes and cures for scores of ailments, including mental maladies. Assertions of God’s sovereignty and God’s ability to heal interspersed his medical account. For the leading New Englander, theological and medical observations were entwined. Mather laced theological writings with images of disease and mixed discussions of health with prayers. He assumed that attending to one’s own health and the welfare of others constituted part of a Christian life.

Second, that a clergyman authored a medical volume shows the authoritative role religious leaders played in a wide range of arenas during the colonial era. While Mather’s book on medicine and sickness remained unpublished for centuries, and independent of its theological content, the text offers one of the most comprehensive glimpses available into colonial medical thought.

Third, a century and a half after Mather’s lifetime, many Americans would define madness as a medical more than a spiritual problem. Mather, though, attempted to claim mental disturbances as valid religious concerns.\(^{13}\) Integrating medical and spiritual

\(^{12}\) Silverman, 406. Beall and Shryock stated that many of the chapters of *Angel* appeared in Mather’s earlier writings and sermons, thus indicating some distribution of Mather’s thought even without the publication of the text during his lifetime. Beall, 62.

\(^{13}\) Tomes noted that debate over medical versus spiritual origins of mental illness had bubbled for centuries: “The conception of madness as disease dated back to classical medicine and the Hippocratic texts. Throughout the medieval period, a tradition of medical rationalism continued to dispute the widespread popular belief that mental disorder had a supernatural or demonic origin.” That debate gained traction outside of the medical profession in significant ways in the eighteenth century. Nancy Tomes, *A
matters, his work displays presumed connections between disturbances of the body, mind, and soul. Mather embraced scientific theory without forfeiting a sense of God’s sovereignty.

Fourth, Mather’s theological reflections featured many of the presuppositions of later Protestant thought. His work included assertions of the role of sin (original and individual) in sickness; it evinced a concern with the state of one’s soul; it also betrayed belief in supernatural causes of disease. Puritan thought shaped how Americans viewed the world around them in coming centuries, including on issues of health and disease.

Finally, throughout history, Americans attributed mental maladies to a combination of supernatural, moral, and medical causes. While the balance of those factors would shift as the centuries progressed, all three elements were present in Mather’s assessment. In the centuries after Mather’s death, America’s Protestants continued to debate the right relationships between the authority of science and religion. They explored theological and medical diagnoses, and assessed religious and medical cures. As they did so, prevailing social norms shaped their conclusions. Mather’s thought introduces the basic components of that investigation.

1.1 The Angel of Bethesda

Mather drew the title of his comprehensive medical treatise from a New Testament passage about healing:

Now in Jerusalem by the Sheep Gate there is a pool, called in Hebrew Bethesda, which has five porticoes. In these lay many invalids—blind, lame, and paralyzed. One man was there who had been ill for thirty-eight years. When Jesus saw him lying there and knew that he had been there a

long time, he said to him, ‘Do you want to be made well?’ The sick man answered him, ‘Sir, I have no one to put me into the pool when the water is stirred up; and while I am making my way, someone else steps down ahead of me.’ Jesus said to him, ‘Stand up, take your mat and walk.’ At once the man was made well, and he took up his mat and began to walk. (John 5:2-9, NRSV)

The clergyman called his Angel of Bethesda “an ESSAY upon the Common Maladies of Mankind.” He implored Christians to care for their teeth, bodies, and minds, all gifts from God. By combining scientific wisdom and theological reflection, the preacher hoped the volume would bring believers to the pool of healing.

Silverman named the Angel of Bethesda Mather’s “single most important achievement in science.”14 Spanning more than sixty chapters, or “Capsula”, the account described symptoms and offered remedies for a variety of ailments including vertigo, gout, intestinal worms, toothaches, and sore throats. Mather’s advice spanned “lesser inconveniences” (“To Fasten the Teeth, Chew Mastick, often”; “For a Stinking Breath, Wash the Mouth often with a Decoction of Myrrh in Water”; “To take out the Marks of Gunpowder, Shott into the Skin, Take fresh Cow-dung, and having warmed it a Little, apply it as a thin Poultis, to the Part affected.”) as well as life threatening conditions like smallpox and consumption (tuberculosis).15 The volume addressed mental maladies in chapters on madness and melancholy, showing that he found mental disorders as worthy of attention as physical ailments.

Mather drew from an extensive collection of contemporary and ancient medical literature, and a combination of folk and medical wisdom filled the volume’s pages. With a few exceptions, The Angel of Bethesda presented a “summary of the medical

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14 Silverman, 406.
15 Mather, 281-285.
practice, beliefs, and theory of the seventeenth century” rather than original work (Mather, 1972, xviii). Most chapters noted treatments to relieve suffering, but a handful addressed prevention and the general maintenance of good health.

1.2 Colonial Medicine

Illness and injury affected most residents of colonial America, but few received formal treatment. Educated colonists had access to a variety of medical writings for advice, but for many, limited access to medical knowledge reduced the possibility of prevention and cure of both simple and complex illnesses. In addition, few formally trained physicians practiced in early America.

1.2.1 Practicing Medicine

With high costs of travelling to Europe to obtain medical training, and few incentives for European physicians to journey to the colonies, apprenticed doctors provided most medical care in the colonies’ first century. Those practitioners were sometimes college graduates in other fields who worked with established doctors, but many were untrained, self-proclaimed “physicians.” By 1720, only one Boston doctor had received formal medical training; all others learned their art via apprenticeship.

Eventually a few men formally educated in topics related to medicine appeared in colonial America. During the eighteenth century, Harvard—though it taught mostly clergy—offered courses in “physic.” As part of that training, the school acquired bodies for studies in anatomy. Twelve of the first 149 graduates from Harvard apprenticed as

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17 Oscar Reiss, Medicine in Colonial America (Lanham, MD: University Press of America, 2000), Chapter 1.

18 Beall, 29. Reiss, 26. Apprenticeship involved several years of working alongside an experienced physician before launching a solo practice.
physicians after graduation. Before the first medical schools opened, other institutions including Yale, and the College of Philadelphia taught courses in anatomy, chemistry, physics, and surgery too.\textsuperscript{19} Demand for medical training grew, although slowly.

With inconsistent training, and no professional standards, the authority of physicians on medical matters remained unsteady. In contrast, Mather’s authority as a public intellectual allowed him to express ambivalence toward doctors, even men who had received training. Midway through “The Angel of Bethesda,” for example, the minister paused to detail “The Uncertainties of the PHYSICIANS.”\textsuperscript{20} His commentary fell just after his discussion of consumption, a common ailment with a high mortality rate. Mather noted that many depended on the advice of physicians for comfort and for their lives, but as evidence of the downside in seeking their help, he displayed a wide variety of contradictory counsel offered by physicians in the face of consumption. Doctors differed about the causes and the cures for the disease, and some, Mather shared, even died from the ailment they professed to treat. With good reason, the authority of clergy to speak about health and healing remained largely unchallenged.

Despite skepticism about professional help, Mather urged suffers to seek the help of physicians, but only if they remembered that true healing came from Christ:

\begin{quote}
\textit{O Thou afflicted, and under Distemper, Go to Physicians, in Obedience to God, who has Commanded the Use of Means. But place thy Dependence on God alone to Direct and Prosper them. And know, That they are all Physicians of no Value if He do not so. Consult with Physicians; But in a full Perswasion, That if God leave them to their own Counsels, thou shalt only Suffer many Things from them; They will do thee more Hurt than Good. Be Sensible, Tis from God, and not from the Physician, that my Cure is to be looked for.}\textsuperscript{21}
\end{quote}

\textsuperscript{19} Reiss, 20. \\
\textsuperscript{20} Mather, 186-191. \\
\textsuperscript{21} Ibid., 189.
Only because they too were creations of God could the help of doctors yield good results.22

Together, Mather’s life and writing show a role for both spiritual and medical cures. Accounts of his ministry indicate that he offered care for the ill and made pastoral visits to the ailing. But, he also called on physicians for himself and family members when sick. His willingness to seek help displayed the understanding, reported by many before and after Mather’s time, that medicine was a gift of God. The clergyman made it clear that God could work through physicians, but no guarantee existed.

1.2.2 Clerical Authority in Treating Disease

While Mather did not formally practice medicine, many colonial clergymen served in both capacities. That dual role may have stemmed from understanding ministers as healers—of body and soul—but may also have resulted from the simple fact that their flocks needed their expertise.

Disease brought distress: “Wandering Pains of the Joints” from Rheumatism, “Haemorrhoidal Veins [that were] distended and Corroded,” and death from “the SMALL POX.” As a clergyman who felt called to address the suffering that illness caused, Mather saw ministers in a unique position to attend to temporal suffering. And, he displayed broad expertise, and claimed authority beyond care for the soul alone. Although he never formally practiced as a physician, he exerted medical authority during epidemics in which he perceived indifference or opposition among physicians. In 1713, for example, having lost a wife and three children to an outbreak of the measles, he urged

22 In contrast, Beall and Shryock noted, “the majority of physicians of Mather’s day” had “abandoned theological explanations of illness.” Beall, 79. Mather’s discussion introduced questions that Christians would struggle with in the coming centuries. Was God at work in the secular world? How should Christians relate to secular help?
physicians to distribute treatment directions. Then, aware that medical professionals might criticize his effort, Mather published his own instructions, in *A Letter, About a Good Management under the Distemper of the Measles, at this time Spreading in the Country. Here Published for the Benefit of the Poor, and such as may want the help of Able Physicians.*23 The minister felt compelled to help.24

While his 1713 publication failed to raise the ire of physicians, his actions during a smallpox epidemic eight years later did. Having convinced himself of the value of inoculations against disease long before the arrival of a smallpox epidemic in Boston, Mather advocated for vaccination. He did so in the face of resistance from physicians in both the colonies and Europe. While the high risk of disease and death from vaccines deterred wide support, Mather persuaded one (non-degreed) physician, Dr. Zabdiel Boylston, to inoculate. Other doctors decried the intrusion of a minister into medical matters.

Opposition exploded on both medical and theological grounds. Not only was vaccination risky, it also interfered with God’s “Providence.”25 The disagreement between the medical and theological communities sparked a “newspaper and pamphlet warfare.”26 The “controversy grew so heated that someone tossed a bomb through Mather’s living room window.” As a result, “Mather became convinced that the opposition was led by the devil,” which deepened his sense “that the souls of the

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23 This paragraph and the next one draw on Beall, 95-113.
24 Reiss, 298. Clergy were not of one mind about inoculation. Some believed the illness to be the work of God and thus to prevent it was “an unrighteous act.” Others felt inoculation was given by God to humans, that God “through his mercy” showed humanity how to help itself. Ibid., 305.
25 Beall, 104.
26 Ibid., 106.
colonists were in jeopardy.” Medical and theological concerns remained part of the same whole for the clergyman.

Other Boston clergy eventually supported Mather and Boylston’s efforts. The episode betokened an extension of clerical authority—in the name of the physical and spiritual welfare of the people—into the practice of medicine. Incursions of this sort decreased with the rise of medical science, and remained controversial. Colonial clergy, however, as general intellectuals with few peers that were as well educated, had the book knowledge to stake such claims. Mather extended his clerical authority into the medical realm, but did so under the banner of superior medical knowledge, and undergirded by spiritual concerns.

Given the scattered nature of colonial medicine, it is no surprise that during the period clergy retained authority in diagnosing illness and offering advice about care. As well-read—and in many townships the best-read—members of community, they passed on remedies of which they were aware, and, in the case of Mather, documented their recommendations. In a natural world understood to be God’s creation and domain, they did so with equal, if not superior authority from those beginning, more formally, to practice medicine.

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27 Margaret Humphreys Warner, “Vindicating the Minister’s Medical Role: Cotton Mather’s Concept of the Nishmath-Chajim and the Spiritualization of Medicine,” Journal of the History of Medicine 36, no. 3 (1981), 281.

28 The historian Margaret H. Warner asserted that the expansion of authority by Mather was a calculated effort to offset the societal “status loss” he and other clergy experienced. “In sermon after sermon the clergy, including Mather, opposed creeping secularization and disrespect for the ministry….Mather sought to study the invisible world scientifically, so that the slumbering souls of his congregation…would be convinced of the truths of Christianity and of the existence of the spirit world.” Only ministers held the expertise to bridge the scientific and the spiritual worlds. Ibid., 280.
1.2.3 Nascent Professionalization

As the colonial era drew to a close, more formal medical training emerged. In November 1765, courses in medicine, taught by physicians trained in Europe, began at the Pennsylvania Hospital.\textsuperscript{29} In 1771, The College of Philadelphia granted the advanced medical degree for the first time to four men.\textsuperscript{30} By the turn of the eighteenth century, Harvard had established its medical school and medical schools opened at Dartmouth, Queens (later Rutgers), and the University of Transylvania.\textsuperscript{31} Despite the presence of medical schools, instruction in medicine lacked standardization, and practitioners often disagreed about both diagnosis and treatment. Even with the presence of physicians and hospitals, not everyone had access to, or chose to consult a medical practitioner. Instead, colonists gleaned medical knowledge from almanacs and newspapers, and turned to patent medicines (elixirs), folk medicine and practitioners for assistance.\textsuperscript{32} They also continued to turn to clergy for advice.

1.3 Sin and Sickness

Practical and theological wisdom informed clergy assistance. Mather’s initial task in \textit{The Angel of Bethesda}, for example, was to explore the origins of sickness. He anchored the cause of all human ailments, whether physical or mental, in a theology that presumed lasting impacts of personal and original sin.

\textsuperscript{29} Reiss, 22.
\textsuperscript{30} Ibid., 23. King’s College in NYC, later Columbia University, granted its first M.D. one year earlier, in 1770. The King’s College medical school stopped operations during the British occupation of the Revolutionary War. Within three decades, the training plan would change, eliminating the bachelor’s degree and strengthening the requirements for a M.D. See my Chapter 2 for discussion of the professionalization of medicine in early America.
\textsuperscript{31} Ibid., 28.
\textsuperscript{32} Ibid., 59.
1.3.1 Remarks on the Grand Cause of Sickness

Mather reflected on the origin of evil in his first chapter: “Some Remarks on The Grand CAUSE of Sickness.” Acknowledging the difficulty of the topic, he observed, “Whence Evil Comes, has been as Vexing a problem as ever was in the World.”33 The clergyman, however, found a clear solution to the longstanding problem: the evil of sickness and disease stemmed from sin. “Bear in Mind,” he counseled, “That Sin was that which first brought Sickness upon a Sinful World, and which yett continues to Sicken the World, with a World of Diseases.”34 This proved a logical conclusion, given Mather’s theological framework. The historian Perry Miller noted that for Puritans, the “seeming contradictions between the creator’s goodness and the creation’s visible evils necessitated no denial of either; they merely reinforced the distinction between God’s revealed and secret wills….No matter how exasperating, no matter how disastrous, because all experience is given of God, it must have some reason behind it.”35

Mather saw sin as the cause of sickness in two ways. First, “the Sin of our First Parents, was the First Parent of all our Sickness.”36 To affirm original sin, Mather cited Genesis: Adam and Eve’s choice to eat, not from the tree of life, but from the tree of knowledge, damned the world to suffer the “wretchedness” of sin. Illness in innocent infants provided proof of original sin as a cause of sickness. In a later chapter devoted to “Infantile-Diseases,” Mather lamented: “Oh! The Grievous Effects of Sin! This wretched Infant has not arrived upon years of sense Enough, to Sin after the Similitude of the Transgression committed by Adam. Nevertheless, the Transgression of Adam…has

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33 Mather, 5.
34 Ibid.
35 Miller, 39.
36 Mather, 5. Miller described the Puritan understanding of original sin: Adam, the “spokesman for all men,” broke the covenant with God and thus “the guilt was ‘imputed’” to all humans as a “legal responsibility….The debt of Adam is laid at their door.” Miller, 400-401.
involved this Infant in the Guilt of it.”\textsuperscript{37} In one way or another, all human ailments resulted from the lasting effects of original sin.

Alongside original sin, Mather argued that sickness resulted from individual transgressions. “Remember, That the Sin of every individual Man,” he observed, “does not but Repeat and Renew the Cause of Sickness unto him.”\textsuperscript{38} Sometimes, through their own “willful repudiations” of God’s covenant, individuals brought sickness upon themselves.\textsuperscript{39} Again, Mather found support of his assertion in scripture, quoting Psalm 107.17: “Fools, because of their Transgression, and because of their Iniquities are Afflicted, with Sickness.”\textsuperscript{40} The minister also assumed that those working against God could be afflicted in response. He described, for example, “a critic of the clergy who after speaking in church was quickly and justifiably punished with madness.”\textsuperscript{41} Illness, then, could be punishment, or at least chastisement for individual sin.\textsuperscript{42} Mather refrained, however, from naming which illnesses stemmed from original or individual sin.

While he urged Christians to attend to personal sins, Mather offered no condemnation of those afflicted with mental illness. The same was not true for those afflicted with venereal diseases. Those individuals he dismissed as wretched sinners in his chapter, “Kibroth Hattaavh, or Clean Thoughts, on, The Foul Disease.” The minister found the topic so distasteful, such a “Nasty Discourse,” that he refrained from

\textsuperscript{37} Mather, 271.  
\textsuperscript{38} Ibid., 6.  
\textsuperscript{39} Miller, 407.  
\textsuperscript{40} Mather, 6.  
\textsuperscript{42} Scripture, the primary source of authority for understanding the causes of illness for Mather, was displaced by scientific and medical knowledge in the following centuries.
suggesting remedies. He assumed those afflicted deserved to continue in their distress: “As for any Remedies under this Foul Disease,—You are so Offensive to me, I’ll do nothing for you. You shall pay for your Cure.” Apparantly, some deserved continued suffering and were beyond clerical help.

1.3.2 The Usefulness of Illness: A Prompt to Turn toward Christ

Regardless of the specific cause, Mather viewed illness as a chance for introspection, an opportunity to identify and root out one’s own sin. The role of “Sickness” he argued, was “to awaken our Concern, first, for the pardon of the Maladies in our Souls.” Physical and mental ailments provided one of many prompts for the believer to turn toward Christ and seek assurance of their salvation.

Mather understood all things—life, death, illness, health, nature, and humanity—theologically. A 1700 sermon showed his seamless mixing of theological and medical imagery. Describing one who had sinned, Mather observed, “He has the Palsey of an unsteady Mind; He has the Feavour of Unchasity…He has the Cancer of envy; He has the Tympany of Pride.” In his discussion of the usefulness of sickness for prompting self-reflection, he offered the following analogy: “I pray, Lett our Sickness itself, be such an

43 Mather, 116-120.
44 Ibid., 8.
45 Puritans, forbearers of American Congregationalists and Presbyterians, adhered strongly to Calvinist notions of the sovereignty of God and the election of the saints. A preoccupation with one’s spiritual state shaped Puritan life. Assurance of God’s gracious salvation of the saints existed, though, alongside perpetual uncertainty about the state of one’s own soul. Affirming all of God’s creation as good, Puritans like Mather knew they could pave the way for God’s saving work. Continual efforts to root out sin—individual and corporate—shaped life in colonial New England.

In The Angel of Bethesda, Mather deployed his concept of the nishmath-chajim (from the Hebrew “breath of life”), “a vital spirit that formed a bridge between man’s physical and spiritual components” – it linked the rational spirit and the physical body. He assumed illness to be rooted in imbalances in the nishmath-chajim. Warnor, 278, 285, 287. Mather was convinced of the connection between physical/mental and spiritual health, and the concept of “nishmath-chajim” enabled him to make the minister central to the healing process.” Ibid., 283.
46 Mather, in Beall, 35.
Emetic, as to make us Vomit up our Sin, with a penitent Confession of it.”

Mather viewed the experience of illness as wasted if not used for its spiritual benefit: “Our Sickness is utterly lost upon us, if it render not a CHRIST more precious unto us than ever.”

Even in the case of illness in children, Mather hoped that “the Uncomfortable Circumstance of my Child, My God will humble me, for the Share which I have in the Sin of our First Parents. May my Repentance for our Original Sin, be brought unto its Perfect Work, by the View of what My Child… is now suffering from it.”

Mather found sacred purpose in all natural phenomena.

1.4 Mental Maladies: A Dismal Spectacle!

The minister’s treatment of mental maladies in The Angel of Bethesda appeared in chapters on Madness and Melancholy. While his assessments of those conditions overlapped, he saw them as distinct. His account lacked detailed accounts of the symptoms of mania and melancholy; rather he focused on causes and then turned to recommended treatments. Missing in Mather’s presentation was any attempt to justify the reality of these conditions, indicating, that defining madness evidently offered no challenge for his audience.

1.4.1 Madness

Madness, according to Mather, resulted from inflamed “animal spirits” in the brain. It caused “Raging,” “Shatter’d Ideas in the Brain,” and “a Confused Manner.”

Mental distress could also inflict bodily effect, including “Extraordinary Strength in the

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47 Mather, 7.
48 Ibid., 8-9.
49 Ibid., 272.
50 Madness and “distraction,” appeared as the most common labels for mental maladies in colonial writings.
51 Mather, 129.
Limbs,…Patience of Cold, and other Inconveniences.” Mather named madness a “DISMAL Spectacle!”, and set it in contrast to human reason. He contrasted the “Calamity” of madness to “reason” and “enlightenment,” and pointed to God as the gracious giver of those powers. Though he did not explain the connection between cognitive and physical aspects of madness, his assessment made clear that he recognized both.

1.4.2 Melancholy

Mather described symptoms more thoroughly in his account of melancholy. With the “Distemper” of melancholy, he noted “the System of our Spirits, comes to be dulled, and sowred.” He characterized sufferers as serious, sad, miserable, and thoughtful. While their behavior often appeared as “Nonsense” and “Folly” to those around them, Mather found melancholy difficult to shed. “The Fancies and Whimsies of People overrun with Melancholy” Mather noted, “are so Many, and so Various, and so Ridiculous, that the very Recital of them, one would think, might somewhat serve as a little Cure for Melancholy.” Melancholy itself seemed to exacerbate suffering: “these Melancholicks, do sufficiently Afflict themselves, and are Enough their own Tormentors. As if this present Evil World, would Really afford Sad Things Enough, they create a World of Imaginary Ones, and by Meditating Terror, they make themselves as Miserable, as they could be from the most Real Miseries.” Melancholy brought deep distress.

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52 Ibid., 129. Mather also cited a paucity or disturbance of “Animal Spirits as the cause of “Dizziness, but there, at fault is a giddy, or over ambitious soul.” In addition, he listed obstruction of the Animal spirits at fault for nightmares. Ibid., 148-149, 153.
53 Ibid., 133.
54 Ibid.
55 Ibid.
1.4.3 The Uniqueness of Mental Maladies

Mather’s description of madness and melancholy differed in two ways from his commentary on physical afflictions. First, he spent more time discussing the relationship of sin to mental distress than he did in chapters on other ailments. The minister did not find all madness and melancholy rooted in individual sin, but he made clear that its causes were not easy to describe. While the source of mental ailments remained unknown, he argued individual sins against God did bring madness, even when physical causes also existed. Second, he noted the universal reach of mental distress. “What is the Whole World but an Entire Mad-house?” Mather did not draw a crisp distinction between humans afflicted with madness and melancholy and healthy ones. Instead, he observed that all suffered, at least in some area of their lives. “Every Man is Mad in some One Point;” Mather asserted; “There is at least One Point, wherein Reason will do nothing with him.” Mental distress proved unavoidable.

1.5 The Role of the Supernatural in Mental Maladies

Mather’s commentary assumed mental disorders were connected to the supernatural realm, whether spurred by sin, divine punishment, a struggle of faith, witchcraft, or demonic possession. Despite speculation about its origins, causes of mental illness remained elusive in colonial America. The ascription of otherworldly influence persisted partly because biological explanations remained unknown. The

56 Ibid., 130.
57 The role of gender in predisposing individuals to certain types of mental maladies made only scant appearance in Mather’s account. For example, women might suffer “Madness of an Uterine Original,” or hysteria. Ibid., 132.
58 Ibid., 130-131. Of these two differences, the second would fade away in descriptions of mental maladies in the coming century. Presumptions about the curability of mental illness and a renewed emphasis on human productivity brought about by the market economy (which demanded productive workers) meant that madness came to be understood as an exception, rather an a universal reality. With the rise of scientific medicine, biological causes for illness moved to the forefront, but suspicions of sin, particularly individual sin, causing illness persisted.
historian David Hall declared, “the people of seventeenth-century New England lived in an enchanted universe. Theirs was a world of wonders.” With the rise of science, the tight connections to the supernatural loosened in the eighteenth and nineteenth centuries, but those notions held fast in the colonial period, and suspicion of supernatural origins of mental disease remained in modern America. For Puritans like Mather that understood the world to be God’s dominion, wonders—rainbows, storms, earthquakes, deadly fires, and physical abnormalities—were “demonstrations of God’s power to suspect or interrupt the laws of nature.”

Not all apparitions were attributed to divine causes, though, and belief in witchcraft and the Devil also shaped understandings of the forces at work in the world. Strangely behaving individuals sometimes threatened the desired decorum, and on occasion, non-normative belief and behavior brought opposition, expulsion, and even death. The Salem witch trials of 1692 and 1693 demonstrated the hysteria that could erupt when society suspected the presence of such deviance. Despite often being linked with the hysteria surrounding the Salem trials, evidence is lacking that Mather “attended the trials except on two occasions,” and he was “severely ill” during the years they took place. Mather did author a document, signed by all Boston clergy, advising the government about the trials, but it displayed ambivalence—it both urged caution and recommended legal proceedings continue. Mather refrained from presuming personal guilt in public accusations of witchcraft and “in 1688 he took charge of two Boston girls

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61 Hall, 71. Hall demonstrated that interpretation of such “abnormalities” simultaneously drew on explanations from theology, astrology, natural history, and Greek meteorology. Ibid., 76 and following.
62 Lovelace, 17.
who could produce the most amazing parapsychological phenomena seen in his region...He treated the girls as ill, and cured them.”  

Mather’s writings made clear his belief in witchcraft, however. Sometimes, unusual phenomena like the aurora borealis and two-headed snakes formed evidence for him of witchcraft’s presence and power. In total, the clergyman’s interest in witchcraft, like his interest in medicine, stemmed from his intellectual curiosity about the workings of God’s world.

Belief in demonic forces played a more central role in the clergyman’s interpretation of madness than did witchcraft. Mather and his contemporaries assumed that the devil undermined God’s intentions and attempted to destabilize proper social order. He observed that some individuals, because of the “the state of their humors” found themselves susceptible to possession by Satan or demons. In an early sermon, he argued that “there is an unaccountable and unexpressable interest of Satan often times in the Distemper of madness.” The devil, for example, could inflict madness upon those attempting to do God’s work in the world. Reflecting on the state of William Thompson, a minister suffering from melancholy, the minister observed that Satan became “irritated by the evangelic labours of this holy man,” and “obtained the liberty to throw him into a Balneum Diaboli.” In Angel of Bethesda, Mather attributed some melancholy to demonic forces, noting that “there is often a Degree of Diabolical Possession in Melancholy,” an assertion not made as forcefully in the case of madness. He also noted,

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63 Jones, “Introduction: Part II,” in Mather, xiii. Silverman argued that while “in the popular imagining of the American past” Mather and the Salem witchcraft trials are “nearly synonymous,” that “the exact connection between the two remains obscure.” Silverman, 87.

64 Jones, in Mather, xiii.

65 Beall, 71. Referencing Mather’s Magnalia.


67 Ibid., 13.
“Maniacks are sometimes more or less Daemoniacks,” in which case he recommended prayer and fasting. Thought of atheism or blasphemy evinced demonic possession, he asserted, and might spur suicidal thoughts. In his later writings, satanic connections to madness diminished. Similarly, they would serve only a background role, a remote suspicion, as later Protestants assessed the causes of mental illness.

In short, colonists made clear distinctions between witchcraft and madness, and found that the latter arose from willful participation with evil. They also discerned a difference between being a witch and being bewitched, the former a matter of choice, the latter the result of possession by outside forces. Mather assumed that possession by the Devil caused only the most extreme forms of madness, likely including, the “furious and forward pangs” and “horrid rage” of his third wife. Mather’s writings display a shift in his understanding of insanity over the course of his life, but throughout, biological, moral, and supernatural explanations blended.

1.6 Attending to Those in Need

Independent of their origins, mental distress prompted individual and corporate responses. Before formal medical definitions of mental distress arose, “mental illness posed social and economic rather than medical problems,” and colonists offered practical, institutional, and spiritual responses.

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68 Mather, 135. Ibid., 130.
70 Mather rarely attributed mental illness to heredity, but did so in the case of his third wife’s illness, speculating that she suffered from “a Distraction which may be somewhat Hereditary” or perhaps demonic possession.” Mather in Dain, 75.
1.6.1 Communal Reaction

With little social infrastructure, care of mentally ill citizens fell most often to families and local communities. The dispersed, agrarian shape of early colonial life left “distracted” or “lunatick” persons less visible to society as a whole, even if troublesome to a few. The community’s attention shifted to the mentally ill only when their presence proved threatening. At times, dependent individuals were legally designated as the responsibility of the community. The concern was largely economic – “guardianship laws were based on the fear that the insane would squander their estate and end up a town charge.”

The pauper insane garnered support reluctantly, but they received assistance in almshouses or from other local families. Colonists viewed insanity as episodic rather than chronic, and proper attention allowed individuals to recover and return to full participation in family life.

In both colonial New England and Virginia, mentally ill individuals whose own families could not, or would not, care for them boarded them out. Caretakers received compensation from either the family or the municipality. In the event that a citizen’s illness threatened public safety, residents made other provisions, including the construction of small living structures to contain violent men and women. Because of limited resources and harsh living conditions for nearly all residents, however, citizens felt responsibility for only dependents from to their community. Towns worked to rid themselves of vagrants and others without local legal residence. Eventually, most towns opened almshouses for the care of a variety of dependent citizens, including widows, the poor, and the mentally ill. Beyond almshouses, few colonial facilities for the insane

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existed. In part, little infrastructure developed because population density remained low and ad hoc solutions remained effective.

Colonists generally accepted the insane, assuming madness could strike those of any social class or profession. Society extended wide tolerance of mental illness to those in positions of leadership or authority. Two eighteenth-century congregations, for example, accommodated their clergymen despite bizarre behavior. “Joseph ‘Handkerchief’ Moody, a minister in the town of York…began to wear a handkerchief over his face in 1738 and never appeared in public without it again.”\textsuperscript{73} The pastor’s congregation tolerated his behavior for three years – even after he could no longer face his congregation and preached with his back turned. Another minister, “Samuel Checkley, suffered a series of personal losses in the 1750s and from that period on he was unable to speak without weeping.”\textsuperscript{74} He began delivering his sermons in gibberish, but his congregation refrained from firing him. Instead, they hired someone to help. Churches not only tolerated leaders with mental illnesses, they found them capable of continuing their duties despite affliction.

\subsection*{1.6.2 Institutional Care}
Severe, chronic illness proved challenging, but formal, institutionally based care appeared only as the colonial era ended, decades after Mather’s death. Hospitals for the insane had operated in Europe for centuries, but limited communal efforts to care for the mentally ill appeared in colonial America. Mentally disturbed colonists initially received attention in general hospitals. The first facility, the Philadelphia Hospital, admitted

\begin{flushendnote}
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\item[74] Ibid.
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insane patients from its opening in 1752. Of the 102 diagnoses given at the Pennsylvania Hospital between 1757 and 1758, 24 specified “lunacy.” The first hospital on American soil devoted to the care of the mentally ill opened in Williamsburg, Virginia in the fall of 1773. Like other early facilities, the Virginia Eastern Asylum (its later name) “served a caring rather than a medical function evident by the choice of a layperson—not a physician—as its principle officer.” Yet, institutions housed just a few patients; most continued to be cared for at home and in local communities, and those that were admitted to facilities often languished for years without cure.

1.6.3 Christian Responsibility and Spiritual Responses

Society made provisions for citizens in need, but Mather argued that Christian discipleship required caring for one’s neighbor, even eccentric or troublesome ones. While persons afflicted with melancholy, for example, “often make themselves Insupportable Burdens to all about them,” he asserted that those around “Malancholicks” must bear the other’s suffering with patience, generosity, and humor.

Mather named prayer as the initial response to madness. Those that did not suffer directly should first offer individual prayers of thanks for “the use of Reason, wherewith” the individual is “Enlightened.” “How Thankful to [their] Gracious God,” healthy individuals should be, “for the Powers of Reason, in the free Exercise thereof, Conferred upon [them], and Continued unto” them. Then, on behalf of sufferers, he recommended “Supplications for the Rescue of the Mad,” asking for God’s pity on those whom God

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75 The Pennsylvania Hospital opened in 1751, but first admitted patients in 1752. Reiss, 134.
76 Ibid., 138.
77 Grob, 20.
78 Mather, 133.
79 Ibid., 130.
80 Ibid.
created. In addition, for susceptible men and women, prayer could keep madness at bay. Individual petitions drew sufferers closer to God: “We are never brought unto a Right Mind, but in and by a Thorough Conversion unto God.”

Corporate religious responses also appeared. Personal journals from the period showed that Puritan leaders, including Mather and the Massachusetts judge Samuel Sewall, held “days of prayer and fasting for distracted neighbors.” Organized public action revealed a sense of communal responsibility and a solution rooted in Christian practice. Prayer proved an individual and a corporate duty.

1.6.4 Physical Cures

Beyond prayer, Mather commended a variety of material treatments for madness and melancholy. Most of those cures reflected the prevailing theory of disease. The understanding of disease—physical or mental—during the colonial era was more than a thousand years old and assumed illness stemmed from an imbalance in the four major fluids or humors of the human body: cold, dry, hot, and moist. Health was a matter of equilibrium among these humors, and imbalance, or disease, called for restoring the body to proper order through bleeding, purging, sweating, dietary remedies, and herbs.

Mather’s suggested treatments for madness ranged widely. He recommended ingested treatments beginning with a carefully monitored diet: “Both the Meats and the Drinks of the Mad, should be very cooling.” Herbal remedies supplemented a proper diet and included St. John Wort and the flowers of Pimpernel. The use of

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81 Ibid.
82 Ibid., 131.
84 These four humors corresponded to the presumed four elements of the universe: fire, water, earth, and air. Reiss, 145.
85 Beall, 25.
86 Mather, 131.
pharmaceuticals was rare in colonial America, and “only two specific drugs were known in 1700, cinchona bark against malaria and mercury against syphilis,” and the latter was known to be dangerous enough to limit its use.\(^87\) Though few medicines existed, Mather suggested opiates as for relief from the suffering caused by madness. Mather also suggested a number of topical remedies, including “Living Swallows, cut in two, and laid reeking hot unto the shaved Head, have been præscribed, as a Cure for *Madness.*”\(^88\) Finally, he recommended physical treatments including bleeding and purging: “*Bleeding often Repeated, has done Something to Extinguish the Fury of the Animal Spirits*” and “*Madmen have sometimes been perfectly Cured by Salivation.*”\(^89\) In caring for mental maladies, the use of these and other age-old physical treatments persisted for more than a century after the colonial era.

Similarly, Mather compiled a range of topical, ingested, and behavioral recommendations for melancholy. Some might find cure from wearing a bag of saffron over their heart, or more temporary relief by drinking a pint or more of cold water. Outdoor exercise such as horseback riding, especially with pleasant company, won approval as did ingestion of “syrup of steel” and “Quincy’s Elixir Hypocondriacum,” a tincture of quinine.\(^90\) A more startling recommendation called for leeches applied to “hæmorrhoidal Veins.”\(^91\) Of this treatment, Mather reported, “‘Tis incredible, how Lightsome and Easy they have grown upon it, and for many Months free from the *Melancholy* that had besotted them.”\(^92\) Despite the supernatural origins of illness and

\(^{87}\) Ibid., 26.  
\(^{88}\) Ibid., 132.  
\(^{89}\) Ibid., 131.  
\(^{90}\) Ibid., 136. See also notes, page 355.  
\(^{91}\) Ibid., 136.  
\(^{92}\) Ibid.
confidence in the effectiveness of prayer, Mather commended physical treatments to provide relief from suffering.

1.6.5 Pastoral Care

Christian intervention appeared in other forms, and Mather presumed that clergy played a key role in the treatment of mental disturbances. Sin interrupted the relationship between humans and God, and pastors held lone authority in discerning the state of the soul. Pastoral care focused on spiritual development moved the individual toward closer relationship with the Creator.

Discerning the right pastoral response required an assessment of the source of melancholy. For melancholy stemming from “Spiritual Troubles,” clergymen must exercise “Exquisite Care…to carry the Troubled Sinner through a Process of Repentance; And after a due Confession of his Guilt, and Impotency, and Unworthiness, Lead him to the Rock: Show Him a Glorious CHRIST, Able to Save unto the Uttermost, and Willing to Cast out none that come to Him.”

Given the Puritan emphasis on discernment of the state of one’s soul, clergy held a key role in ushering people through trials of doubt to awakening in God. But, perhaps stemming from his own experience, Mather warned ministers to be wary of the time consumed by talking with those suffering from Melancholy. After several hours with sufferers, with no improvement occurring, he saw the work of Satan in keeping clergy from “their more Useful Studies.” He advised clergy to make God’s help clear, but warned that spending too much time would be fruitless. “Bestow some Suitable Book [of the Bible] upon them” Mather noted, but then

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93 Ibid., 134.
94 Ibid., 133.
“so take your Leave.” While authoritative guides about health, and healing, clergy placed ultimate responsibility for recovery on God.

In contrast to the comfort offered to those whose melancholy resulted from spiritual distress, Mather warned that temporal distress caused by human action (or inaction) should be met with forceful counsel: “Rebuke the Pining, Moaning, Languid, and Slothful Sort of Christians, and let them know, that they must be rowsed out of their Inactivity, and abound more in Direct Acts, than in Reflex ones.” Even in those cases, though, such advice should aim toward “a Soul Turning and Living unto God.”

Mather’s comments hint at a sense of personal laziness as a suspected root of distress, a condition that right thinking and right action would remedy. That sense of moral responsibility for mental maladies would expand widely by the late nineteenth century.

1.7 Conclusion

As one concerned about temporal and spiritual health, The Angel of Bethesda displayed two roles Mather played. He partook of the secular wisdom of his age and dispensed medical knowledge in medical terms. The pastor also shared wisdom about the theological causes of and treatments for disease. While distinct, those two roles formed part of the same whole for Mather. A desire to understand God’s creation more deeply shaped his interest in medicine, as did his hope to care for God’s people.

While he devoted most of Angel of Bethesda to physical ailments, Mather’s inclusion of a quotation from a Dutch physician betrays his evaluation of the place of mental maladies:

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95 Ibid., 135.
96 Ibid.
97 Ibid.
‘Adverse health, the threat to and death of members of the body is considered rather terrible. But of all things which can happen to man, the worst is illness or loss of the mind. If we seek so diligently for medication for the sick body, why not with greater care work hard to find what cures and revives the mind?’

Mather, by gathering available medical wisdom and reflecting theologically, hoped to serve like the biblical angel at the pool in Bethesda in bringing healing to those around him, especially those afflicted with mental distress. His pragmatic and theological reflections offered assessments that later Protestants would both embrace and reject.

\[98\] Mather, 326.
2. Benjamin Rush: The Rise of Medicine in the Revolutionary Era

In reviewing the slender and inadequate means that have been employed for ameliorating the condition of mad people, we are led further to lament the slower progress of humanity in its efforts to relieve them, than any other class of the afflicted children of men. For many centuries they have been treated like criminals, or shunned like beasts of prey; or, if visited it has been only for the purposes of inhuman curiosity and amusement. Even the ties of consanguinity have been dissolved by the walls of a mad house, and sons and brothers have sometimes languished or sauntered away their lives within them, without once hearing the accents of a kindred voice. Happily these times of cruelty to this class of our fellow creatures and insensibility to their sufferings are now passing away.

-- Benjamin Rush, 1813

2.0 Introduction

Two decades after Cotton Mather’s death, Benjamin Rush (1746-1813) was born near Philadelphia, Pennsylvania. Like Mather, Rush proved well read in religion, science, and medicine. Unlike his New England predecessor who served as a clergyman and dispensed medical advice, Rush, a statesman and reformer, labored as a physician. The doctor’s Christian faith guided his endeavors, including his efforts to improve the treatment of mental maladies.

In the years surrounding the American Revolution, Rush distinguished himself as a prominent and outspoken member of society. His friends included Presidents Thomas Jefferson and John Adams, founding father Benjamin Franklin, and the controversial patriot Thomas Paine.¹ In addition to corresponding with those men throughout his life

(and working to reconcile the feuding Jefferson and Adams in the early nineteenth century), as a patriot, he served the country alongside them. Beginning in 1775, he participated as a delegate to the Continental Congress and signed the Declaration of Independence the following year. Appointed as surgeon general of the army during the Revolutionary War, he later quit, frustrated that politics prevented necessary reforms in the medical care of troops. In 1797, President Adams appointed him Treasurer of the U.S. Mint, a position he held until his death. Rush’s reaction to public service proved mixed. He later recalled, “the time [he] spent in the service of [his] country with pleasure and pain.” He relished “acting for the benefit of the whole world, and of future ages, by assisting in the formation of new means of political order and general happiness,” but lamented the division sown by party politics.²

Rush provoked divergent reactions among his peers. Contemporaries called him “wise, and again foolish; generous, and egotistic; a genius and an intellectual fumbler.”³ A forthright man with strong opinions, the doctor’s enemies proved as famous as his friends. Among his adversaries, he counted President George Washington and many fellow physicians. Overall, however, he earned the respect of his colleagues, even those whose political or medical opinions differed. Following Rush’s death, Adams reflected that “as a man of Science, Letters, Taste, Sense, Philosophy, Patriotism, Religion, Morality, Merit, Usefulness, taken altogether Rush [had] not left his equal in America,

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² Ibid., 161. Based on his own experiences, Rush entreated his sons “to take no public or active part in the disputes of their country beyond a vote at an election.” His son Richard disregarded this advice and served as a statesman and diplomat. Ibid., 162.
³ Ibid., 10.
nor that I know in the world.” After years of friendship and detailed correspondence, Adams lamented that he would miss that “main Prop” in his life.4

Despite political participation, Rush’s primary work involved practicing, teaching, and reforming medicine. He attended to thousands of sick Americans and trained many of the period’s physicians. In the final two decades of his life, he relinquished public pursuits and devoted himself to his patients, writing projects, correspondence, and family.

In the narrative of the church and mental illness, Rush serves as a paradigmatic figure for the years of the early republic for four reasons. First, though different from Mather’s, the physician’s work demonstrated that his Christian beliefs fashioned his vocational choice and public involvement. Rush’s disciplined Calvinist inculcation and hopeful Universalist leanings shaped his dedication to sick Americans. Second, his commentary on mental maladies marked a shift in the understanding of those disorders. While he did not enter medicine to cure mental illnesses, they formed a focus of his medical advocacy and his lasting medical legacy. Unlike Mather, who pinned the origins of mental distress in original and personal sin, Rush focused on physical and biological causes. He treated mental illness as simply another human disease, becoming the first American to identify and systematize biological explanations. While later advances in medicine negated many of his presumptions, his categorization of mental maladies and proposals for their treatment remained the standard for nearly a century, and earned the doctor recognition as the father of American psychology.

Third, Rush practiced medicine at a transitional point in U.S. medical and social history, a time that saw the creation of the first American medical institutions. He served at the nation’s first hospital and taught at one of the earliest medical schools. He practiced during the time when the professionalization of medicine unseated clergy as primary intellectual experts and reduced church authority over sickness and suffering. Finally, the Philadelphia doctor’s story demonstrates one choice modern Christians made in response to their faith: they became physicians. While early colonists like Mather claimed authority and expertise in theology and medicine, changes in the early years of the republic prevented almost all later clergy from being recognized as dually proficient.

2.1 Rush’s Religious World

Christianity infused Rush’s world. Religious reflections and observations peppered his Commonplace Book. A keen observer, he commented on the religious convictions of others, sermons he had heard, the launch of new congregations, and his own spiritual practice. He celebrated the strength he found in his Christian faith and questioned the Deism of his peers. Biographer Alyn Brodsky argued that, if measured by church attendance, Rush proved the most pious physician in Philadelphia. His faith however, extended far beyond sanctuary walls. Like Mather, Rush’s religious training and intellectual curiosity inspired his medical pursuits.

In July 1751, when Rush was just six, his father died, leaving his mother to ensure his religious and secular education.5 After her husband’s death, Susanna Rush and her

5 Rush’s father was a member of the Episcopal Church; his mother was reared Presbyterian. Religion animated decisions of Rush’s ancestors. In the seventeenth century John Rush, Benjamin’s great-great-great-grandfather, left England for Pennsylvania to practice his Quaker beliefs without persecution. He, his wife, eight children, and several grandchildren arrived in 1683, just a year after the launch of William Penn’s colony. Rush’s family eventually fell away from the Society of Friends, a group he grew to detest for their pacifist opposition to fighting in the American Revolution. Rush, Autobiography, 23-25.
children worshiped at Philadelphia’s Second Presbyterian Church under the leadership of the Rev. Gilbert Tennent, a key proponent of the First Great Awakening.\(^6\) Out of respect for her late husband, Susanna also instructed her son in the “tenets of the Episcopal Church.”\(^7\) Beyond his mother’s tutelage, much of his early education fell to his uncle, the Rev. Dr. Samuel Finley, who trained under New Light William Tennent, Gilbert’s father.\(^8\) Finley, the Tennents, and other New Light Presbyterians supported the religious revivals that swept through the colonies and emphasized a renewed personal piety, a piety imparted to their young charges.

At age eight, Rush began attending Finley’s West Nottingham Academy in Maryland. New Side Presbyterians founded the boarding school as a feeder to the newly formed College of New Jersey (later Princeton University). Years later, he recalled his uncle’s tutelage as “highly calvinistical.” Beyond lessons in doctrine, Finley prepared his students to connect their faith and their work in the world. He exhorted Rush and others “to fight relentlessly the corruptions and temptation of a wicked world, eschew indulgence, and, above all, pursue meaningful lives. He saw as his primary goal the promotion of a boy’s usefulness to society within the context of religion.”\(^9\) Those lessons exerted lasting impact on Rush, even as his own religious convictions evolved.

Over time, the doctor’s theological allegiance shifted. In adulthood, he studied conflicts about salvation theory between Calvinists (who held precise views of

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\(^7\) Ibid., 16. Rush was baptized at Christ Church (Episcopal) in Philadelphia by the Rev. Eneas Ross, the father-in-law of Betsy Ross, purportedly maker of the first U.S. flag. Rush, *Autobiography*, 162n11.


\(^9\) Brodsky, 20.
predestination) and those who favored the “Universality of the atonement.” That reading, he reflected, “prepared [his] mind to admit the doctrine of Universal salvation.”

Persuaded, in part, by the Reverend John William Fletcher’s *Appeal to Matter of Fact and Common Sense*, he adopted a more inclusive approach, one that assumed the salvation of all, not just those who had been “prenatally” predestined by God. While he embraced hope in universal salvation, Rush allowed that “actively and negatively wicked” persons were consigned to hell. Notwithstanding his universalist leanings (and a preference for a God that saved), the doctor never abandoned belief in consequences for sin including “future punishment, and of long, long duration,” nor did he formally align himself with the emerging Universalist movement. Rush rejected the strict Calvinism of his forbearers, but not its call for personal discipline. The doctor sampled the diverse theology landscape, and was neither an orthodox Presbyterian nor Universalist.

Politics also played a role in Rush’s theological evolution. After the American Revolution, and “based on the incontrovertible thesis that all men are equal,” the religious political leader found he could no longer embrace the predestining God of Calvinism in light of the newly formed American republic. Nor did he believe that humans were as evil nor the “Deity…so wrathful as postulated by Calvin.”

Despite changes in his thought, a biblically rooted faith continued to shape his life. “The Gospel

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11 Brodsky, 269. Rush’s beliefs remained firmly Trinitarian, and thus not Unitarian. See, for example, Rush’s July 18, 1792 entry in his *Commonplace Book*. There he lamented “how few Sects honor Father, Son, and Holy Ghost in Religion as they should do.” Rush, *Autobiography*, 224. Until the late nineteenth century, Universalists professed generally orthodox Trinitarian beliefs alongside the view that humans did not possess the power to frustrate God’s will to save.
13 Ibid., 164.
of Jesus Christ,” he advised his children, “prescribes the wisest rules for conduct in every situation of life.” The Pennsylvania patriot remained a committed Christian.

Rush’s religious practice, however, remained untethered to any particular tradition. He rented pews simultaneously at Presbyterian, Episcopal, and Unitarian churches in Philadelphia, allowing him to worship close to his medical work in any given week. And, after “submitting” to confirmation at the Episcopal St. Peter’s Church with his wife in 1788, he “declined after a year or two” to commune in the church, and had his children baptized Presbyterian.

Rush found bits of the religious truth in many groups, convinced that most Protestants adopted “too partial notions of God, and his attributes,” and thus extolled “one attribute at the expense of the rest.” Such diversity allowed him to speculate, “it would seem as if one of the designs of Providence in permitting the existence of so many Sects of Christians was that each Sect might be a depository of some great truth of the Gospel, and that it might by that means be better preserved.” While maintaining a theological preference, Rush saw value in multiple expressions of Christianity.

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16 Rush’s church attendance remained steady throughout his adulthood. He reported “constant” attendance while living in Edinburgh. Ibid., 47.
17 Ibid., 226.
18 Ibid., 339. Here Rush observed, “Thus to the Catholics and Moravians he has committed the Godhead of the Savior, hence they worship and pray to him; to the Episcopal, Presbyterian, and Baptist Church the decrees of God and partial redemption, or the salvation of the first fruits, which they ignorantly suppose to include all who shall be saved. To the Lutherans and Methodists he has committed the doctrine of universal redemption, to the Quakers the Godhead and influence of the Holy Spirit, to the Unitarians, the humanity of our Savior, or the doctrine of ‘god manifested in the flesh’…Let the different Sects of Christians not only bear with each other, but love each other for this kind display of God’s goodness
Still, the doctor reserved a role for divine providence. In 1760, after graduating with a B.A. from the College of New Jersey, and following a six-year medical apprenticeship in the colonies, he trained for a career in medicine in Edinburgh, Scotland, earning his M.D. in 1768. Initially, he had planned to pursue a career in the law. His mind changed after undertaking a period of prayer and fasting recommended by his uncle Finley. "Providence overruled my intentions" the young man reflected, "[and] I now rejoice that I followed Dr. Finley’s advice. I have seen the hand of heaven clearly in it." His uncle’s influence also showed in a letter Rush wrote to a friend before leaving for Europe. He mused that he hoped to be of “use to society when I return.” Optimism about his place in God’s story remained evident in his comparison of himself to the prophet Jeremiah and his conviction that God spared him from a near fatal illness in 1778. For Rush, divine providence dictated both his path and his purpose, but he understood his role as a faithful servant rather than as a prophet. His faith sustained him amidst criticism and the hardships of providing medical care in eighteenth-century Philadelphia. He declared that “the comforts and support with which Christianity

whereby all the truths of their Religion are so protected that non of them can ever become feeble or lost. When united they make a great whole, and that whole is the salvation of all men.” Ibid., 339-40. He also found providential the roughly simultaneous lives of Martin Luther and John Calvin and John Wesley and George Whitefield. Ibid., 345.

19 Rush came fully to support republican forms of government while in Europe. An earlier opponent of the 1765 Stamp Act, “Never before,” Rush reflected of his time abroad, “had I heard the authority of Kings called into question.” Ibid., 46. Rush also gained exposure to men who would later bear “an active part in the events of the first years of the French Revolution.” Ibid., 68. Rush’s thesis for the degree of Doctor of Medicine (written in Latin), addressed the digestion of food in the stomach. Binger, 40.


21 Brodsky, 40.

22 Rush identified with Jeremiah’s life of strife and controversy and sensed that he, like Jeremiah, was “called upon by God to set the crooked straight.” Binger, 298.

23 Pointing to himself, Rush noted that “Humble and unworthy instruments are often employed in promoting the physical as well as moral happiness of mankind in order to confound the splendor of those external circumstances which attract and fix the esteem of the world.” Rush, Autobiography, 88.
abounds to those who suffer persecution in the cause of truth and humanity” enabled him to continue serving patients even when “defamation and ingratitude” arose from critics.\textsuperscript{24}

Rush’s Calvinist heritage tempered the influence of Enlightenment principles on his study and practice of medicine. During his instruction at West Nottingham and Princeton, for example, he learned to “account for all things by invoking God, the first cause,” a view he never abandoned. Finding God’s hand amidst scientific phenomena presented no problem for the faithful medical man. He accepted Newtonian and Cartesian modes of scientific thought, but also valued experientially based, theological reasoning. He adopted the empirical medical approaches of his Scottish teachers, and came to embrace the idea of “secondary causes to explain natural events,” but his approach to religion remained unchanged. “To keep science consistent with Christianity,” Rush claimed, “the Newtonian universe was designed by God.”\textsuperscript{25} Many of his contemporaries embraced the detached God and mechanistic world of Deism, but not Rush. Underlying all of the physician’s thought was the presumption of God, an active, necessary, and perfect being.\textsuperscript{26}

The physician’s religiously rooted desire to serve the world shaped his participation in a wide range of moral and reform efforts. A sense of the need for public morality grounded in religious principles spurred, for example, forays into educational reform. The educated leader campaigned for free public schools and the education of girls and women. In 1783, he helped found Dickinson College as an alternative to

\textsuperscript{24} Ibid., 104.
\textsuperscript{26} This section relies on Brodsky, 47-50.
Princeton for western Pennsylvanians. Rush also opposed slavery, considering it a “violation of the laws of nature and Christianity.” In 1773, he published *An Address to the Inhabitants of the British Settlements in America upon Slave-Keeping* and “endeavored to show the iniquity of the slave trade.” A year later, he helped found The Pennsylvania Society for Promoting the Abolition of Slavery and the Relief of Free Negroes Unlawfully Held in Bondage. He supported the formation of African American churches in Philadelphia. In addition, he pled for temperance in both the Army and society, and argued for its benefits both to individuals and to the social body.

Convictions about Christian charity prompted the physician to help provide care for citizens in need. Directly related to his practice of medicine, in 1780 he participated in the founding of the Philadelphia Humane Society, a group that hoped to educate citizens about health and hygiene. In 1786, he led the creation of Philadelphia’s Dispensary for the Poor. The following year, with deist Benjamin Franklin, he helped create The Philadelphia Society for Alleviating the Miseries of Public Prisons. He also worked for prison reform and the abolition of the death penalty in Pennsylvania. Beyond

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27 Rush, however, believed that each religious sect was best equipped to train its own youth, and in his educational reforms, called for separate schools by sects.
28 Binger, 95-96.
29 Rush, *Autobiography*, 82-3. Rush noted that while the publication helped sway public opinion, it also resulted in lost business from those who presumed he had “meddled with a controversy that was foreign to my business.” Despite later opposition to slavery, Rush did own a slave, William Grubber, whom he “bought and liberated” after ten years of service. He noted Grubber’s death on June 17, 1799. Ibid., 246.
formal organizational involvement, Rush donated food including watermelons and turkey
to Philadelphia jails in hopes that prisoners “should consider that God, by disposing the
heart of one of his fellow creature to show them an act of kindness, is still their Father
and Friend.”

The causes he championed displayed Rush’s belief in the goodness of the
Creator and his hope to make his endeavors of use to society and his life purposeful.
Notwithstanding Rush’s long list of reform activities, medicine formed his primary mode
of service.

2.2 Revolutionary Era Medicine: Practice amidst Professionalization

During the years Rush practiced, medicine in America began to professionalize.
New hospitals were constructed, medical schools formed, and the country’s first medical
journals were published. Nevertheless, apprenticeship continued and “by 1840, only
one-third of physicians practicing in New England had been trained in medical school;
the rest had learned their medicine under the older tutorial method.”

Despite signs of professionalization, a lack of oversight, control, and shared standards persisted. Amidst that climate, Rush and a handful of other physicians that trained in Europe refashioned medicine in the United States.

2.2.1 A Charitable Medical Practice

In July 1769, following medical school and in internship in London, Rush
launched a medical practice in the colonies. Working mostly in Philadelphia, he treated
thousands over the course of his career, including many indigent citizens unable to pay.
He accepted barter in return for care, but also provided services for those who could pay

31 Rush, Autobiography, 238.
32 Oscar Reiss, Medicine in Colonial America (Lanham, MD: University Press of America, 2000), 53.
nothing. A string of epidemics in the final decades of the eighteenth century—scarlet fever, croup, influenza, measles, smallpox, and cholera—kept him busy as he cared for the city’s poor. To be sure, the doctor attended to more aristocratic patients, but, he observed that he lacked the “principal means which [typically] introduce a physician into business” including “the patronage of a great man,” “the influence of extensive and powerful family connections,” and “the influence of a religious sect or political party.” Rush could not expect automatic patronage, and his “natural disposition” toward the poor and “sympathy with distress of every kind” directed his work.\(^\text{34}\) The doctor described his first years of six years of practice as a time of “constant labor and self-denial.” “My shop,” he noted, “was crowded with the poor in the morning and at meal times, and nearly every street and alley in the city was visited by me every day.” Rush confessed to risking infection from his patients, and that at times he became infested with vermin after visits. Patient need, not social standing or religious affiliation, dictated his clientele.\(^\text{35}\)

Rush understood his service to the poor as part of his Christian responsibility. Resonating with the parable of the Good Samarian, he repeated to himself the words “‘Take Care of him, and I will repay thee’…a thousand times” after leaving the sickrooms of the poor. He trusted in God’s promises as he served his fellow citizens—promises of healing for the sick and strength for the servant. “To His goodness in accepting my services to His poor children” he ruminated, “I ascribe the innumerable blessing of my life; nay more, my life itself.” The doctor reported, “including the


\(^{35}\) Political forays interspersed, and sometimes interrupted, Rush’s medical career. At times, such as when he tended to the sick and wounded in the Pennsylvania militia and served as a surgeon general (and later Physician General) in the Revolutionary War, Rush combined his passions. Rarely willing to remain silent on an issue he cared about, Rush created loyal friends and enemies in the political and medical realms.
business [he] did without charging for it, and bad and absolved debts,” that he had “not been paid for more than one fifth of the labor of my life.”  

In 1780, an outbreak of “break bone fever,” brought Rush near death. While recovering, the weary physician dreamed about his service to the poor:

I dreamed that a poor woman came to me…and begged me to visit her husband. I told her hastily, that I was worn out in attending poor people, and requested her to apply to another Doctor. ‘O! Sir (said she, lifting up her hands) you don’t know how much you owe to your poor patients. It was decreed that you should die by the fever which lately attacked you, but the prayers of your poor patients ascended to heaven in your behalf, and you life is prolonged only upon their account.’  

While confessing to be “little disposed to superstition,” Rush reported that he awoke in tears. The dream left a lasting impression. It “enreased (sic) my disposition to attend the poor and never, when I could not serve them, to treat them in an uncivil manner.” Shortly after the dream, and to ease the burden of attending to the growing needs of Philadelphia’s poor, Rush hired his first assistant.

2.2.2 A Physician and Teacher

Alongside his medical practice, Rush was well known as a teacher of medicine. Initially, he took on apprentices, he boarded them in a neighbor’s barn, provided training, and offered advice as they established their own clientele. In August 1769, the College of Philadelphia elected him professor of chemistry, and he taught while maintaining his private practice. In 1787, he helped found the College of Physicians of Philadelphia. Two years later the medical school at the College of Philadelphia appointed him

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37 Break bone fever referred to the mosquito-transmitted dengue fever that included severe joint pain.
39 Ibid., 86.
40 Brodsky, 84.
41 Reiss, 23.
professor of Theory and Practice of Medicine. There, Rush trained (directly or indirectly) a large majority of physicians in the newly independent country. Brodsky noted many believed that “every outstanding American physician down to the Civil War was either a pupil of Rush or of a Rush pupil.” He proved centrally positioned to participate in the leading medical conversations and controversies of his day.

2.2.3 A Focus on Prevention
Unlike many of the physicians of his time, Rush emphasized preventative medicine and public health measures. He argued, “obviating diseases is the business of physic [medicine] as well as...curing them” and he told his students it “required as much skill to prevent diseases as to cure them.” His efforts altered health measures in the city of Philadelphia and in the nation’s Army. Ahead of his contemporaries, Rush recommended a bland diet comprised mostly of vegetables alongside “active” exercises including walking, running, dancing, fencing, swimming, and talking as preventative measures. While a surgeon general, his 1777 treatise, “To the Officers in the Army of the United State: Directions for Preserving the Health of Soldiers,” pioneered military hygiene. He suggested banishing linen shirts (too likely to retain perspiration), keeping hair short and well groomed, and limiting rum consumption. Without such changes, he feared more soldiers would die from poor sanitary conditions than from combat. He assumed that the well-being of all aspects of society required healthy citizens.

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42 This figure does not account for the many physicians who continued to train via informal apprenticeship or those that claimed medical expertness for other reasons. Brodsky, 5. Between 1779 and 1812, 2,872 students registered in Rush’s medical classes. In addition, he shepherded between 6 and 30 private apprentices at any one time. Binger, 84.
43 Rush, in Brodsky, 93, 252. From an article published in the Pennsylvania Journal.
44 Ibid., 96-97.
45 Ibid., 178-181. Flannel clothing helped soldiers avoid illness, but not for the reasons Rush presumed. Rush thought flannel (versus linen) would prevent fevers. Instead, flannel proved too thick for illness-carrying mosquitoes to penetrate. In addition, his prescriptions aimed at cleanliness (to remedy excess sweat) likely helped stem the spread of a variety of insect-borne illnesses. Binger, 124-5.
2.2.4 Physical Cures

Beyond advocating prevention, Rush attended to acute illness. Some of his medical techniques, however, provoked controversy among his peers (and condemnation by later medical professionals.) Rush was one of the first Americans to challenge the older system of medicine that held “that fluids of the body were the source of diseases.” Instead, he advocated a theory advanced by his Edinburgh teacher, William Cullen, “that the cause of disease lay in the nervous or vascular system.”

Venesection, or bloodletting, formed a logical response to disease assumed to lie in the circulatory system. His widespread practice of bloodletting and his use of calomel (mercury) to purge the body, particularly during the 1793 yellow fever epidemic, however, earned him critics. It also diminished the once strong stream of referrals he received from other Philadelphia physicians.

Nonetheless, widespread illness assured a steady client base. The yellow fever epidemics of the 1790s (which some Philadelphia “Quakers saw…as divine vengeance for their sons having forsaken the sect’s drab traditional garb for the lace and ruffles and bejeweled shoe…as well as forsaking traditional values”) proved particularly deadly. In 1793, before a cold snap killed the unknown cause of the epidemic—mosquitoes—more than ten percent of the population of Philadelphia died. During the epidemic, Rush was the first to proclaim “that the disease, like so many others, like malaria, was indigenous, and not endemic like, say, the plague, and was therefore avertable through

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46 Brodsky, 91. Lacking knowledge of the central nervous system, Rush and his contemporaries assumed that the nervous and the vascular systems were synonymous.
48 Note the presumed connection between sin and illness professed by Quakers.
49 Brodsky, 323, 332.
proper hygiene and maintenance of salubrious environmental conditions.\textsuperscript{50} When yellow fever returned, he proposed draining the marshes and gutters in Philadelphia of their “noxious miasma.”\textsuperscript{51} Though city leaders failed to heed his advice, by Rush’s count, deaths from the yellow fever epidemic would have been fifty percent higher without the heroic treatments he prescribed. Critics disputed his claim and supporters praised his efforts. Regardless, he saw divine help in the “success which attended the remedies it pleased God to make” him “the instrument of introducing into general practice.”\textsuperscript{52} He continued to attend to patients amidst opposition, even when he contracted illnesses. Rush remained dedicated to healing others – to upholding the Hippocratic Oath and his responsibility to alleviate suffering.

2.3 Mental Maladies: Rush's Everyday Observations

Those suffering from mental maladies also sought help, and for the Philadelphia physician, healing madness brought greater satisfaction than ameliorating physical ailments. “There is a great pleasure,” he wrote near the end of his life, “in combating with success a violent bodily disease, but what is this pleasure compared with that of restoring a fellow creature from anguish and folly of madness, and of reviving within him the knowledge of himself, his family, his friends and his God!”\textsuperscript{53}

2.3.1 Cases of Madness

As a keen observer of God’s creation, Rush catalogued observations of mental disturbance in his \textit{Commonplace Book}. In June of 1792 he reported meeting William Glendenning, a Methodist minister “who had been insane for four years and an half

\begin{flushright}
\textsuperscript{50} Ibid., 5. \\
\textsuperscript{51} Ibid., 333. \\
\textsuperscript{52} Rush, \textit{Autobiography}, 96. \\
\textsuperscript{53} Benjamin Rush, M.D., “Letter from Rush to Board of Managers of Pennsylvania Hospital, 1810,” \textit{American Journal of Psychiatry} 58, no. 7 (1901), 196.
\end{flushright}
during all which time he said he was in a state of despair.” Bodily pain, mental anguish, excessive sleep, and a loss of interest in food and other people accompanied the man’s melancholy. Sometime family members sought legal action to control ailing relatives. Rush relayed, for example, that in court, the family of John Vanderen, a local miller, used the man’s proposal to “bring the waters of the Wissahiccon Creek to Philadelphia by means of pipes” as evidence of his insanity. Despite speaking “shrewdly and wittily in his own defense” at the 1790 trial, Vanderen found himself committed to the Pennsylvania Hospital for the remainder of his life. In January 1798, Rush recounted the death of a friend, the Reverend Jacob Duché. Among other ailments, Duché was “much disordered in the evening of his life, with a tendency to palsy, and with Hysteria.” He “sometimes laughed and cried alternately all day.” Despite his affliction, Rush remembered his friend as “truly amiable, pious, and just.” Concern and curiosity marked the doctor’s reporting of mental distress, and Rush remained fascinated with the diversity of the world around him.

2.3.2 Suicide

Rush also documented men and women that took their own lives. During an economic crisis in 1792, he mentioned the suicide of a Frenchman resulting from

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54 Rush, *Autobiography*, 220-221. Despite his focus on mental disorders in his later years, and his attention to them in his journal, they receive no mention in his autobiography.
55 To this entry, Rush notes that “Dr. [Benjamin] Franklin bequeathed £1000 for that very purpose,” demonstrating Rush’s doubt in the strength of the charge, although not the man’s insanity. Ibid., 188 n49.
56 Ibid., 240.
57 Rush rarely drew a direct connection between suicide and insanity, but assumed the presence of some sort of mental disorder in most cases. For example, in notes for a “Lecture on the Medical Jurisprudence of the Mind,” he concluded, “Suicide is madness.” Ibid., 350. Although speculation about causes did not accompany his portrayal of general cases of insanity, Rush noted causes in most of his reports about those who took their own lives.
unsuccessful economic investment.\textsuperscript{58} In July 1794, he “paid a visit of condolence” to a Mrs. Capper, “whose husband shot himself…from a dread of meeting his creditors.” That entry included his attempt to soothe the widow’s concerns about the state of her husband’s soul. Displaying his theological leanings, Rush “endeavored to comfort her from consideration of universal repentance after pardon of death.”\textsuperscript{59} In August 1800, he marked 24 suicides in New York since the spring, “3 of whom were servant girls, one in consequence of being rebuked by her mistress.”\textsuperscript{60} In 1803, he prepared a list of medical questions for Meriwether Lewis to gather responses to on his exploration of the west with William Clark. As Rush thought about the Native American people Lewis would encounter, he wondered, “Is suicide common among them?” and whether “Ever from love?”\textsuperscript{61} In 1804, Rush noted that “Mrs. McCurrach threw herself into the Skuilkil and perished…She had been melancholy for some months, and had a few weeks ago been saved from death which she attempted to bring on herself by taking 1 oz. liquid laudanum.”\textsuperscript{62} Finally, Rush relayed a debate with the Frenchman Compte de Volney about suicide and whether it proved “justifiable where a sense of evil predominated over a sense of good” (Volney’s view) or whether it “[arose] from derangement” (Rush’s assertion).\textsuperscript{63} The physician never condemned those who took their own lives.

\footnotesize{\textsuperscript{58} Ibid., 219. Here he also reported, “as yet I have heard of not one instance of Insanity” because of dire economic conditions. On September 4, 1801, Rush noted, “Amos Taylor died this day of suicide by rope. He had been unsuccessful in speculation.” Ibid., 255. \\
\textsuperscript{59} Ibid., 231. \\
\textsuperscript{60} Ibid., 252. \\
\textsuperscript{61} Ibid., 266. Alongside other ailments, Rush also wondered whether madness was “known among them?” Ibid., 265. \\
\textsuperscript{62} Ibid., 269. Laudanum, a preparation of opium was used to treat a variety of ailments. \\
\textsuperscript{63} Ibid., 242.}
2.3.3 Care and Concern

Rush’s *Commonplace Book* entries offered observations of insanity and suicide, but recommended no treatments. That he assumed mental maladies could be ameliorated, however, was clear. Thanks to his influence, the Pennsylvania Hospital, which opened in 1752, included a ward for the insane. From 1783 until his death, he served as an attending physician at the facility, the nation’s first. In 1787, he undertook “exclusive care” of the “maniacal patients,” and made careful observations of the pathology of mental illness, hoping to improve treatment.⁶⁴

Rush’s attention to the insane persisted for decades and motivated public action. In March of 1792, prompted by a short publication by Rush, the lower house of the Pennsylvania Assembly allotted £15,000 to build a separate “madhouse” for the insane at the hospital.⁶⁵ In January of 1803, he met with the hospital’s managers and proposed that “a man of education” be appointed “to superintend the Lunatics, to walk with them, converse with them, &c., in order to awaken and regulate their minds.”⁶⁶ The compassionate physician advocated for the best care possible for those suffering with mental maladies, not simply confinement.

On February 3, 1810, Rush recorded a more personal connection to mental maladies. “This day,” he wrote, “my son John Rush arrived from New Orleans in a state of deep melancholy brought on by killing a brother officer in the Navy…Neither the embraces nor tears of his parents, brothers, or sister could prevail upon him to speak to them. His grief and uncombed hair and long beard added to the distress produced by the

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⁶⁴ Binger, 177.
⁶⁶ Ibid., 262.
disease of his mind.”67 John never recovered from the shock of killing of his close friend, the Lieutenant Benjamin Taylor, in a duel. With the exception of one brief return to his parents’ home, John spent the next twenty-seven years in a cell on the wards his father knew well in the Pennsylvania Hospital. Rush mentioned his son’s illness in letters to Thomas Jefferson, but the family never made the young man’s condition public.68 In the final years of his life, his son’s affliction personalized Rush’s compassion for those suffering from mental maladies.

2.4 Causes and Origins: Changing Views of Madness

2.4.1 Madness as Medical

Stemming from his special interest in insanity, Rush systematized observations about mental disorder, and that work shaped the country’s transition to a medicalized understanding of madness. The historian Mary Ann Jimenez named the period in which Rush worked “a watershed in the history of insanity” because of the reconceptualization of causes of mental maladies that occurred.69 The shift, though, proved piecemeal. Although scientific innovation and optimism shaped medical theory and while many physicians modified their approaches to madness, wider professional adoption rates and opinions varied, as did the willingness of the public to abandon old ideas about mental distress.

67 Ibid., 288. For additional background on John Rush and his illness see ibid., 369-370, Binger, 282-283, and Brodsky, 105, 348, 364.
68 Why the public silence? Rush called for the removal of stigma associated with mental maladies, but also supported privacy for those who suffered. It remains unclear whether Rush and his family sought to protect their son, themselves – or both – from public shame.
69 Jimenez, 65. Jimenez’s account focused on Massachusetts, but opinions in the rest of the Colonies followed this pattern by the early nineteenth century.
Rush hoped that by categorizing the biological causes of mental maladies, “those diseases [could] be brought under the dominion of medicine” and cured. In 1812, a year before his death, he published *Medical Inquiries and Observations upon the Diseases of the Mind*, outlining the symptoms, causes, and treatments of mental maladies. The experienced physician hoped to “convince the world that mental disease was to be equated with organic disease,” illness that could be prevented and treated just like physical ailments.

2.4.2 Shifting Expertise

Despite the slow-going standardization of treatment, doctors, following Rush’s lead, came to view mental maladies primarily a medical concern rather than a social, economic, or spiritual problem. As a result, the assumed proper locus of care began to shift, slowly, from the home and community to medical institutions. With growing confidence in the ability of science to bring cures, medical care usurped religious authority. Rush supported that shift. He believed physicians needed to “assert their prerogative” and “rescue mental science” from ‘the usurpation of schoolmen and divines.” Physicians, he proclaimed, were the “best judges of sanity.” A 1767 sermon demonstrated that some clergy shared that view. Preaching after a suicide, the Reverend Samuel Phillips “urged his congregation to call a doctor at the first sign of distraction. ‘Don’t say as many do, that no Physician can relieve us because our Trouble

70 Rush, *Medical Inquiries*, vi.
73 Binger, 181. Dain, 63.
is altogether a Trouble in Mind, and Body not at all affected.’ This attitude is ‘wrong’ because ‘Trouble of mind’ often starts with ‘Trouble in the body.’” The sermon emphasized somatic aspects of madness and stressed the importance of a physician’s intervention to interrupt the course of illness. Indeed, Phillips “suggested that the family of the distracted should call a minister only if a physician failed to help.” Americans continued to turn to clergy in times of mental anguish, but Phillips’ recommendations demonstrated that even ministers found medical alternatives preferable.

2.4.3 Sin and Illness: An Evolving View

Medical conceptions of insanity prompted reassessment. A biological view of madness challenged human sinfulness as the primary source of disease. Three distinct presumed causes of madness appeared in this period: 1) personal sin, 2) the violation of natural moral laws, and 3) the inherently limited nature of creation. Responses and treatments varied with presumed causes. While acknowledging all three, most of Rush’s efforts and writing focused on the third. Rush, for example, attested that “many antisocial actions considered sinful, such as suicide, impulse to murder, habitual lying, drunkenness, and compulsive stealing, might [instead be biologically rooted] emotional disorders.” He was comfortable, though, maintaining belief in the supernatural alongside scientific expertise. The doctor posited an indirect role for sin in sickness, writing, “the powers of the human mind” were “thrown out of their order by the fall of man.” Nowhere, however, did he explicitly root illness in sin nor point to spiritual cures for sickness. Despite belief in the power and possibility and divine intervention,

75 Mary Ann Jimenez, “Madness in Early American History: Insanity in Massachusetts from 1700 to 1830,” *Journal of Social History* 20, no. 1 (1986), 34.
76 Dain, 20.
Rush believed that scientific insight would prove that “all diseases [were] curable,” given time to discover cures. Rush professed belief in “intellectual as well as physical miracles,” but relied on the former to bring cures. While such opinions debunked sin as the root cause of many mental conditions, transitions in public viewpoints proved complex.

Rather than disappear entirely, the role that the public attributed to sin shifted. Alongside scientific optimism that mental illnesses were curable, came growing suspicion that personal wrongdoing (and not simply original sin) lay at the root of insanity, especially illness that remained resistant to treatment. As supernatural explanations waned, and as physicians promoted cures, the public increasingly attributed mental disease to “failure to live within certain moral limits.” Americans based those moral limits in the divine law, but even those laws were “increasingly discussed in the context of natural law, a law accessible to human reason.” As a result, right behavior, and not right belief (or right relationship with God) became central for recovery. When “moral irregularities and excessive passions” bought on madness, Americans assumed that human intervention—their own actions or the help of physicians—might cure, or at least ameliorate, mental disorder.

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78 Ibid., 353. See also Binger, 213. Rush blended faith and practical action. In a letter to his wife he wrote, “While I depend upon divine protection and feel that at present I live, move, and have my being in a more especial manner in God alone, I do not neglect to use every precaution that experience has discovered to prevent [becoming ill.]” Ibid., 206.


80 Jimenez, Changing Faces of Madness, 23.

Lay persons lagged behind medical professionals in their adoption of new conceptions of mental illness and continued to put credence in supernatural influence in illness. For most Americans, medical advances that challenged notions of supernatural causation eventually displaced sin as the presumed primary underlying cause of mental maladies. But, without the ability to pinpoint exact causes of, or cures for, mental illness, over the next two centuries laypersons and professional alike would look to both medicine and morality to explain mental maladies.

2.4.4 Definitions of Disease

Disease appeared inevitable as part of an inherently limited creation. Regardless of its ultimate etiology, late eighteenth century physicians like Rush continued to deploy the same basic categories of insanity used by Cotton Mather—melancholia, mania, madness—although more as degrees of illness than separate conditions. A 1794 dissertation provided a definition of insanity recommended by Rush: “A false perception of truth; with conversation and actions contrary to right reason, established maxim, and order” characterized insanity.82 That definition included a symptomology coupled with the assertion that those symptoms fell outside of established social norms, and showed the influence of social perceptions on illness.

Rush relied on decades of personal observations to understand mental distress. Akin to his understanding of physical illness, he concluded that the symptoms, causes, and successful treatments of mental illness pointed to madness originating in the blood vessels of the brain. Before justifying his theory that problems with the vascular system

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caused madness, he detailed earlier medical theories of madness he hoped to overturn, and rejected dysfunctions of the liver, spleen, intestines, and nerves as causes.

While asserting that dysfunction of the blood vessels formed the primary source of madness, Rush also presented “remote and exciting causes of intellectual derangement.” Such remote causes might be physical and included: falls and other direct impacts to the brain, isolation, odors, famine, excessive “use of ardent spirits,” “inordinate sexual desires and gratifications,” blood transfusions, great pain, “extremely hot and cold weather,” intestinal worms, and irritation from foreign objects, such as a small bullet, lodged somewhere in the body.\textsuperscript{83} Beyond physical causes, he highlighted factors that acted on the understanding to cause madness. These remote influences included the intense study of many subjects (including trying to fix the exact date of biblical prophesies and the disappointment that occurs after the predicted date passed), switching the mind too rapidly from one subject to another, “inordinate schemes of ambition or avarice,” extravagant joy, excessive anger, terror, disappointed love, fear, grief, public and private defamation, and absence from one’s native country. No one was immune to mental maladies, and Rush offered an example of a “clergyman in Maryland [who] became insane in consequence of having permitted some typographical errors to escape in a sermon which he published upon the death of general Washington.”\textsuperscript{84} Altogether, his observations generated his conviction that physical and experiential factors caused mental maladies, not supernatural forces.

In addition to outlining causes of madness, Rush documented attributes and conditions that predisposed individuals. He observed a hereditary disposition to mental

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\textsuperscript{83} Rush, \textit{Medical Inquiries}, 28-33.  \\
\textsuperscript{84} Ibid., 35-40.
\end{flushright}
maladies. He listed dark hair color, great wit, the acquisition of sudden fortunes, and, in Christian countries, “infidelity and atheism” as predisposing conditions. Noting, “maniacs seldom live to be old,” Rush named those between ages twenty and fifty as most likely to suffer. Single people suffered more than the married, the rich more than the poor, those living in colder climates more than those living in warmer ones, and those with creative occupations (poets, painters, sculptors, musicians) more than those with logic-oriented professions (chemists, naturalists, mathematicians, and natural philosophers.)

Rush found women more likely to suffer than men, although each gender experienced events that predisposed them to mental illness. Women had a greater predisposition “imparted to their bodies by menstruation, pregnancy, parturition [giving birth], and to their minds, by living so much alone in their families.” Rush found men more likely to experience madness stemming from the experiences of war or from excessive drink, and identified men as more likely to commit suicide.

While clear that religion did not cause mental illness, Rush argued that mental disease could manifest with religious expression. Certain kinds of mental disease, he observed, appeared:

most frequently in the enthusiasts in religion, in whom it discovers itself in a variety of ways; particularly; 1) In a belief that they are the peculiar favourites of heaven, and exclusively possessed of just opinions of the divine will as revealed in the Scriptures. 2) That they see and converse with angels, and departed spirits of their relations and friends. 3) That they are favoured with visions and the revelation of future events. And, 4) That they are exalted into beings of the highest order.

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85 Trained in chemistry, Rush fell into the category of the less predisposed.
87 Ibid., 57.
88 Ibid., 59.
89 Ibid., 135-136
As evidence, Rushed remarked that he had “seen two instances of persons who believed themselves to be the Messiah” and had “heard of each of the sacred names and of the Father, Son, and Holy Ghost having been assumed at the same time by three persons the influence of this partial form of derangement in a hospital in Mexico.” 90 With those observations, Rush noted that while in the past such persons were fined, put in prison, or even to death, that medical science now saw their actions as illness rather than impiety.

Despite a long list of causes and predisposing conditions, Rush contended that madness might simply appear, even in good, moral, otherwise healthy individuals:

To the history that has been given of the correspondence between the ravings and conduct of mad people and their natural tempers and dispositions, there are several exceptions. These are, all those cases in which persons of exemplary piety and purity of character, utter profane, or impious, or indeclicate language, and behave in other respects contrary to their moral habits. The apparent vices of such deranged people may be compared to the offensive substances that are sometimes thrown upon the surface of the globe by an earthquake, mixed with the splendid fossils formerly mentioned, which substances had no existence in nature, but were formed by a new arrangement in the particles of matter in consequence of the violent commotions in the bowels of the earth. 91

He admitted that medical science could explain some, but not all, occurrences of mental disease. Regardless of their origins, mental illnesses warranted a response.

2.5 Corporate Responses Emerge

Mental and physical maladies drew public attention. In 1751, with assistance from Rush and Benjamin Franklin, a group of Philadelphia Quakers, petitioned the Pennsylvania Assembly for help with the colony’s first hospital. Philadelphia was the largest city in the colonies, and Quakers had stepped aside from political participation after their pacifist beliefs came in conflict with the need to defend the colony’s western
border. They turned to philanthropic work, and hoped to launch a medical facility.\textsuperscript{92}

While intending the hospital to treat both the physically and mentally ill, the petition to the Assembly began with a plea about care for the mentally disturbed:

That with the number of people the Number of lunaticks, or Persons distempered in Mind, and deprived of their rational faculties, hath greatly increased in this Province.

That some of them, going at large, are a terrour to their neighbors, who are daily apprehensive of the violences they may commit; and others are continually wasting their substance, to the great injury of themselves and families, wickedly taking advantage of their unhappy condition, and drawing them into unreasonable bargains,

That few or none of them are so sensible of their condition as to submit voluntarily to the treatment their respective cases require, and therefore continue in the same deplorable state during their lives; whereas it has been found, by the experience of many years, that above two thirds of the mad people received into Bethlehem Hospital, and there treated properly, have been perfectly cured.\textsuperscript{93}

An appeal for care of the insane in the largest colonial city made sense. Growing population densities in cities made madness more visible, more difficult to contain in almshouses and family homes, and thus more problematic. Hospitalization offered safety for the public and care for the insane.

The proposal for a new hospital succeeded, but the institution failed to guarantee better treatment. The facility admitted insane patients from its opening in 1752, but they

\textsuperscript{92} “In place of political power, they sought to influence society at large through private, voluntary, and nonsectarian organization that embodied positive social purposes….Quakers attempted to retain moral leadership through example, remonstrance, and persuasion.” Grob, \textit{Mental Institutions}, 17.

\textsuperscript{93} Benjamin Franklin, \textit{Some Account of the Pennsylvania Hospital: From its First Rise to the Beginning of the Fifth Month, Called May, 1754}. (Philadelphia: Office of the United States Gazette, 1754), 4-5. The nation’s second hospital, it was chartered in New York City in 1771. Hospital plans included cells for the insane. Though a fire and then the Revolutionary War, slowed the hospital’s completion, it finally opened in 1791. The nation’s first hospital devoted to the insane – located in Williamsburg, VA, received approval in 1769 and admitted its first patient four years later. Grob, \textit{The Mad Among Us}, 19-20.

received largely custodial care until Rush joined the staff in 1783. Prior to Rush’s direct administration, patients endured “hot and cold showers alternately,” had “their scalps...shaved and blistered,” and were “bled to syncope and purged until only mucus came from their intestines.” They “were chained by ankle or waist to the wall of the cell,” and because “mad people were not supposed to appreciate temperature differences...cells were not heated.”

Why did such harsh treatment persist for decades? The Enlightenment heralded human reason and equated a loss of reason with a loss of humanity. Despite medical advancements, Americans viewed the mad as less than human. Even Rush contended, “a man deprived of his reason partakes” in “the nature of...animals.” Nonetheless, the poor treatment of this patient population, and the lack of cures, disturbed the doctor and prompted his deeper explorations of mental distress. His work was part of a “wide movement for reform [in care of the insane], arising almost simultaneously, though independently.”

2.5.1 A New View: Moral Treatment

After the turn of the nineteenth century, American institutions incorporated an approach that differed from the one practiced in the early years of the Pennsylvania Hospital. Those new ideas influenced the creation—and later the reform—of facilities for the insane throughout the nation. Several private intuitions formed and emphasized the “moral treatment” pioneered by French physician Philippe Pinel and mirrored in the work of English reformer William Tuke. That practice sought to eliminate, or at least

94 Reiss, 137.
95 Gamwell and Tomes, 32. Public visits to the Pennsylvania Hospital show the presumed “bestial nature of the insane.” At times the hospital charged admission for the ability to gaze upon its patients in hope of discouraging such visits, but public viewings continued through the 1830s. Ibid., 35.
96 Binger, 250.
minimize, the abuses and harsh treatments found in facilities like London’s Bethlehem Hospital. While Pinel’s *traitement moral* was known in England and America as “moral treatment,” his methods (and the French *moral*) had no explicit “moralistic content.” It did not assume, for example, that moral faults caused mental illness. Instead, such work concentrated on “behavioral aspects of insanity,” and attended to treatments more so than specific diagnoses. 97 “Moral management,” as it was also called, sought to “gain the patient’s confidence and instill hope” to bring healing. Working independently, Pinel and Tuke’s reforms included similar presumptions. Believing that “insanity could be cured,” they “based their therapeutics on kindness and the consideration of each patient’s physical and emotional needs,” and dismissed harsh treatments (including bleeding and corporal punishment) as ineffective. 98

Moral treatment named both a disposition toward care and a set of techniques. The conditions at the asylum that Pinel took charge of in 1793 upset the French doctor (who at one point had considered the priesthood). In response, he removed physical restraints from patients, avoided “heroic” measures, and instead created a well-ordered environment to promote health. Presuming that “madness did not ‘imply a total abolition of the mental faculties,’” he appealed “to the patient’s reasoning abilities.” Doing so required authoritative asylum leadership to “persuade patients to internalize the behavior and values of normal society” Pinel’s “moral management,” which required confinement in asylums, brought surprising improvements in patients and bolstered confidence that treatment should include psychological approaches. 99

99 Koenig, 24.
In 1796, William Tuke, a Quaker merchant, opened the York Retreat in England. Distressed by abuses in existing institutions (including the death of a Quaker woman who died six weeks after being admitted to an asylum), Tuke and the Quaker community established their own facility. Treatment took on much the same form as it did in Pinel’s French institution. Based on Quaker virtues of gentleness and quietness, they created the York Retreat as “a place in which the unhappy might obtain refuge—a quiet haven in which the shattered bark might find a means of reparation or safety.”

Tuke hoped to treat both mind and spirit. The staff at the York Retreat relied on the Quaker belief in the Inner Light that assumed that this divine spark was never fully extinguished, even by disease. They hoped to help patients recover their sense of the divine in themselves. Life for patients at York included a “regimen of exercise, work, and recreation.” The staff treated patients as “brothers capable of living a moral, ordered existence if treated with kindness, dignity, and respect in a comfortable setting.”

Governed by the Friends General Meeting, the hospital’s rooms were well heated and ventilated, and the eleven-acre property included room to grow crops and raise cows. All but the most violent patients were free to travel throughout the facility and grounds. Moral treatment, Pinel and Tuke asserted, would “assist patients in developing internal means of self-restraint and self-control” and aid healing.

Moral management made its way to the United States as the result of close relationships between Quakers on either side of the Atlantic. The Friends Asylum (originally, The Asylum for the Relief of Friends Deprived of Their Reason), established

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101 Koenig, 24.
102 Reiss, 125-127.
in 1813 in Philadelphia and opened in 1817, appeared as the first private hospital in the U.S. dedicated to the care of those with mental illness. Over the next decade, mental hospitals opened in Boston (McClean Hospital, 1821), New York (Bloomingdale Asylum, 1824), and Connecticut (Hartford Retreat Center, 1824). Each of those institutions followed the York Retreat model. Most facilities, however, paired moral treatment (including “occupational therapy, religious exercises, recreation, and the employment of mechanical restraint…only when absolutely necessary”) with medical therapeutics.104

2.6 Rush’s Treatment Protocol

Though Rush’s work predated the appearance of those religiously based institutions, his treatment repertoire included a blend of moral treatment and medical care. He prompted humane treatment environments. To facilitate healing, he believed, “great regard should be had to cleanliness in the persons and apartment of mad people.” To protect patients from being exposed to the public as showpieces he asserted, “mad people should never be visited, nor even seen by their friends, and much less by strangers, without being accompanied by their physician.” This offered protection for the one who suffered, hindered the disease from being known to the community, and allowed the doctors to control asylum environments.105 To make treatment more agreeable to women, Rush argued that female patients should be housed separately from men and cared for by female attendants. Finally, when suicide proved a possibility, all precautions possible should be taken to prevent it.106

104 Ibid., 65-66.
105 This action hints as stigma associated with mental illnesses. Bethlehem Hospital in London became famous as a tourist destination, and for many years charged visitors admission to view patients.
106 Rush, Medical Inquiries, 235-238.
Unlike those who focused exclusively on behavioral treatments, Rush also recommended physical remedies. His arsenal included bloodletting, purges, emetics, forced salivation by ingesting mercury, a reduced diet, stimulating drinks (including Madeira wine), and baths (both warm and cold). In order to stimulate the blood, he commended frictions to the trunk of the body and physical exercise. The doctor also invented two devices to treat mental illness. The first, a tranquilizer chair strapped patients in keeping them upright, in order to “save the head from the impetus of the blood as much as possible.”\(^\text{107}\) By “lessening muscular action or reducing motor activity, the tranquilizer [chair] was supposed to control the rush of blood toward the brain and presumably reduce the force and frequency of the pulse, thereby inducing a calming effect.”\(^\text{108}\) He also devised a “gyrator.” The machine spun patients on a turntable, in hopes that centrifugal force would restore proper blood flow to the brain. Injuries resulting from both devices led to their abandonment, both by Rush (who preferred bloodletting) and other practitioners.\(^\text{109}\)

At times, Rush supplemented physical treatments with psychological ones. Cotton Mather had noted that conversation between a clergyman and sufferers could alleviate madness. Moving beyond clergy as the only appropriate conversation partners, Rush assumed that patients benefitted from talking to their physicians. Such attention, he argued, marked that the physician took the disease seriously, even if he was bored by the details: “It will be necessary, therefore, for a physician to listen with attention to his

\(^{107}\) Rush, in Dain, 19n47.  
^{108}\) Brodsky, 361.  
^{109}\) Ibid., 361-362.
tedious and uninteresting details of its symptoms and causes.”¹¹⁰ Mather and Rush recommended conversation with different objectives. Mather hoped to help individuals root out sin that lay at core of their illness and connecting individuals to God for healing; Rush anticipated healing by validating the experience of illness.

Despite the centrality of physical or psychological medical treatment, Rush sometimes recommended the assistance of a clergyman. He advised that when individuals thought they were unpardonable (or assumed they had committed an unforgiveable sin) they should seek council from a clergyman. In addition, “if the disease be derived from a sense of guilt, it is generally connected with ignorance or erroneous opinions in religion,” he argued, and “the former must be removed, by advising the visits of a sensible and enlightened clergyman.”¹¹¹ For those suffering religious delusions, Rush recommended either a physician or pastor remind patients that God rarely delivered prior revelations to lone individuals or without witnesses. Religious assistance remained authoritative, but only in a subset of cases.

Beyond conversation, Rush recommended non-physical treatments that echoed approaches of European moral treatment. He advocated keeping busy, industriousness, being social, and even reading novels (so that the mind was kept active, even if the body was not). He observed that “building, commerce, a public employment, an executorship to a will; above all agriculture have often cured this disease. The last, that is, agriculture, by agitating the passions by alternate hope, fear, and enjoyment, and by rendering bodily exercise or labour necessary, is calculated to produce the greatest benefit.”¹¹² In addition,

¹¹⁰ Rush, Medical Inquiries, 104.
¹¹¹ Ibid., 113.
¹¹² Ibid., 116.
he encouraged “certain amusements” including checkers, cards, shooting, the theater, listening to children playing, listening to music, matrimony, memorizing or copying prose, and travel for the treatment and prevention of mental maladies. To combat mental disease, Rush deployed a wide range of treatment options.

2.7 A Public Advocate

Beyond attending to his own patients, documenting medical theory about mental ailments, and recommending treatments, Rush continued to seek funding to ensure better treatment for sufferers. And, by demanding “that mental illness be freed from moral stigma,” he worked to increase the likelihood that those needing treatment received care.113 In a November 11, 1789 letter to the Board of Managers of the Pennsylvania Hospital, the compassionate physician noted that without proper physical space to house patients, he could not provide adequate treatment for those suffering from mental maladies:

Gentlemen: Under the conviction that the patients afflicted by Madness should be the first objects of the care of a physician of the Pennsylvania Hospital, I have attempted to relieve them, but I am sorry to add that my attempts which at first promised some Improvement were soon afterwards rendered Abortive by the Cells of the Hospital.

These apartments are damp in Winter & too warm in Summer. They are moreover so constituted, as not to admit readily of a change of air; hence the smell of them is both offensive and unwholesome.

Few patients have ever been confined in these Cells who have not been affected by a cold in two or three weeks after their confinement, and several have died of Consumption in consequence of this cold.…

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113 Dain, 15.
Should more wholesome apartments be provided for them, it is more than probable that many of them might be Relieved by the use of remedies which have lately been discovered to be effectual in their disorder.

Nearly a decade later, he wrote again to the Board of Managers. He called for better physical care and recommended employment for patients.\textsuperscript{114} Alongside direct appeals to the Board of Managers, Rush took his fight public, publishing a series of articles in the city newspapers and petitioning members of the state legislature for funds for a new wing of the Pennsylvania Hospital for the insane.\textsuperscript{115}

Three years before his death, Rush wrote to the Board of Managers once more and outlined specific recommendations based on twenty-five years of experience. He proposed:

1. Separate buildings should be built for the admission of severely ill patients “in order to prevent the injuries done by the noises” from causing other patients to miss sleep or experience “distress from sympathy with their sufferings.”
2. Male and female patients should be kept on separate floors.
3. “Certain kinds of labour, exercise and amusements be contrived” for patients in order to exercise their bodies and minds” and speed recovery. Labors should include the ordinary work of the hospital. For those whose social status ranks them “above the obligations or necessity of labor,” the recommended exercise and amusements include: swinging, seesaw, riding a hobby horse, chess, checkers, listening to music, and short excursions into town.
4. Patients be attended to by “intelligent” staff members of their own gender.

\textsuperscript{114} From April 30, 1798: “Mr Coates will please to recollect the following Propositions to be laid before the Managers for the benefit of the Asylum for Mad people, viz: 1st Two Warm and two cold Bath rooms in the lowest floor--all to be Connected; also a pump in the Area to supply the Baths with Water, 2d Certain Employments to be devised for such of the deranged people as are Capable of Working, spinning, sewing, churning &c. might be contrived for the women: Turning a Wheel, particularly grinding Indian Corn in a Hand Mill, for food for the Horse or Cows of the Hospital, cutting Straw, weaving, digging, in the Garden, sawing or planing boards…would be useful for the Men. Benj Rush.” Benjamin Rush, M.D., “Letters from Rush to Board of Managers of Pennsylvania Hospital, 1789,” \textit{American Journal of Psychiatry} 58, no. 7 (1901), 193-194.

\textsuperscript{115} Brodsky, 357.
5. Visitors be restricted to those approved by the attending physician in order to prevent the types of exposure and embarrassment that prevented those who suffered from receiving treatment.

6. Comfortable accommodations, including “a number of feather beds and hair mattresses, with an arm chair” be provided to patients whose conditions warrant, and who are able to pay sufficiently for boarding at the hospital.

7. That instead of unhealthy, malodorous chamber pots, patients be provided with “a close stool with a pan half filled with water in order to absorb the foetor from their evacuations.”

Rush’s commitment to society and his fellow humans meant that he cared about more than medical innovation. Society was bettered only if the conditions of those who suffered most improved. He knew that insufficient funding prevented the implementation of all of the requests he made to the hospital’s Board of Managers, but hoped that they adopted some assured both the “comfort of the mad people” and the “reputation of the institution.”

As Rush proposed new understandings of mental illness and pushed for revised treatments, he sensed the challenges ahead and pled for God’s guidance. He opened Medical Inquiries connecting his work to God’s providence and his call as a Christian:

In entering upon the subject of the following Inquiries and Observations, I feel as if I were about to tread upon consecrated ground. I am aware of its difficulty and importance, and I thus humbly implore that BEING, whose government extends to the thoughts of all his creatures, so to direct mine, in this arduous undertaking, that nothing hurtful to my fellow citizens may fall from my pen, and that this work may be the means of lessening a portion of some of the greatest evils of human life.

Reflecting on his medical innovations, he pointed to God as their source: “It is not to him that willeth, nor to him that runneth, but to the overruling hand of Heaven alone that we

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117 Rush, Medical Inquiries, 7.
are to look for the successful issue of human actions whether of body or mind.”  Rush assumed that all in nature was God’s creation, and that individual and societal health were linked. His pious upbringing and quest for faithfulness shaped his public work, whether medical or political. Pain, in Rush’s eyes, including the suffering that stemmed from mental maladies, formed primarily a medical problem, one that Christians had a responsibility to address through medical innovation and advocacy.

2.8 Conclusion

Rush’s autobiography included portraits of the signers of the Declaration of Independence. He offered a pithy description of his own character: “He aimed well.” Rush, shaped by Protestant values, studied medicine to alleviate the distress of others. Although he met opposition, he helped many, and his contributions to medicine won wide recognition, evidenced by the “handsome ring” sent to him “from the Emperor of Russia.” He demonstrated a concern for public health and turned public and professional attention to mental maladies as valid medical concerns. He shaped early institutional care for sick citizens and proved a model of Christian charity. The doctor believed hard work to combat suffering and injustice would help usher in the Kingdom of God.

Illness afflicted most colonial and Revolutionary era Americans. Mental maladies invaded the lives of fewer citizens, but appeared frequently enough to be deemed worthy of attention by leaders in the church, the medical community, and society. While the professionalization of medicine had begun, treatments for all types of illnesses remained

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119 Ibid., 148.
120 Ibid., 297.
far from modern or standardized. Only by the early nineteenth century did many Americans, especially physicians like Rush, shift to view sickness primarily through medical and not spiritual lenses. Though widespread lay adoption of this change lagged elite acceptance, the role of the church in defining mental distress had changed forever. No longer could a voice like Cotton Mather’s carry the authority it once had about the causes of and solutions for physical and mental suffering. Voices like Rush’s demanded a hearing.

Still, Christians continued to feel called to alleviate suffering, and felt compelled to find new ways to participate in tending to the distress of their fellow humans brought by mental maladies. As medical approaches to mental illness gained scientific complexity, and as institutionalization grew more standardized, believers like the reformer Dorothea Dix and the pastor Anton Boisen forged new paths. They did so amidst growing suspicion that mental maladies unresponsive to treatments signaled moral deficiencies in those afflicted. Dix and Boisen, however, remained undeterred.
3. Dorothea Dix: Advocate of the Helpless, Forgotten, and Insane

I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane, and idiotic men and women; of beings sunk to a condition from which the most unconcerned would start with real horror; of beings wretched in our prisons, and more wretched in our almshouses.

-- Dorothea Dix, 1843

3.0 Introduction

Legend held that while walking down a Boston street in 1841, Dorothea Dix overheard two men denouncing the squalid conditions at the Middlesex County jail in East Cambridge, Massachusetts, an institution that housed criminals and the insane side by side. The conversation, one she might have otherwise ignored or forgotten, struck a nerve. Dix had been feeling guilty about her self-centeredness, having been “so engrossed in the cultivation of her mind and the society of Boston’s literary men” that she neglected not only her closest acquaintances, but also her fellow citizens. Other accounts reported that her exposure to the plight of mentally ill Americans housed in prisons took place when the Unitarian minister James T.G. Nichols begged her to take over his Sunday school class with female inmates at the jail. Either way, the horrid conditions she found while visiting the institution sparked the work that made her famous and fulfilled her search for a God-given vocation.1

Dix (1802-1887) spoke of that encounter as her Damascus Road experience. It spurred her quest—as a calling from God—to remedy the plight of America’s insane. In the years that followed her visit to the Middlesex County jail, she toured hundreds of

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prisons, almshouses, institutions, and private homes gathering evidence about America’s treatment of the mad. Aiming to improve and expand care for those living with mental disease, she spearheaded reform efforts throughout the United States. Benjamin Rush’s attention to mental maladies took place in his study and in Pennsylvania sick rooms. Dix’s crusade occurred on the public stage in state legislatures and in dilapidated almshouses and prisons. Without formal training in medicine or institution building, from 1843 to 1865, her efforts helped launch and expand thirty hospitals for the insane. By taking up the cause of the country’s mentally ill, she found a place where the world’s need, her passions, and her God given abilities aligned.  

Dix’s career as a social activist did not begin until she was forty-one years old and yet she appeared indefatigable in the four decades that followed. A single woman with humble New England beginnings, she emerged as a renowned and respected advocate for the country’s insane. She crisscrossed the nation inspecting public institutions. She dined and vacationed with intellectual and social elites. A Protestant, she garnered the attention of Pope Pius IX and commanded notice from state and national politicians. A layperson, President Abraham Lincoln appointed her the Superintendent of Women Nurses for the Union during the Civil War. Before these feats, however, she faced decades of uncertainty and personal struggle.

3.1 A Christian Reformer

Dix’s advocacy for mentally ill Americans demonstrated four shifts in the story of American Protestantism and mental illness. First, while Christians had always looked inward toward the state of their souls and outward toward faithful action in the world, in

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2 Frederick Buechner, Wishful Thinking: A Theological ABC (New York: Harper & Row, 1973), 119. “The place God calls you to is the place where your deep gladness and the world’s deep hunger meet.”
the nineteenth century, American Protestants presumed the proper reach of their faith extended beyond their homes and congregations to the new nation. This included its rapidly expanding social institutions. Beyond providing care for family members and neighbors, Protestants felt called to ensure help for all in need. They made provisions for this work in a variety of ways. They formed outreach societies. They took matters into their own hands and attended to others. Often, they held governments responsible for aiding their Christian mission to attend to suffering.

A second change accompanied this shift in focus—lay Christians claimed spiritual authority in caring for mental maladies. Continuing a process begun in the prior century, the professional and lay domains professing authority over illness evolved. The clergyman Cotton Mather understood physical and mental maladies as spiritual problems; attending to sin formed a logical response. The scientific categorization of physician Benjamin Rush brought mental illness solidly under medical jurisdiction. Other doctors adopted Rush’s approach and the transition co-opted clergy authority. By 1850, most Americans agreed that mental illnesses were best cared for in medical facilities, by medical professionals.

The historian E. Brooks Holifield distinguished between authority stemming from office, profession, and calling. His categories described “the legitimate use of power” generated by “charisma of office,” “rational authority,” and “charisma of person” (via divine gift) respectively. While Holifield’s account focused on Protestant clergy, these categories help describe the figures profiled here. In their attention to mental maladies, Mather used the authority of his office, Rush the (rational) authority of his profession and medical training (as did Karl Menninger (Chapter 5)), and Dix the (charismatic) authority
of her calling as a Christian. Anton Boisen (Chapter 4) claimed elements of all three types of authority.\(^3\)

Not all Protestants that cared about mental illness were physicians or clergymen. Some, like Dix, claimed authority from their identities as Christians called to fulfill God’s mission. Amidst these changes, believers like Dix operated with a new sort of authority, a moral authority rooted in their Protestant faith. To be sure, Protestant clergy continued to counsel the troubled, but their focus shifted to helping parishioners navigate religious life amidst the country’s rapidly changing economic and social systems. By 1850, ministers consulted asylum physicians for advice about the mental health of their parishioners.

A new view of mental ailments emerged in the years before the Civil War, and shaped Protestant responses in a third way. With evolving notions of Christian responsibility for the world and with a growing discussion of public morality, Protestants understood mental illness as a social (and thus moral and ethical) problem. Many blamed modern civilization for the presence of mental disease and as a result held society responsible for ameliorating the condition.

Finally, Dix’s public advocacy took place during a time of immense religious, medical, and social optimism. A combination of Enlightenment hopefulness, giddiness over the successful new country, and confidence in the power of religion to effect change made a cure for all ills—medical or social—seem possible. Americans were convinced of their ability to solve problems, cure disease, and bring about social change. A sense of God’s divine blessing of the new nation fueled that hope. A democratic spirit paired with

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energy from religious revivals infused Protestantism and emboldened individual Christians to make changes in the world around them. Though some of that optimism proved misplaced—especially when it came to the ability to cure mental maladies—Dix’s story exemplified the power of a desire for social change rooted in religious mission and fueled by scientific and political optimism.4

Altogether, by the nineteenth century, expertise in matters of mental illness had diversified into three realms: some defined the problem, some directly provided treatment, and others helped ensure medical facilities were available to house those in need. Protestants dabbled in all three areas during this period, but following Dix’s lead, firmly grabbed hold of the final role.5

3.2 An Uncertain Future

Years before her work as a reformer, Dix’s family provided a mixed set of lessons that shaped her fiercely independent character and enabled her mission. From her grandparents the young woman received tutelage in philanthropy and wealth. Dix was the granddaughter of a self-made Bostonian, a doctor, merchant, and land speculator who married into money.6 The riches her grandfather Elijah accumulated funded moral reforms including the construction of a school and prison in Worcester, Massachusetts. He also built a grand house in the middle of Boston where Dorothea later lived. The

4 Dix harnessed authority as a Christian to transgress gender social norms (of speaking publically, moving outside of the domestic sphere), but did so in a way that differed from her abolitionist and equality seeking contemporaries. She thought, for example, that the abolition and the suffrage movements were a waste of time.

5 The nineteenth-century shift in Christian authority with respect to mental maladies revealed an attempt to compensate for lost spiritual authority. The ability for Christians suffering from mental illness to claim authority about care from their experience of suffering developed very slowly, with only a few individuals, like the Rev. Anton Boisen embracing that power. In the years before the Civil War, Christians focused their concern on providing care for others, not advocating for themselves when ill.

elder Dix’s professional pursuits and philanthropy ended abruptly, though, after his unexpected death when Dorothea was seven.\(^7\) Thanks to a modicum of inherited wealth and, later, her publishing income, as an adult, Dorothea lived independently with adequate means. Her frugal lifestyle helped, as did memories of her earlier years.

Dix’s father offered an example of capriciousness and struggle that Dorothea hoped to avoid. The black sheep of his family, Joseph dropped out of Harvard, entered a marriage that his family disapproved of, moved to rural Maine, and remained perpetually destitute and frequently ill. In Maine, he took up Methodism during the revivals of the Second Great Awakening and worked as an itinerant lay minister. His family of origin marked his religious conversion as a move into commonness. As elite Congregationalists, they viewed Methodism as “a crude, homespun evangelism” that appealed to society’s downtrodden, not those of high social standing.\(^8\) Joseph’s only daughter shared the wider family’s sense that Methodism lacked the “gradual, self-disciplined cultivation of piety and rectitude” that she grew to admire in Congregationalism and its offshoot, Unitarianism.\(^9\)

After her birth in Hampden, Maine, Dorothea’s immediate family moved frequently. They lived in poverty, at times only steps from the almshouse. Unpredictable and suspected to be an alcoholic, Joseph proved prone to extreme “religious spells” as the family wandered through the New England frontier. Dix recoiled from her father’s Methodism and detested being forced to help him bind religious tracts for sale. Joseph’s

\(^7\) Ibid., 350. cf. n 16. Some sources, including Gollaher’s biography, indicate that Elijah Dix was murdered. Brown disputed this claim, citing circumstantial evidence.

\(^8\) Gollaher, 17.

\(^9\) Brown, 7.
explosive faith, though, imparted a deeply personal piety and a quest for personal perfection.

As an adolescent, Dorothea seized responsibility for her life. Her mother Mary, after giving birth to Dix’s two brothers ten years her junior, proved too ill to rear children. Early biographers painted a picture of a home devoid of love that included emotional, if not physical mistreatment. Whether or not such abuse occurred, Dix adopted a “lasting image of herself as an orphan prematurely deprived of parental attention and burdened with the grave responsibilities of adulthood.” She tried to wipe her parents from her memory and throughout adulthood referred to herself as an orphan.

At age twelve, Dorothea fled secretly to Boston to live with her paternal grandmother, for whom she was named. Dorothy Lynde Dix’s home provided an escape for Dorothea, but offered a cold, disciplined environment, and the two women sustained a tense relationship. In a letter to a friend, the younger Dix warned that living with her grandmother required “moral and physical courage to face the Medusa!” After a year under her grandmother’s roof, she left Boston to help care for her brothers who had been abandoned with an aunt in Worcester. Lacking financial resources, and unsure of a place in her grandmother’s will, she opened her first school, needing to care for her brothers and hoping to become self-sufficient.

The education that enabled Dix to teach came from a variety of sources. Her father provided training in the Bible and classics. After leaving home, she acquired a borrowing card for a Boston research library thanks to the help of her uncle, the librarian

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10 Gollaher, 20. Gollaher shared this assessment, but noted that corporeal punishment and harsh discipline characterized the parenting style of early nineteenth-century Evangelicals, and so may not have been unusual. Brown refuted accounts of abuse.
11 Brown, 8.
12 Ibid., 68.
and scholar, Thaddeus Mason Harris. The scores of books she checked out occupied her for three or four hours each night as she read and commented on literary classics, physical and natural sciences, and philosophy. Attendance at public lectures in Boston added insight about astronomy, mineralogy, and botany. Like Mather and Rush before her, Dix was interested in the natural world and science as “a demonstration of the divine order of the world.” Yet, also like her Protestant predecessors, scientific progress failed to dislodge her sense of God’s presence in the world. Aware of her God-given, keen intellect, she struggled with how best to put it to use. Always purposeful, she hoped improving her education would not only provide income, but also serve as a “means to unriddling the mystery of God’s calling for her life.” Her education extended beyond book learning and lectures. Time living with relatives in Boston and Worcester introduced Dix to upper class social norms of behavior and dress. Both book learning and education in social norms became valuable tools as she later navigated the country investigating treatment of the insane.

Eventually, Dix returned to Boston with her brothers, becoming the head of her own household at age sixteen. She was well educated, but as a woman in the nineteenth century, she lacked access to a wide range of places to deploy her knowledge. Teaching formed a logical outlet. Dix opened schools and to train students worked at a pace that her friends deemed obsessive. At her first school, she hoped to “rescue some of America’s miserable children from vice and guilt, dependence on the Alms-house, and finally from what I fear will be their eternal misery.” Dix proved a strict, demanding,

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13 Ibid., 19-20.
14 Gollaher, 44.
15 Ibid., 40.
16 Dix in Brown, 19.
and inflexible instructor. Students described her as “stern,” “overbearing and
dictatorial.” More than book-knowledge, the determined teacher wanted to instill in her
students “habits of discipline, perseverance, and seriousness of purpose.” While never
fully satisfied, she spoke of her time in the classroom as “the cause and work, for which
and to which Providence has adopted…me.” She became one of Boston’s “most
prominent young schoolmistresses,” and while teaching formed a satisfying pursuit, it
was not her permanent vocation.

Growing out of her teaching, Dix attracted widespread public attention as an
author of children’s books. The first, *Conversations on Common Things; or, Guide to
Knowledge: With Questions* (1824), she published at age twenty-two. To compile that
reader intended for use with lower level schoolchildren, Dix corresponded with a number
of prominent scientists and scholars, asking questions and seeking new knowledge. The
book became a financial success, going through sixty editions before the Civil War.

Over the next decade, she published four more books, largely in the form of devotional
guides for families and children. Operating schools provided a means for the focused
New Englander to further her own education and to exert authority. As a writer and a
teacher, both acceptable occupations for a woman in Jacksonian America, Dix was able
to “keep her mind alive and even exercise a measure of ambition.” Her work received
praise from Boston’s leading citizens, made her a public figure, and provided needed
income.

17 Gollaher, 29.
18 Brown, 19.
20 Gollaher, 47. Dix’s thirty-year scientific correspondence through the mail with Benjamin
Silliman, a leading geologist, suggested the breadth her intellectual interest and capability. See Brown, 21
for discussion of *Conversations on Common Things*.
21 Gollaher, 84.
Dix’s education, income, and access to other prominent Americans marked her as an elite member of American society, but she preferred to think of herself as an outsider. While preparing material for a never-published memoir, she reflected that “the whole of my years, from ten years till the present, differ essentially from the experience and pursuits of those around me.”\textsuperscript{22} In many ways, she was right. Dix garnered public accolades, but maintained just a handful of close friendships and a sterile emotional distance marked most of her relationships. She never married and thus failed to conform to a primary social norm for nineteenth-century women. Often a loner, she corresponded and dined with the nation’s most prominent women and political and religious men, but spent much of her later life inside almshouses, prisons, and asylums gathering data. She survived (and clung to) a sense that she failed to fit in society, biographer David Gollaher argued, because of her confidence that “life had a purpose that revolved around discovering and carrying out the will of God.”\textsuperscript{23} Bright and hard working, Dix had her grandfather’s philanthropic legacy, but neither the assurance of inherited wealth nor the satisfying assurance of a lifelong vocation. Her future remained uncertain, and the work that cemented her place in American history remained decades away.

### 3.3 Changing America

Not only was Dix’s life marked by frequent change, from 1800 to 1850, the world around her underwent dramatic social, economic, intellectual, and religious transformations. Those shifts shaped attention to the nation’s dependent citizens, including the poor, prisoners, and the mentally ill.

\textsuperscript{22} Brown, 1.
\textsuperscript{23} Gollaher, 34.
Demographic transitions anchored social change. Americans migrated from rural areas to cities, and an influx of immigrants from Europe helped fuel the growth of cities. In 1790, only six cities boasted populations more than 8,000, by 1850 eighty-five did. No American cities included more than 50,000 residents in 1790; in 1860, New York City alone housed half a million residents. Four more cities held 100,000 to 250,000 citizens, and twenty more cities contained populations between 25,000 and 100,000.\textsuperscript{24} Alongside those shifts, the country evolved from a largely rural, “self-subsistence agricultural economy” to an urban, mercantile and factory capitalism.\textsuperscript{25} Much of the country remained rural, but growth in cities yielded higher levels of poverty and population concentration made squalid conditions and behaviors deemed deviant, such as mental maladies, visible to more Americans.

As citizens moved and modes of production evolved, life that once centered on families and household industries now revolved around the workplace and social institutions. An increasingly segmented society resulted, with “firm boundaries” drawn between “the domestic and the economic,” between men that spent their days in the public, economic sphere and women that spent their days at home.\textsuperscript{26} That privatization of family life led to a reduction in the “educational and welfare functions of” individual households.\textsuperscript{27} Public (and quasi-public) institutions, including schools and hospitals, appeared to address those needs. An increasingly rich merchant class seeking continued productivity helped fund the early development of those institutions.

\textsuperscript{25} E. Brooks Holifield, \textit{A History of Pastoral Care in America: From Salvation to Self-Realization} (Nashville: Abingdon Press, 1983), 112.
\textsuperscript{26} Ibid., 113. Portions of this section rely on Holifield’s discussion of “Social Order” in antebellum America.
\textsuperscript{27} Grob, 24.
A distinction also grew between capitalists and laborers, with the latter increasingly valued for their productivity and contribution to the economy. Despite the egalitarian rhetoric pervasive since the American Revolution, social life remained stratified. As a result, more than in the prior century, Americans deemed one another good members of society based on their economic productivity. Those unable or unwilling to work, including the mentally ill, emerged as visible and socially problematic citizens.

### 3.3.1 Religious Transition and a Unitarian Piety

In the decades before 1850, the American Protestantism in which Dix was firmly entrenched, also experienced upheaval. The revivals of the Second Great Awakening fueled change following the American Revolution. Sharing similar theological emphases on new birth, conversion, and salvation with the revivals of the early eighteenth century, the movement spread farther geographically. The nineteenth-century awakenings deemphasized the Calvinist notion of the “depravity of human nature and the futility of human intervention.” Instead, many clergy and believers adopted a theological Arminianism, focusing on a “loving and beneficent God,” a moral universe, human possession of free will, and the perfectibility of humanity. Optimism rather than pessimism increasingly animated religious thought. Just as Americans had successfully defined their political future, they now felt free to affect their own salvation and found themselves emboldened to bring that redemption to others. That hopefulness shaped the development of both social outreach and medical care.

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28 Ibid., 30.
From 1776 through 1840, a broad evangelical consensus undergirded much of Protestant life, despite differences in belief and practice. Protestantism, however, diversified at an unprecedented rate as charismatic leaders rose to shape new traditions. New sects and denominations took a variety of forms, from the frontier revivalism of Joseph Dix to the rationalist, Unitarian reaction to the perceived emotional excess of awakenings of Boston’s elite Congregationalists. Joseph’s daughter stood at the crossroads of those, sometimes contradictory, religious impulses.

The historian Nathan Hatch named the post-Revolutionary shift and diversification in American Protestantism the “democratization of Christianity.” A profoundly egalitarian spirit enabled many, including Dorothea Dix, to embrace a personal faith and piety that shaped both their life choices and engagement in the world. Hatch isolated three forces behind that charged atmosphere. Each shaped Dix’s experience.29

First, populism “instinctively associated virtue with ordinary people rather than with elites.” Clergy retained spiritual authority, but they now shared it with laity in novel ways. Ministers preached about salvation, but individual men and woman held responsibility for claiming their eternal destinies. Unlike the earlier Puritans, many Americans now felt sure of their virtue and salvation. Dix admired and professed loyalty to a number of clergymen, but they were figures of her choosing. She looked to them to help inform—but not dictate—how her faith should be enacted. In those men, she found inspiration, but she needed no permission to interpret how her faith shaped her actions.

While she spoke and corresponded frequently with prominent clergymen, an egalitarian impulse allowed her to declare her religious mission, and then to pursue it outside of church or denominational structures. Dix claimed religious authority for her vocation and implored others to live up to Christian ideals too.

Second, the revivals in the young nation “empowered ordinary people by taking their deepest impulses at face value rather than subjecting them to the scrutiny of orthodox doctrine and the frowns of respectable clergyman.” No longer needing clergy to validate their religious experiences, believers could trust their own instincts. When, at last, Dix found her calling, she proved sure of her vocation.

Finally, “religious outsiders, flushed with confidence about their prospects, had little sense of their limitations.”30 While Dix differed from the outsiders Hatch described, she too claimed outsider status and emboldened by her faith, acknowledged few limits to her ability to pursue her mission to society.

A variety of religious influences had molded Dix’s piety and her sense of her purpose and role in the world. In her childhood, her father worked to indoctrinate his daughter with his fiery faith. Under his roof her father’s evangelicalism required, for example, that she bear witness to her conversion. Dix was “exhorted to be contrite, repent of her sins, and desperately throw herself on the mercy of God. Only at this point, having purged her soul of sin and committing it purely to the divine will, could she receive sanctification.” Those experiences shaped her piety, but given her reserved

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30 Ibid., 10.
nature, she found the “unbridled emotionalism and abandonment of self-control” of her father’s revival religion hard to bear and longed for alternatives.\(^\text{31}\)

Others shared Dix’s desire for a more rational religion. Indeed, many declared the revivals of the Second Great Awakening excessive displays of emotionalism and hoped to counter such spectacles with reason. The democratic spirit that marked religion after the Second Great Awakening meant believers were free to advocate alternatives. Their objections shaped, in part, the liberal evangelical trajectory that first appeared together in the Unitarianism of the first half of the nineteenth century.\(^\text{32}\)

Amidst those liberal Protestants, Dix found her spiritual home. Three characteristics defined that modernist Protestant impulse according to the historian William Hutchison. First, it included “the conscious, intended adaptation of religious ideas to modern culture.” It also assumed that “God [was] immanent in human cultural development and revealed through it,” instead of solely through scripture or tradition. Finally was the belief that “human society [was] moving toward realization (even though it may never attain the reality) of the Kingdom of God.”\(^\text{33}\) Human effort and innovation, rather than the miraculous or divine intervention, helped shape the world as God intended.

\(^{31}\) Gollaher, 22.

\(^{32}\) Strands of liberal Protestantism first appeared in the eighteenth century and were advocated by those like the Rev. Charles Chauncy who emphasized the “truths of religion and the morality duties” of humanity rather than a pietistic religion of the heart. Such individuals also downplayed specific conversion experiences and instead affirmed, “the Christian life was a continuous rational process of self-dedication.” Historian Sydney E. Ahlstrom placed Unitarianism as the first formalized liberal tradition in America. For additional discussion of the emergence of liberalism and Unitarianism see Ahlstrom, *A Religious History of the American People*, Second ed. (New Haven, CT: Yale University Press, 2004), 390-402.

Hutchison named William Ellery Channing, the minister of Federal Street Church in Boston, as the most influential of the first generation of Unitarians. Unlike their more revivalist Protestant counterparts, early Unitarians appealed not only to scripture, but also to reason as a source of authority. Channing, later Dix’s pastor and friend, and others also ascribed authority to “the spirit of the age,” a “tutelary authority perceived as a projection of individual reason, yet increasingly spoken of as something palatable and identifiable in itself.”

Claiming that threefold authority (scripture, reason, and culture) imparted a particular focus to Protestantism. Religion, Channing asserted in an 1824 ordination sermon titled, “The Demands of the Age on the Ministry,” “must be dispensed by men who at least keep pace with the intellect of the age in which they live.” Clergy should still attend to theology, but “the bulk” of their attention should be “given over to an attempt to define the leading intellectual and social imperatives of the age.”

Ministers also held responsibility for identifying “implications for religious reform.” The primary implication, given what Channing and others saw as “unprecedented demands” of modern life, was a call for engagement beyond “the cell of the monk,” “the school of the verbal disputant,” and “into life and society.” Channing hoped to progress beyond doctrinal disputes and attend to the “grossly defective” society with a realistic optimism. Channing advocated a view of Christianity that held “but one purpose, the perfection of human nature, the elevation of men into nobler beings.” Christians, he argued, should look inward to perfect themselves, and then move out into the world to raise the station of others.

34 Ibid., 16-17.
35 Channing, cited in ibid., 17.
36 Ibid., 17.
37 Ibid., 19.
38 Channing in Ahlstrom, 399.
Dix’s religious journey included several temporary stops before she found a home in Channing’s congregation. After leaving Maine for Boston in her teens, Dix had worshiped at Hollis Street Church with her grandmother in the family’s rented pew. Appearing in that Congregational setting seemed to mark Dix free of her frontier revivalist roots. Nonetheless, much of her father’s Methodist devotional influence continued. She prayed daily, read scripture, and sought God’s will for her life. She also failed to shake a sense that “sinful human nature was a constant drag on her soul” and the need to strive for perfection.\(^{39}\) She viewed humans as “woefully fallen” and human nature as “hot-blooded, reckless, venal, and predisposed to betray the soul to everlasting shame.”\(^{40}\) At least she suspected that of herself. Dix’s writings from early adulthood displayed a preoccupation with her own sin. She noted that a half dozen “faults must be abandoned by [one] seeking prosperity: sleep, drowsiness, fear, anger, laziness” and “loitering.” She confessed to suffering from all six.\(^{41}\)

Dix was also sure God called individuals to serve in specific ways. “We are not sent into this world merely to enjoy the loveliness therein” she reflected, “no, we were sent her for action – for constant action. The soul that seeks to do the will of God with a pure heart fervently, does not yield to the lethargy of ease.”\(^{42}\) She remained deeply uncertain of her calling in the world, but convinced that God would reveal it in time if she remained faithful.

While in Worcester caring for her brothers, Dix worshiped with members of her extended family at the Second Congregational Society. The minster there, the Rev. Dr.

\(^{39}\) Gollaher, 49.  
\(^{40}\) Ibid., 50.  
\(^{41}\) Ibid., 35.  
\(^{42}\) Brown, 41.
Aaron Bancroft, served as the first president of the American Unitarian Association, and “emphasized the harmony between reason and religion,” a message that resonated with the intellectual young woman.\footnote{Gollaher, 39.} Under Bancroft’s influence, she migrated toward Unitarianism’s logical, embodied impulse. She traded an inward preoccupation with the possibility of salvation for an external focus on public service that ushered it in (in her life and the lives of others). She came to believe that “salvation depended solely on ‘purity of life, and devout affections,’” and found little value in “speculative opinions, abstract principles, and creeds.”\footnote{Brown, 10.} In Unitarianism, Dix found assurance that her God given intellect, if properly and practically deployed, could contribute to her salvation through her work in the world.

After returning to Boston, the Rev. John Pierpont, minister of Hollis Street Church, helped continue Dix’s theological transition. Pierpont emphasized the social obligations of Christians and assumed that the church’s ministry should “include the welfare of all Bostonians,” not just those in the congregation.\footnote{Gollaher, 39.} That approach seemed correct to Dix, and her writing from that period displayed her focus on the suffering humanity of Jesus as a model for her own life. Increasingly, she understood Christ as a man of action, and Christianity as a call to follow his caring example. A hymn from one of her children’s books displayed this sentiment:

That mutual wants and mutual care
May bind us man to man.
Go clothe the naked, feed the blind,
Give the weary rest;
For sorrow’s children comfort find,

\footnote{Gollaher, 39.}
And help for all distressed.46

Pierpont’s teaching and ministry to the city’s poor inspired Dix’s schools in Boston. The Rev. Joseph Tuckerman, pastor of the Congregational Church in Chelsea provided similar influence. In addition to sermons about Christian responsibility to care for the poor, his ministry included firsthand provision for the material needs of impoverished Bostonians. By helping Tuckerman collect shoes, clothing, and books for the city’s impoverished children, Dix witnessed how an individual working in cooperation with institutions could prompt social reform, an awareness that undergirded her later reform efforts.47

Finally, at William Ellery Channing’s Federal Street Church in Boston, Dix found what she called “a church of my own,” and aligned fully with the optimism and hopefulness of the Unitarian movement. 48 Like Tuckerman, Channing proclaimed that God’s servants should minister in the world rather than remain isolated in churches. Channing himself “never became an active social reformer,” but his “belief that the Gospel applied to social problems and his confidence in the redemptive power of moral education” deeply influenced Dix.49 Unlike many of his contemporaries, Channing refused to see the world around him as actually undergoing beneficial progress. Improvement remained only a possibility. Instead, he saw “an age of sin and moral decline, ‘obviously and grossly defective when measured by a Christian standard.’” Christians, in Channing’s eyes, had a duty to “press vigorously ‘into life and society’” to

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46 Dix, in ibid., 52.
47 Ibid., 56.
48 Dix, in ibid., 64. After worshipping at Federal Street, Dix became part of Channing’s religious, social, and family circles.
49 Ibid., 79. Channing and others rejected Orthodox Protestant conceptions of the Trinity. See ibid., 55.
prompt change. The elder Unitarian statesman’s urging to work in the world, and his sense of ongoing human depravity, matched Dix’s understanding of faith and society. His slight of “heart-felt religion” and piety did not. Dix maintained that “a man certainly cannot be religious without good morals,” but that “one can have good morals without the essence of religion, *viz*, vital piety.” While many found the revivalist and rational impulses of Protestantism antithetical, Dix refused to reject the lessons of her father’s fervent piety in her transition to a more rational and active faith.

In general, nineteenth-century evangelicals (whether they sided with revivalists or endorsed a more “rational” faith,) kept a focus on individual salvation, but paired it with a sense that that personal salvation bore social consequences. Alongside a “millennial vision of a perfected society, evangelical Protestantism was transformed into an active social force” with a “generalized faith that institutions could be improved and that individuals could be perfected.” Under the leadership of those like Presbyterian minister Charles G. Finney, “abolition leagues, temperance societies, missionary programs and a host of other voluntary organizations were formed in an effort to bring

50 Ibid. In addition to weekday classes, Dix taught Sunday school classes at Channing’s church. For a time in the 1820s, she served as a tutor and governess for the Channing family. As part of those duties, she accompanied them on summer trips and other travels including a several month stay in St. Croix. The trip seemed well timed for Dix, who decided to accept the family’s invitation, in part, to recover from exhaustion.

Letters from Dix’s time in St. Croix reveal a contradiction in her care for humanity. Dix expressed outrage over drinking and sexual relationships between whites and blacks on the island, but none about the harsh conditions resulting from slavery and an unrestricted slave trade.

51 Social outreach by the members of Federal Street Church, and other congregations, can be viewed as faithful Christians working to ameliorate poverty and poor living conditions. It might also be understood as an effort on the part of Boston’s wealthy to make the lives, lifestyles, and education of their “inferiors” conform to their expectations. Likely, both motivations existed, even if subconsciously. Suspicions of this darker side of social reform efforts remained unspoken for decades, but as we will see critique of “good deeds” eventually surfaced, particularly in response to mental hygiene efforts of the early twentieth century. See discussion of social control at the close of this chapter.

52 Brown, 39.
53 Grob, 30.
the salutary effects of Christian faith to citizens in Antebellum America." Some also pursued their religious vocations alone. Given her preference “to regard her religion as a diffuse movement to improve individual spiritual direction rather than a sharply defined denomination,” that Dix’s religious mission took place beyond formal denominational structures seemed expected.

Protestant influence grew in American life in the antebellum years “despite forces from the Enlightenment, Revolution, and denominational rivalries that might have undermined Christianity’s cultural impact.” Religion offered hope for individual perfection and promise for success of the country’s nascent institutions. In 1829, President Andrew Jackson’s first inaugural address reflected the early-century religious and institutional hopefulness alongside an optimistic anthropology. “I hold”, proclaimed Jackson,

to the doctrine that man can be advanced; that man can be elevated; that man can be exalted in his character and condition. We are told on high authority, that he is made in the image of his God; that he is endowed with a certain amount of divinity. And I believe man can be elevated; man can become more and more endowed with divinity; and as he does, he becomes more Godlike in his character and capable of governing himself. Let us go on elevating our people, perfecting our institutions, until democracy shall reach such a point of perfection that we can exclaim with truth that the voice of the people is the voice of God.

Conviction that change was good marked Dix’s era. Some of the optimism of the Jacksonian Era diminished in the aftermath of the Civil War, but before then, individual

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54 “Second Great Awakening” in Dictionary of Christianity in America, ed. Robert Dean Linder et al. (Downers Grove, IL: InterVarsity Press, 1990), 1068.
55 Brown, 40.
57 Quoted in Grob, 30. See also Lillian Foster, Andrew Johnson, President of the United States: His Life and Speeches, ed. Andrew Johnson, Sabin Americana (New York: Richardson, 1866), 104.
initiative and institutional growth—both fueled by changes in Protestantism—occupied center stage.

Despite a growing sense of the proper role of faith in the larger world, Dix continued to search her own soul. She worried about the presence of evil, and wrote that only a life “virtuously sacrificed for the benefit of others” allowed one to escape such peril. In particular, frequent illness and growing exhaustion from her teaching, writing, and charity work gave her reason to reflect on the religious meaning of illness. Dix “thought of her diseases as spiritual tests, or in some instance, deserved punishment.”

She suspected sloth amidst her illness and wrote to a friend that sickness proved evidence of “a hidden disposition…a secret desire to escape from labor.” While never explicit that she assumed the same about the sickness in others, it seems plausible, even if Dix reserved the harshest judgment for herself.

3.3.2 Medicine Evolves

A concern with illness brought Dix in contact with both physicians and patients. In the first half of the nineteenth century, serious illness remained a threat for most Americans. Medical care improved, but only sporadically. From 1790 to 1825, “infectious diseases continued to devastate the country,” especially in port cities that received immigrants. Urbanization and immigration meant more ailed, further reducing physician effectiveness. As in the prior century, yellow fever epidemics persisted. Malaria, small pox, scurvy, and bubonic plague abated, though, in part because of more

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58 Gollaher, 37, quoting Dix’s journal.
59 Ibid.
60 Ibid.
widespread inoculation and the use of cinchona bark to counter malaria. The origins of most diseases, however, physical or mental, remained as mysterious as effective cures.

Physicians continued to train in the United States, but leading antebellum doctors still sought schooling in Europe. Many that practiced in the U.S. lacked formal education, and without widespread teaching hospitals, training through apprenticeship continued, especially in rural areas. Charlatans plied their trade and medical sects including homeopathy, hydropathy, Grahamism, and Tomsonianism appeared and drew adherents. Lacking certain cures, patients gravitated to any treatment that brought relief.

The respect that physicians had gained during Benjamin Rush’s era waned in the early decades of the nineteenth century. With a great diversity of care available—and public feuds between physicians about whose techniques were best—public trust of medical professionals diminished. Continued use of bloodletting and purging, also failed to endear the ailing to doctors. Training practices including dissection caused public outrage and even riots in Philadelphia. In addition, by 1840 “popular distrust of medical treatments was based...on more than a dislike of unpleasant or dangerous remedies...Medicine seemed to have fallen behind the other sciences.”

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63 Hydropathy practitioners used water—internally and externally—to bring cures. Grahamism and Tomsonianism focused on dietary and botanical remedies, respectively. For additional details on these approaches and homeopathy, see Norman Dain, Concepts of Insanity in the United States, 1789-1865 (New Brunswick, NJ: Rutgers University Press, 1964), 160-162. See also William G. Rothstein, American Physicians in the Nineteenth Century: From Sects to Science (Baltimore: Johns Hopkins University Press, 1985), chapters 7 and 8.
65 Shryock, 170-171.
and natural sciences drew more certain conclusions than did medicine. The workings of the human body remained mysterious. Compounding this, post-Independence attacks on elitism made citizens fear the rising professional power of doctors. Many advised cultivating personal hygiene in order to avoid the need to see a physician. As a result, America’s physicians lost, for a period, some of the authority they had gained in the prior century. That lost authority migrated, not back to the ministers that held it in colonial days, but to common citizens that presumed the right and the ability to discern the therapy they needed and the best sources for that treatment.

Despite trouble with their public image, physicians remained optimistic about their abilities and effectiveness. Formal professionalization of the practice of medicine had begun in the years following the American Revolution, but Jacksonian era deregulation dismantled most of the nascent licensing standards. “By 1845 there were at least eight states which gave their populations no guidance as to medical standards, and in many others, graduates of chartered medical colleges could ignore the remaining licensing provisions.” In the absence of state or federal regulation, physicians joined in medical associations. In 1847, the American Medical Association formed and undertook a study of the state of medical education in the country, aiming to standardize training and further differentiate between regular (professional) and irregular practitioners.

While disagreements continued, changes hinted at the coming standardization and modernization of medicine. The emergence of physical science prompted physicians to

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66 Stevens, 26.
67 Dr. Nathaniel Chapman, a University of Pennsylvania physician, asserted that, while European doctors might have had more schooling, “in penetration, and promptness of remedial resources…we are perhaps unrivaled” and that “it may be safely said…that in no country medicine…better understood or more successfully practices than in the United States.” Shryock, 203.
68 Stevens, 27.
69 Ibid., 28.
abandon older theories of disease. Many now argued for medicine as science, instead of an art. Moving beyond the longstanding view of humoral causes and cures, physicians defined localized bodily origins of disease, and the assumption that disease stemmed from lesions in specific areas of the body changed treatments.\textsuperscript{70} Bleeding and purging declined by 1850, and largely disappeared from physicians’ toolkits by 1870. Generalized treatments no longer made sense amidst a growing understanding of the specific origins of disease.\textsuperscript{71}

Most antebellum physicians practiced as generalists, a reality necessitated by the need to treat a wide variety of patients without the help of hospitals in many locations. After 1830, however, the changes in theories of disease led to one of the early specializations, surgery. Paired with the emerging use of anesthesia, surgeons now attended to more than just broken bones. The growing infrastructure of asylums led to the other early medical subfield—alienists, specialists in the care of the mentally ill. It was with those practitioners that Dix formed her closest alliances. By doing so, she would not only further her own cause, but also help build their public credibility.

\textsuperscript{70} The humoral approach assumed that illness stemmed from an imbalance in the four major fluids or humors of the human body: cold, dry, hot, and moist. See my Chapter 1 for additional discussion.

\textsuperscript{71} Technological advances also changed nineteenth-century medicine. Stethoscopes appeared by the 1820s, anesthesia and antiseptics later in the century. The use of immunizations continued, and by the end of the century, germ theory, which had been debated since Cotton Mather’s time, began to be put into practice. Finally, the emergence of the field of statistics meant that medical professionals tracked and shared details about illness and treatment effectiveness. With the exception of statistical analysis, few of those innovations benefited those suffering from mental maladies.

Increasingly squalid conditions in cities generated a formal interest in public health and hygiene appeared. From 1810 to 1857, for example, the death rate in New York City grew from 21 to 37 out of 1000. Cities established boards of education that offered advice to residents and city leaders, particularly in times of epidemics. Independent public hygiene efforts combined with more targeted treatments and led to amelioration of the devastating effect of diseases. By the end of the nineteenth century, public health efforts focused on prevention of disease, as much as treatment. Disagreement appeared, however, between contagionists who advised limited contact between sick and others and sanitarians who argued that cleaning up the city environment would prevent the most illness. Shryock, 128.
Altogether, demographic, religious, and medical changes made understandings of all illness, mental and physical, ripe for reconsideration and reform. Dix’s part in that process, however, remained a few years away.

### 3.4 European Respite

Falling victim to serious illness, including an ailment such as her father’s alcoholism, terrified Dix. She hoped that disciplined work and strong morals would ward off sickness, but her tireless teaching eventually produced the opposite effect. In March 1836, she experienced a physical and emotional breakdown. “The gloomy ruminations reflected in her letters and journals [from this time] show a woman increasingly depressed by her failure to settle on a suitable vocation, to work out an acceptable relation with society, to decipher God’s calling and lead a life worth living.”\(^{72}\) Dix brooded over congestion in her lungs, ongoing depression, and thoughts of suicide.

Always analyzing, Dix searched for religious meanings of her suffering. Like Cotton Mather, she assumed connections between illness (physical and mental) and sin. Health, she thought, depended on observing divine laws; illness resulted from breaking them. Sickness alerted believers to their wrongdoing. “God never withholds the train of….results he has annexed to wrong conduct,” she reflected, “and the pain that visits the involuntary transgression is often our first index to a broken law.”\(^{73}\) Whether or not her breakdown helped her empathize with others, the time she spent recovering provided her insight about moral treatments for mental illness. She struggled, however, to navigate a path through her melancholy.

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\(^{72}\) Gollaher, 83.

\(^{73}\) Dix in ibid., 105.
The introspective Dix felt sure that her condition was just punishment, a “chastisement” inflicted by God “for the soul’s health.”74 Her friends, including Channing and Ralph Waldo Emerson convinced her that a sea voyage and tour in Europe were necessary to cure her ills and paved the way for her stay, sending her with letters of introduction to their acquaintances overseas.75 Noting compulsive work—and not laziness—as the root of her illness, a letter written by Channing explained that Dix “injured her health by her singular devotion to her work.”76

One of Channing’s European connections, the Liverpool resident William Rathbone III and his family nursed Dix back to health. Rathbone, a Quaker with Unitarian sympathies, politician, and philanthropist and his wife offered her compassionate care and intellectual company during the many months she remained in their home. Once refreshed, she studied in Liverpool, reading about prevailing theories of disease and European approaches to public care.77 Amidst her recovery, Dix observed social reform efforts in Europe, including efforts to overhaul the treatment of madness. She was inspired by the European quest to find new ways to determine who qualified for welfare programs, an effort resulting from investigations documenting poverty in the countryside. Through Rathbone, she met European social reformers including Samuel Tuke, the grandson of William Tuke, a pioneer of moral treatment for mental illness, and

74 Dix in ibid., 94.
75 Such trips formed conventional therapy among the well-to-do of nineteenth-century America, although an extended trip abroad, such as Dix’s, was unusual for a woman. Ibid., 116.
76 Channing, in ibid., 96.
77 Disturbing to Dix was the prevailing assumption that “heredity determined one’s proclivity to contract any disease, from tuberculosis to lunacy.” To a friend she confessed being haunted by a “‘hidden disposition’ that threatened ‘to overcome and destroy’ her best qualities.” Thinking of her parents, she lamented that “she could place little hope ‘upon a fabric the basis of which is insecure.’” Ibid., 108.
now the proprietor of the York Retreat.\footnote{See Chapter 2 for a discussion of the work of William Tuke. “Moral treatment,” rather than working to inculcate morality, referred to the humane methods of care provided. It involved the absence of harsh physical restraints and a focus on psychological (frequent recreation, occupational therapies) rather than medical approaches to treatment See my Chapter 2 for discussion of moral treatment and its origins.} Dix visited the Retreat and found a spirit of optimism about the possibility of curing mental illness through kind, gentle, moral treatment. The approach resonated with her experience of receiving compassionate care at the Rathbone estate. Because of her exposure to European social reforms, her study of medicine, and the attentive care she received, Dix left Europe physically and mentally restored, and with a renewed humanitarian drive and sense of purpose in life. Nascent American medical institutions posed a perfect target for her energies.

### 3.5 Insanity and Institutional Care

Many colonial Americans had assumed that the work of an omnipotent God exceeded their understanding and accepted their fates—good and bad. By the nineteenth-century, however, Enlightenment influence brought faith in human reason not only to understand, but also to eliminate problems. That “faith in reason and science and in the ability of humanity to alleviate problems and change its environment slowly began to influence theories of insanity and prevailing practices.” Americans like Dix now assumed that illness, along with poverty, vice, ignorance, and insanity, were all problems that “purposeful human intervention” could remedy.\footnote{Grob, 25.} Public institutions seemed the logical place to start.

Hospital construction boomed in the nineteenth century. By the Civil War, 178 hospitals operated in the U.S., one third of those mental asylums.\footnote{Ibid., 18.} Most often, the new institutions treated socially marginal individuals, including the insane, who no longer...
received care at home. General hospitals provided confinement more than diagnosis or treatment as they replaced care once administered in the infirmaries of almshouses. Through the 1850s, those enterprises were “something Americans of the better sort did for their less fortunate countrymen; it was hardly a refuge [the well off] contemplated entering themselves.” Despite the good intentions of benefactors, by 1860 large city hospitals were overcrowded and often grossly unclean. Standards of care improved only in the post-bellum era as hospitals emerged as “centers for specialized varieties of disease and treatments” and the location for medical research and the training of medical students.

3.5.1 Religiously Motivated Asylums

The first institutions devoted to the care of the insane in America were private facilities with ties to Christian groups. The earliest, the Friends Asylum, opened in Frankford, Pennsylvania in 1817. Facilities like the Friends Asylum admitted just a handful of patients in their early years, and eventually restricted their services to the wealthy, who could afford to pay for treatment. Until 1834, the Friends Asylum admitted only Quakers, and even many poorer Friends found themselves beyond assistance.

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82 Charles E. Rosenberg, cited in Grob, 18.
83 Medical America in the Nineteenth Century: Readings from the Literature, ed. Gert H. Brieger (Baltimore: Johns Hopkins Press, 1972), 234.
84 Ibid., 233.
85 Quaker commitment to pacifism, “faith in the perfectibility” of humanity, and an understanding that all possessed an “inner light” and were thus “partly divine and worthy of humane treatment” shaped the Friends’ optimistic and gentle care of the insane. While Quakers at the Friends Asylum emphasized moral treatment, records show that they also deployed physical treatments (restraints, bleeding, purging) when thought necessary. Dain, 30-31. Two other early institutions with church ties appeared. The McLean Asylum for the Insane (chartered in 1821, opened in 1818, renamed in 1826) stemmed from religious philanthropic rivalries in Boston. The Hartford Retreat (Connecticut, 1824) grew out of the revivals of the Second Great Awakening in that state. See Grob, 31-35.
Superintendents at early asylums believed that treatment was most effective when their charges were cared for surrounded by those from their own social class, further exacerbating the “growing exclusiveness” of care provided. Initially, other mental hospitals served slightly more heterogeneous populations, but rising costs meant that the ability (or inability) of patients to pay for their care shaped admissions at each of the private facilities.

After 1824, the asylum landscape shifted. The narrowness of the admissions process at the first hospitals, limits to the availability of private philanthropy, and the high costs of protracted care for the incurably insane meant that early institutions failed to satisfy demands for treatment. At the same time, many physicians proved ready to adopt new practices. The approaches of William Tuke and Philippe Pinel assumed wider influence among doctors and the social elite after their writings became widely available in America, Pinel’s translation in 1806 and Tuke’s *Description of the Retreat* in 1813. American physicians were optimistic that offering moral treatment on a wider scale would demonstrate the curability of mental maladies. Between 1825 and 1850 state administered care for the insane emerged as the standard nationwide and the moral treatment advocated by Rush, Tuke, and Pinel moved beyond church-sponsored intuitions. Optimism about the ability not only to care for—but also to cure—mental maladies marked this twenty-five year period.

While private hospitals failed to meet demand, according to the historian Gerald Grob, three additional forces enabled the appearance of the first public asylums for the insane. The first included the active social force of Protestantism stemming from the

87 Both Grob and Dain mark this transition year. See Dain, 5 and Grob, 39.
88 See Chapter 2 for a fuller discussion of the work of Tuke and Pinel.
optimism of the Second Great Awakening. Christians put their faith to work in the world around them. Second, and particularly in New England, a wealthy elite class found itself in competition with the newly rich, and responded with philanthropic giving that combined with an availability of public funds. Third, a “growing consensus” emerged that government had an obligation for the welfare of its citizens, an attitude that led to legislative approval of new institutions.\textsuperscript{89}

Though nascent, church-run institutions failed to meet demand, accounts of burdensome community-based treatment also contributed to a desire for alternatives. An 1821 report by a committee investigating the insane in Connecticut lamented horrible treatment of mad individuals and the burden they placed on families. Of the relatives, the report noted that:

\begin{quote}
their peace is interrupted, their cares are multiplied, their time is engrossed, and their fortunes reduced or entirely dissipated in attempting to restore to reason one unfortunate member….The misery which they suffer is communicated to a large circle of friends and the whole neighborhood is indirectly distributed by the malady of one.\textsuperscript{90}
\end{quote}

The report displayed the prevailing logic behind the change in focus from local, family systems able and willing to attend to sufferers to a concern with the well-being of those providing care.\textsuperscript{91} In a time of optimistic institution building, Americans shifted their confidence to facilities—whether hospitals, schools, or prisons—that professed the ability

\textsuperscript{89} Grob, 29-31.
\textsuperscript{90} Cited in ibid., 33-34.
\textsuperscript{91} Ibid., 31. The movement of care out of homes and communities implied that more traditional modes of dealing with mental maladies began to fail in early eighteenth society. It also signaled growing trust in medical treatments.
to improve life for all and to fulfill public responsibility to care for society’s dependent.\textsuperscript{92} Together, those realities ushered in an era of public asylum building.

\textbf{3.5.2 The Founding of Public Institutions for the Insane}

While Dix would play the lead role, other church leaders proved influential in the founding of public institutions. Surveying the state of care of sufferers in the first years of the nineteenth century, the Congregational minister Jedidiah Morse voiced indignation that insane persons were “committed to close confinement, under circumstance of great wretchedness.” He worried others were “left, forlorn and friendless, to roam through the country exposed to the insults of the thoughtless and wicked; to hunger, cold, and various calamitous and fatal accidents, a terror to female delicacy, and a grief and a continual cause of anxiety to their relations.”\textsuperscript{93} In response, Morse called for the creation of a “hospital for lunaticks.” Shortly thereafter, the Massachusetts General Court began fundraising for the hospital. The largest donations came from Congregationalists. Ministers used denominational rivalries to their benefit in their fundraising appeals. “When calling attention to the charitable activities of other Christian denominations,” their leaders asked, “‘Shall the Congregational scion alone be barren of the sweetest fruits which the tree of Christianity had produced?’”\textsuperscript{94} Notwithstanding denominational competitiveness, Morse’s account demonstrated some remaining clerical authority, not in prescribing cures, but in calling for the formation of institutions to provide assistance.

\textsuperscript{92} Grob declared that the shift from private to public institutions was driven jointly by optimism and fear: optimism about the ability of institutions to solve problems, and fear about the burden and threat that pauperism and sickness posed to the productivity of society. See ibid., 40.
\textsuperscript{93} Ibid., 32. Clergy also campaigned to raise funds for the construction of the Hartford Retreat and the McLean Asylum.
\textsuperscript{94} Ibid.
Helping ensure institutional treatment proved a logical task for Christians.\textsuperscript{95} The Rev. Thomas Robbins of East Windsor, Connecticut, spoke at the dedication of the Hartford Retreat and equated its work to Christ’s healing of those possessed with devils. As he did so, he displayed an Enlightenment-driven doubt in the miraculous. Robbins observed that while “the insane found a safe retreat in Christ,” having demons exorcised, he felt that “this power to cure insanity through miraculous means ‘[was] now withdrawn,’ and the insane could only be restored by natural means.”\textsuperscript{96} While ministers continued to offer private spiritual remedies, in public they asserted the need for the secular treatment, or at least the containment, that institutionalization provided.

Lay Christians also staked a claim in the provision of institutional care. Dix’s efforts to expand asylums to reach those of all classes followed earlier reformers including Horace Mann (1796-1859.) Mann, a member of the Massachusetts house and senate, was an educational reformer who, after chairing a committee that counted the insane in Massachusetts, urged the legislature to open a hospital. Mann, a Unitarian, grounded his efforts in his Christian faith, believing that “to be a social activist was to fulfill a religious mission.”\textsuperscript{97} Encouraging his fellow legislators to act quickly in the face of suffering citizens, Mann offered a plea:

While we delay, they suffer—another year not only gives an accession to their numbers, but removes, perhaps to a returnless distance, the chance of their recovery. Whatever they endure, which we can prevent, is virtually inflicted by our own hands…It is now…in the power of the members of this House to exercise

\textsuperscript{95} Evidence demonstrated that both laity and clergy also hoped to heal mental maladies in order to “save their souls, for persons bereft of their reason could not receive Christian dispensation.” See Dain, 37, 51.

\textsuperscript{96} Ibid., 36.

\textsuperscript{97} Grob, 44.
their highest privileges as men; their most enviable functions as legislators, to become protectors to the wretched, and benefactors to the miserable.\(^{98}\)

In 1833, Mann’s efforts resulted in the creation of a new hospital in Worcester, MA. Worcester State Lunatic hospital “shone as a model of Christian charity and civic responsibility for the helpless.”\(^{99}\) Larger than prior private institutions, the hospital became a blueprint for facilities built in other states, in part because it reported recovery rates of more than eighty percent.\(^{100}\)

### 3.6 Dix Goes Public

Dix returned from Europe in the fall of 1837, early in the initial public asylum building boom. By this time, inheritance from her grandmother’s estate and royalties from her books offered Dix a measure of independence. After a period of domestic travel, Dix returned to Boston and began teaching religious class in a Massachusetts jail. There she found insane inmates confined with criminals.

Her experiences in Europe prompted Dix to learn more about the treatment of prisoners and the insane in other area institutions. Her past scientific study helped to catalogue her findings. After visits—and correspondence with local jailers, physicians, and officials—she spent a year travelling throughout Massachusetts chronicling the condition of insane citizens.

Dix found mentally ill men and women starving, chained (by waist, neck, leg), filthy, lacking fresh air, naked, exposed to the elements, without sunlight, and wondering what they had done to be deserted by God. Often having to demand that jailers and

\(^{98}\) Mann in ibid.
\(^{99}\) Gollaher, 4.
\(^{100}\) Grob, 45. Later study revealed the inaccuracy or reported high cure rates. See my Chapter 4.
almshouse keepers let her inspect their facilities, her persistence generated volumes of observations like these:

_林肯。一个被关在笼子里的女人。梅德福。一个白痴被锁着，而且有一个在狭小的隔间里七年。皮珀尔。一个经常被双重锁住，手和脚；另一个暴力；几个和平的现在。布鲁克菲尔德。一个被关在笼子里，舒服。格兰维尔。一个经常被紧紧关着；现在正在失去他的四肢的使用。圣查理蒙特。一个被关在笼子里。……伦诺克斯。两个在监狱里，反对这些不适合的条件，囚犯长官抗议。_ 

 Dix recorded similar conditions each night of her journey. In addition to outrage over treatment in inadequate institutions, she worried about insane men and women she saw “wandering reckless and unprotected” throughout the countryside. She spoke compassionately about the tenacity of sufferers, amazed at their ability to survive amidst horrible conditions. Unlike past observers that described the mad as beast-like, Dix drew “pictures of real individual men and women” and asked her hearers to “sympathize with them and to acknowledge their dignity.” In doing so, she “transported the insane out of the realm of impersonal phenomena.”

 Dix admitted that visits left her “sick, horror-struck, and almost incapable of retreating,” but it was the conditions the ill suffered through that she found despicable, not the mad themselves. Though ill, Dix viewed them as fellow, beloved, creatures of God.

 Dix’s advocacy had begun. In January 1843, with her observations in hand, and encouraged by the Boston reformer Samuel Gridly Howe, she petitioned the Massachusetts legislature to expand Worcester Hospital. The presentation, her thirty-page _Memorial to the Massachusetts Legislature_, formally launched her career as a

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101 Dorothea Lynde Dix, "Memorial to the Legislature of Massachusetts 1843," _Old South Leaflets_ (Boston: Directors of the Old South Work, 1902), 492 (4).
102 Gollaher, 152.
103 Dix, 510 (22).
public reformer. “I have come to present the strong claims of suffering humanity,” she announced, “I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast.” She did not speak on her own behalf, but “as the advocate of helpless, forgotten, insane, and idiotic men and women; of beings sunk to a condition from which the most unconcerned would start with real horror; of beings wretched in our prisons, and more wretched in our almshouses.”

Dix presented her Memorial “as an amalgamation of humanitarianism, colored with religious imagery, and stark facts.” Part sermon, part graphic account, she won the rapt attention of her audience: “I proceed, gentlemen, briefly to call your attention to the present state of insane persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience.” Dix’s controlled yet assertive demeanor, paired with the content of her proclamation and the fact that she was a woman communicating directly to legislators, made her part prophet, part moral authority, part civic expert. She insisted that the state’s obligation to provide asylum care was moral, humanitarian, medical, and legal.

Although clear about the injustices she found, Dix exempted wardens, keepers, and officers of institutions from responsibility. The conditions she encountered were not their fault, at least not directly: “most of these have erred not through hardness of heart and wilful cruelty so much as want of skill and knowledge, and want of consideration.” Prisons and almshouses, Dix argued, were simply not designed to care for the mentally

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104 Ibid., 490 (2). Dix later spoke directly to state legislatures. Her “Massachusetts Memorial” was presented by Samuel Gridley Howe on January 19, 1843.
105 Gollaher, 143. 2 Corinthians 11:25 states “Three times I was beaten with rods. Once I received a stoning. Three times I was shipwrecked; for a night and a day I was adrift at sea.” (NRSV)
106 Dix, 490 (2).
107 Grob, 47.
108 Dix, 490 (2).
ill. Instead of institutional leaders, Dix implicated the Commonwealth as a whole for the abuses. Dix accused her fellow citizens of “callous indifference to suffering and…lofty pretensions of Christian virtue that struck her as hypocritical so long as they tolerated such flagrant brutality in their midst.” 109 Her findings demanded a response.

Dix suggested proper reactions. First, individuals should respond with thankfulness for their health, but also with empathy. “She implored her readers to place themselves ‘in that dreary cage,’ deserted by kindred, and imagine how they would want to be treated.” 110 Above all, they should devote themselves to ameliorating the conditions of sufferers. 111 While neglect and abuse might persist, she asserted that if the government and all individuals did “what they could”—what she herself was willing to do—then treatment could surely improve.

3.7 Institutional Expansion

Dix’s pleas occurred as institutional expansion had just begun. By 1841, sixteen public and private mental hospitals incorporating Tuke and Pinel’s principles of moral treatment operated in the U.S. 112 State institutions in Pennsylvania, New York, and

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109 Gollaher, 3. That approach also allowed Dix to keep asylum physicians as allies. She needed their permission and assistance in bringing change.
110 Ibid., 153
111 Dix asked, “Could we in fancy place ourselves in the situation of some of these poor wretches, bereft of reason, deserted of friends, hopeless, troubles without, and more dreary troubles within, overwhelming the wreck of the mind as ‘a wide breaking in of the waters,’ -- how should we, as the terrible illusion was cast off, not only offer thethank-offering of prayer, that so mighty a destruction had not overwhelmed our mental nature, but as an offering more acceptable devote ourselves to alleviate that state from which we are so mercifully spared?” Dix, 511 (23)
112 The most influential included: Friends Asylum at Frankfort, PA (1817); Massachusetts General Hospital’s McLean Asylum, Somerville, MA (1818); New York Hospital’s Bloomingdale Asylum, New York City (1821); Hartford Retreat, Hartford, CT (1824); Worcester State Hospital, Worcester, MA (1833); Maine Insane Asylum, Augusta, ME (1840). Tomes, 74.

The terms psychologist and psychiatrist did not come into general use until the twentieth century. Dain, 55. Early nineteenth-century physicians with an interest in the mentally ill often called themselves alienists. I use the terms asylum physician and alienist interchangeably. Grob, 36.
Rhode Island opened in the following years.\textsuperscript{113} Most of the first superintendents of those institutions, some formally trained, some apprenticed into medicine, were Protestants reared in small towns and rural areas. Like Dix, the men believed they had a mission to “assist less fortunate individuals.” They formed a tight knit group, regarding themselves as “brethren” with much to learn from one other.\textsuperscript{114} In 1844, their association, and the practice of asylum medicine, took formal shape with the creation of the Association of Medical Superintendents of American Institutions for the Insane.\textsuperscript{115} The cadre of alienists met annually to discuss insanity and institutional treatment.\textsuperscript{116}

Dix helped prompt the creation of institutions, but from 1840 to 1880, that group of men directly shaped the care of the insane in America. It took decades, however, for care for mental diseases to standardize. While Benjamin Rush’s treatise on mental ailments proved outdated by the 1840s, no new American general psychiatric text appeared until 1883. Until then, each superintendent maintained comprehensive control of his establishment and dictated courses of treatment.\textsuperscript{117}

3.7.1 Alienists: A Specialty Evolves

Before 1865, while asylum physicians hoped to present a common front, they also disagreed. (Dix steered clear of these debates, but they occupied the alienists she

\textsuperscript{113} Pennsylvania Hospital for the Insane (1841); New York State Lunatic Asylum, Utica, New York (1843); Butler Hospital for the Insane, Providence, Rhode Island (1845). Tomes, 74.

\textsuperscript{114} Grob, 56. Samuel B. Woodward, a liberal Congregationalist, the first superintendent at the asylum in Worcester, MA, “rejected the mere pursuit of worldly goods and insisted that human beings had a duty ‘to contribute to the happiness and welfare of all the creation of God…and to exhibit in our lives and conversation the influence of the principles of Christianity, and the love of God in our hearts the governing motive of our conduct.’” ibid., 57.

\textsuperscript{115} This predates the formation of the American Medical Association by three years. In the same year, publication of the\textit{ American Journal of Insanity} (later the\textit{ American Journal of Psychiatry}) began.

\textsuperscript{116} This section draws from Tomes, 74-75.

\textsuperscript{117} In this period, asylum superintendents were the nation’s experts on mental illness. “No systematic, consistent instruction in psychiatry was available [at medical schools] from [Benjamin] Rush’s death in 1813 until 1867, and psychiatry probably received little attention in regular medical lectures.” That segmentation left doctors specializing in the care of mental diseases isolated from the rest of the medical community. Dain, 149-150.
befriended.) Doctors debated whether mental disease stemmed from somatic or psychological origins. Each advocated a different mix of medical and psychological treatments. They moved—but at varied speeds—from an understanding that mental disease stemmed from inflammation of the blood vessels (as Benjamin Rush had asserted) to the conviction that irritation of the nervous system was at fault.

Alienists also differed in their understandings of how the mind and brain related. Most maintained an immaterialist conception of the mind and a view of the unity of the human soul consistent with their Christian faith, but scientific advances prompted reconsideration. Phrenologists, for example, who designated areas of the brain as responsible for different behavioral, cognitive, or emotional traits, presumed that insanity resulted from any imbalance in those faculties. Met with charges of being “atheistic materialists” that perceived minds as possible of being diseased, they “maintained that the mind and brain were intimately connected but separate; the nature of their relationship was a mystery.” Opponents worried that their theories risked overturning the eternality (and imperviousness to disease) of the mind and soul. Pliny Earl, a Quaker, and prominent asylum superintendent, for example, held tightly to traditional beliefs. “Were the arguments for the hypothesis that in insanity the mind itself is diseased tenfold more numerous than they are, and more weighty,” he reflected, “I could not accept them.” “My ideas of the human mind are such that I cannot hold for a moment that it can be diseased,” he argued, because disease implied death, “but Mind is eternal. In its very essence and structure…it was created for immortality.” Earle and others held that the mind proved “superior to the bodily structure, and beyond the scope of the wear and tear

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118 Dain, 57-66.
119 Dain, 57, 61.
and disorganization and final destruction of the mortal part of our being,” even if they failed to understand how.\textsuperscript{120} Those alienists simply accepted that “psychological factors could irritate the brain and cause physical disorder,” producing “emotional derangement” that characterized insanity.\textsuperscript{121} Mind and brain, however, remained separate entities.

Despite a commitment to somaticism, physicians could only observe psychological symptoms and often relied on psychological explanations. Yet, alienists increasingly leaned toward somatic conceptions of mental disease, and for more reasons than adherence with their religious beliefs. As the rest of medicine moved toward somatic causes, alienists hoped they too could identify a “relationship between bodily lesions and symptoms.” Somatic conceptions of illness also helped practitioners fend off demonological and superstitious definitions of insanity, views that created cases they were not qualified (or needed) to treat.\textsuperscript{122}

When attending to mental maladies, the practices and treatments of general practitioners lagged behind their asylum counterparts. Before considering institutionalization for their patients, “local doctors…attempted to treat mental illness by traditional methods…Long after most hospitals had discarded venesection, superintendants complained about new patients who were exhausted from excessive bleeding by their local physicians.”\textsuperscript{123} Asylum-based physicians tried to educate general practitioners about the benefits of hospital care, but readership of the journal articles they authored proved limited.

\textsuperscript{120} Pliny Earle in ibid., 64-65.  
\textsuperscript{121} Ibid., 64.  
\textsuperscript{122} Ibid., 66.  
\textsuperscript{123} Ibid., 152. 
Despite disagreements and still-elusive etiology, alienists held wide agreement on a number of topics. First, the classification of disorders remained simple and relatively unchanged from the prior century: mania, monomania, melancholia, dementia, and idiocy formed the common diagnostic categories. Second, asylum doctors agreed about causes of mental maladies. They assumed physical causes—perhaps lesions on the brain—existed, but focused on easier-to-identify and treat behavioral and moral causes, including: “intemperance, masturbation, overwork, domestic difficulties, excessive ambitions, faulty education, personal disappointment, marital problems, excessive religious enthusiasm, jealousy, and pride.” Such “deviations from acceptable lifestyles” remained suspect. Third, with causes still difficult to pinpoint, doctors increasingly suspected heredity as a factor in the predisposition to succumb to mental ailments. Even when a direct hereditary link seemed absent, some assumed illness resulted from “some bad and often sinful ancestral trait.” Finally, modern civilization itself was blamed as a cause. The psychiatrist Edward Jarvis, for example, concluded that insanity was part of the price we pay for civilization...The increase of knowledge, the improvements in the arts, the multiplication of the comforts, the amelioration of manners, the growth of refinement, and the elevation of morals of themselves do not disturb men’s cerebral organs and create mental disorders. But with them some more opportunities and rewards for great and excessive mental action, more uncertain and hazardous employments, and consequently more disappointments, more means and provocations for sensual indulgence, more dangers of accidents and injuries, more groundless hopes, and more painful struggle to obtain that which is beyond reach, or to effect that which is impossible.

124 Grob, 59-60.
125 Dain, 111. Eventually, heredity and incurability were linked in nineteenth-century psychiatric thought. See ibid., 12.
126 Jarvis in Grob, 62.
The presumed impacts civilization had on causing illness varied. Less civilized people of the world were thought to suffer less frequently. Physicians included slaves in the southern U.S. in that group, but considered freed slaves in the north ten times more prone to mental distress. Poor and uneducated Americans, including Irish immigrants, doctors thought, were less able to control their minds, and thus more susceptible. The greatest incidence of mental maladies, however, was presumed to exist in the northeast (where, not coincidentally, statistics on illness were gathered more assiduously.)

Despite many unknowns, through 1850, those treating mental maladies remained optimistic that cures existed and that institutions were the best places for the administration of care. While some educational and eugenic measures could be enforced in the community, asylums provided a more controlled environment. Given the focus on moral causes, attention prevention involving a “synthesis of medicine, religion, morality, and social activism” became popular.

As the profession solidified and treatments standardized, alienists and asylums “reinforced and conferred legitimacy upon the other.” Asylum medicine offered a secure profession in the first half of the nineteenth century—not only could physicians help shape an emerging field, “compensation and benefits were both secure and above average.” In a time when the “supply of orthodox physicians far exceeded demand,” asylum specialists enjoyed a secure client base and strong control over their patients, staffs, and practices. Dix counted many of the nation’s leading alienists as her friends and coworkers in the campaign to improve care. She relied on them for medical expertise

127 See Dain, 90-104 for a discussion of causes of, and assumptions about, disease prevalence.
128 Grob, 55.
129 Ibid., 56, 57. Living expenses for physicians and their families were often covered by asylums. Paid by the state, alienists did not need to worry about collecting fees from patients.
and access to asylums. They valued the visibility and funding she secured to grow their institutions.

3.8 Shifting Public Perceptions

Despite Dix’s advocacy and medical advances, perceptions of mental maladies changed slowly. Nineteenth-century medical professionals awakened “to the needs of the insane and the possibility of their cure,” but “only the most educated and religiously liberal persons of the urban classes followed the progress of physicians” and understood mental illness as primarily a medical problem.\(^{130}\) A few elite members of society, Dix among them, helped increase access to asylum care, even while some citizens objected to receiving help.

Three elements—the Bible, popular medical works, and newspaper reports—influenced common perception of mental maladies, and the prevailing morality shaped each of those factors. The public proved more likely than physicians or the elite to deploy the supernatural in their understandings. Drawing on the Bible, the most widely available book in the early nineteenth-century, many Americans continued to assume that “demonological possession” caused insanity and that it was best treated by “exorcism and often more drastic means.” Relatives of the insane hesitated to discuss madness, “reluctant to talk or write freely about it; to them insanity was the mark of the devil or a deplorable strain in their heredity.”\(^{131}\) As a result, some shunned intuitional and medical treatment, fearing exposure or opting for other solutions. The trustees of the Worcester asylum, for example, reported that a woman with a deranged son refused treatment for him because “an evil spirit…troubled him, and until the Lord was pleased to take it off,

\(^{130}\) Dain, 28.
\(^{131}\) Ibid., 37.
she was quite sure, that nothing any man could do would be useful to him."132 Like Americans from prior centuries, many assumed that only spiritual cures and the will of God could remedy spiritual problems.

One of the most popular medical handbooks of the eighteenth and nineteenth centuries, *Domestic Medicine*, by the Scotsman William Buchan also shaped early public opinion and resistance to institutional care.133 Buchan acknowledged melancholy and mania as real ailments, but based on observations of the first U.S. and European asylums he believed that those “institutions, as they [were] generally managed, [were] far more likely to make a wise man mad than to restore a madman to his senses.” Instead of institutionalization, Buchan recommended soothing and diverting the attention of sufferers with amusements and good company, plenty of exercise, and a diet of vegetables.134 Similarly, the Rev. John Wesley’s widely read *Primitive Physic* (1773), commended exercise, temperance and proper eating habits.135 For more severe illnesses, Wesley recommended “placing a violently mad patient directly under a powerful

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132 Ibid., 43.
133 Buchan (1729-1805) first published *Domestic Medicine* in 1769. It became the “foremost ‘home’ medical book” in both England and New England. Its influence persisted for several generations, with American printings in Philadelphia (1774), Hartford and Boston (pre 1800), Charleston (1807), Exeter, NH (1828), and elsewhere averaging one edition per year for one hundred years. Adam G. N. Moore, “Dr. Buchan and American Family Medicine,” Boston Medical Library https://www.countway.harvard.edu/bml/william_buchan.htm (accessed May 17, 2011) “According to Buchan, melancholy and mania were caused by: hereditary predisposition; intense thinking, especially about one subject; violent passions or affections such as love, fear, joy, and ‘over-weening pride’; excessive venery; ‘narcotic or stupifactive poisons’; a sedentary life; solitude; suppression of evacuation; and acute fevers or other diseases.” Dain, 38.
134 Ibid., 39.
waterfall for as long as he could bear it.”  

Perceptions of the causes of illness shaped popular approaches to treatments as much as did suspicions about intuitional care.

When citizens did seek treatment, they preferred gentle approaches, but an exception to that desire appeared with insane individuals that committed violent crimes. Newspaper accounts portrayed such individuals as less than human. Physicians like Rush had hoped to subdue even violent patients, but “reporters and witnesses in criminal trials frequently expressed the opinion that the insane were beasts who deserved their fate and warranted no sympathy” because they were morally responsible for their crimes. The “loss of reason was seen as the loss of the soul and of humanity and God’s grace.”  

If God had withdrawn support from such humans, were not other citizens justified in doing the same?

3.9 Dix’s Perceptions  
Dix proved more interested in cures for insanity than causes. “I have been asked if I have investigated the causes of insanity,” she wrote, “I have not.”  

When she did mention the source of mental distress, her views matched what she gleaned from asylum physicians, and she happily deferred to their medical expertise. While touring, she rarely recorded speculations about causes, but she did record the case of a woman who had once been “a respectable person, industrious and worthy.” The woman from Danvers, Massachusetts fell ill after “disappointments and trials shook her mind.”  

Undue stress

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136 Dain, 40.  
137 Ibid., 44-45. News reports from trials revealed characteristics of those considered insane: irrationality, inability to distinguish right from wrong, lack of a sense of guilt for crime, violent temperament. “The courts assumed that the moral faculty was almost always intact; unless totally insane, a person knew right from wrong…Physicians like Rush, who acknowledged the possibility that the moral faculty could be deranged while the reason remained unaffected, appeared to leave the courts without any moral basis for punishing crime.” Ibid., 49.  
138 Dix, 505 (17). The provision of humane, moral treatment did not require knowledge of causes.  
139 Ibid., 493 (5).
might trigger illness, and all proved susceptible. Mental maladies, she argued, could befall the poor, and the “most prosperous and affluent” including physicians and public officials.

Dix admitted that sin might play a role in insanity. But, even if sin caused illness, she pled for humane treatment:

I have been told that this most calamitous overthrow of reason often is the result of a life of sin; it is sometimes, but rarely, added, they must take the consequences, they deserve no better care. Shall man be more just than God, he who causes his sun and refreshing rains and life-giving influence to fall alike on the good and the evil?

Is not the total wreck of reason, a state of distraction, and the loss of all that makes life cherished a retribution sufficiently heavy, without adding to consequences so appalling every indignity that can bring still lower the wretched sufferer?

Have pity upon those who, while they were supposed to lie hid in secret sins, ‘have been scattered under a dark veil of forgetfulness, over whom is spread a heavy night, and who unto themselves are more grievous than the darkness.’

Illness itself, she realized, provided just punishment in many cases. Sinners and saints alike garnered God’s love and deserved care from their fellow citizens.

Salvation came from God, but Dix wrote that she found “no redemption but in action” – for herself or others. The role of religion showed not only in her motivations, but also in her assumption that it should influence the responses of others. In pleading with the men of the Massachusetts legislature, Dix called on their Christian charity and religious responsibility: “Raise up the fallen, succor the desolate, restore the outcast, defend the helpless, and for your eternal and great reward receive the benediction, ‘Well

140 Ibid., 505 (17).
141 Brown, 143.
done, good and faithful servants, become rulers over many things!"\textsuperscript{142} She also invoked God and God’s mission in her closing words: “Gentlemen, I commit to you this sacred cause. Your action upon this subject will affect the present and future condition of hundreds and of thousands. In this legislation, as in all things, may you exercise that ‘wisdom which is the breath of the power of God.’\textsuperscript{143} Care for the suffering formed a mission for Dix, one she believed all Christians should embrace.\textsuperscript{144}

Dix’s advocacy spread public awareness of mental illness. It touted the benefits of humane treatment more broadly among the lower classes and engaged the sympathies of the elite to fund better treatment. Her work played a large role in shaping public perceptions and bringing change in the years after 1843. Eventually, the public desire for humane treatment, emerging awareness of gentle institutional care, and outrage over the reality of treatment of the pauper insane converged to accelerate the growth of asylum care.

\textbf{3.10 Reports of Success}

When new asylums opened, admissions and resident populations rose steadily. Existing facilities expanded. The Worcester hospital, for example, grew from 120 beds in 1833 to over 360 by 1846. In the United States, “eight asylums admitted an average of 180 patients” in 1840, “a decade later twenty-two institutions admitted nearly 329 persons.”\textsuperscript{145} What contributed to such rapid growth? First, as early public resistance

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\textsuperscript{142} Dix, 513 (25). This citation refers to the parable of the talents in Matthew 25:23 “His master said to him, ‘Well done, good and trustworthy slave; you have been trustworthy in a few things, I will put you in charge of many things; enter into the joy of your master.’” (NRSV)

\textsuperscript{143} Ibid., 519 (13).

\textsuperscript{144} Her writing also hinted that she thought religion could bring healing by imparting morality. She “firmly maintained her Unitarian conviction that ‘sober thought, steady self-discipline, and close meditation, are [the] agents of conversion and parents of godliness.” Brown, 253.

\textsuperscript{145} Grob, 48.
\end{flushright}
waned, the appeal of the asylum changed. The historian Nancy Tomes demonstrated that “rising expectations of domestic life, as well as greater faith in the asylum’s efficacy predisposed nineteenth-century families to commit insane relatives more readily, and for a broader range of reasons, than did their eighteenth-century ancestors.”¹⁴⁶ The availability of asylums also solidified the legitimacy of mental maladies as medical phenomena best dealt with in institutions. That change crossed class lines, and even enticed upper class Americans to turn to mental hospitals for help. “Although they shunned institutional care for any other ailment, affluent families were obviously willing or, perhaps more accurately, driven to seek hospital treatment for insanity.”¹⁴⁷ New hospitals filled quickly with a mix of Americans.

Asylum building continued and hopefulness about society’s newfound ability to heal mental illness persisted. Optimism about treatment effectiveness also helped fuel growth. Even institutions that once specialized in moral treatment began to address issues first with medical treatments before turning to psychological cures. Physicians believed that medical attention prepared patients for moral treatments and together they formed the most potent medicine for madness.¹⁴⁸ As the range of treatments administered widened, reported recovery rates rose. In 1825, the Hartford Retreat, for example, cited a ninety-one percent cure rate of recent cases.¹⁴⁹

¹⁴⁶ Tomes, 13.
¹⁴⁷ Ibid., 73.
¹⁴⁸ Historian Tomes explored this change in the career of Thomas Kirkbride, the inaugural (and long serving) superintendent of the Pennsylvania Hospital for the Insane. Citing reflections from his journal during his year of training at the Friend’s Asylum in Frankford, she documented his sense that “medical and moral means were ‘parts of the same system’ and gave ‘full benefit’ only when practiced together.” See ibid., 66.
Treatment in institutions grew more palatable for a wider range of Americans, but care still failed to reach all in need. The location of new asylums proved inconvenient for many. States built most new hospitals in rural areas, under the assumption that centrally located facilities provided easy access for all of the state’s residents. Urbanites, though, balked at travel to remote hospital locations. City populations remained underserved and municipalities were left to find other solutions, often reverting to almshouses and prisons. Even after the first wave of public institutions launched, many mentally ill Americans continued to receive inadequate care. Dix reacted to those realities.

On January 25, 1843, just five days after the presentation of her *Memorial*, the Massachusetts legislature approved a $25,000 appropriation from state funds and $40,000 from an endowment to enlarge the asylum in Worcester. Whether swayed by Dix’s testimony or simply by the numbers—the 1840 census had identified 978 lunatics in the state, 229 housed at Worcester, 124 at the Boston Lunatic Hospital, so 625 lived without asylum treatment—Dix viewed the legislature’s approval as “a brilliant victory” proving that she was indeed “doing God’s work.”\(^{150}\) Elated by her success with the legislature, Samuel Howe asserted that he could not “but be impressed with the lesson of courage and hope” that Dix had “taught even to the strongest men.” Horace Mann offered his thanks for her accomplishing “the Christian labor of doing good to those who cannot require you.”\(^{151}\) Affirmation from men, men she respected, emboldened her work. Dix relished success and the recognition of her efforts.

To be sure, some resisted Dix’s work. A few legislators and local administrators questioned the accuracy of her observations. Some towns published rebuttals to her

\(^{150}\) Gollaher, 155, 154.

\(^{151}\) Howe and Mann, in ibid., 156.
findings, defending the care they provided. Dix, however, remained steadfast about the truthfulness of her reports. Her social status and prominent acquaintances helped her deflect criticism. Those that tried to discredit Dix learned that “anyone who thought she could be brushed off as some meddlesome spinster vastly underestimated Dorothea Dix.”¹⁵² That proved true, in part, because she offered, not a general, abstracted account, but one that profiled individual lives and particular horrors.

Taking her success in Massachusetts as a sign from God that she “was now an instrument of divine mercy,” Dix moved on to make similar assessments and pleas in other states over the next decade.¹⁵³ In each location, she followed the same pattern—compiling research, presenting to legislatures, and often writing newspaper articles to garner public support. Her campaigns in other states were met with enthusiasm. After appealing for a new asylum in Tennessee, for example, the legislature printed 4,000 copies of the memorial she presented. Local papers urged fellow Tennesseans to enact the suggestions of this “most distinguished philanthropist.”¹⁵⁴

Continued success meant that Dix shaped public policy throughout the country. Young physicians exploring the possibility of working in asylums consulted her. Hospital boards included Dix in hiring decisions when hospital superintendent positions became vacant. Members of the Association of Medical Superintendents counted on her “great influence” to strengthen solidarity among their geographically disperse group. Persistence and experience, coupled with her personal connections, meant that legislatures took her seriously.¹⁵⁵ Within two years of her Memorial to the Massachusetts

¹⁵² Ibid., 5.
¹⁵³ Ibid., 163.
¹⁵⁴ Brown, 146.
¹⁵⁵ Grob, 47. Brown, 181.
legislature, Dix’s travels took her over ten thousand miles to three hundred county jails, eighteen state prisons, and five hundred poorhouses and other institutions.\textsuperscript{156} Traveling more widely than an itinerant preacher, she estimated that she had covered 32,470 miles by August 1847.\textsuperscript{157}

Throughout her travels, Dix preached the gospel of humane treatment, and she remained convinced that asylum-based care formed the right solution to ameliorate suffering. “The conviction is continually deepened that hospitals are the only places where insane persons can be at once humanely and properly controlled,” she asserted. “Poorhouses converted into madhouses cease to effect the purposes for which they were established,” she lamented, “and instead of being asylums for the aged, the homeless, and the friendless, and places of refuge for orphaned or neglected childhood, are transformed into perpetual bedlams.”\textsuperscript{158} Violent, severe treatments only “exasperate the insane,” but “kindness and firmness” brought recovery.\textsuperscript{159}

3.10.1 Federal Appeals

In May of 1848, Dix began preparations for an assault on Congress to secure a federal endowment for state hospitals.\textsuperscript{160} She faced resistance. Because municipalities sometimes held responsibility for paying for their citizens’ care in state asylums, they often opted for cheaper, local almshouses. In addition, superintendants still preferred private patients whose payments proved more reliable than those from municipalities.

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\textsuperscript{157} Brown, 144.
\textsuperscript{158} Dix, 513 (25).
\textsuperscript{159} Ibid., 498 (10).
\textsuperscript{160} Brown, 148.
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Those realities threatened to overturn the progress Dix had enabled through the creation of state hospitals.

Dix remained undaunted. Echoing those that argued modern civilization caused mental maladies, she claimed, “free civil and religious institutions create constantly various and multiplying sources of mental excitement.” Further, she concluded that insanity was inevitable where “every individual, however, obscure, is free to enter upon the race for the highest honors and most exalted stations.”

Because Dix assumed that the nation’s freedoms could cause insanity, it seemed right to her that the federal government should support her proposal and fund asylum care. Confessing that “through God’s good Providence,” that she and her “cause are now rather popular,” Dix felt sure Congress would act quickly on her Bill for the Benefit of the Indigent Insane. Federal legislators, though, had other priorities including territorial expansion and growing sectional strife over slavery. The bill passed in 1854, only to be vetoed by President Franklin Pierce who argued that states, not the federal government, held responsibility for social welfare.

Despite her failure in the nation’s capitol, Dix turned the country’s attention to the plight of the mentally ill. Grob argued that Dix’s success resulted, in part, because she belonged “to a generation that was naively optimistic about mental disorder and social welfare.” Newly formed and expanding state legislatures had vast amounts of land and good funding available, which allowed them to grant wide approval to public infrastructure projects of all sorts, often without the detailed investigations that preceded...
funding decisions in the next century.\textsuperscript{163} That she was female also played a role in her effectiveness. Her gender let Dix approach men in power without seeming threatening, but because society assumed women “were the repository of morality and virtue,” it also gave her an air of authority.\textsuperscript{164} As society’s moral guardian, Dix proved able to influence state and federal legislatures despite the fact that she could not vote.

Biographer Gollaher argued that her work garnered such swift reaction because of the personal face she painted of madness alongside her clear compassion for those that suffered. “Her willingness to make simple human contact with these outcasts sparked flashes of unanticipated humanity and serenity. She was the first in America to identify with their plight and to invest the insane with the dignity of individual identity.”\textsuperscript{165} While Dix might not have been the first, she certainly became the most public. Her aloofness, “intellectual self-assurance and moral certitude” combined with “polished manners,” and “implacable reserve” seemed to “epitomize upper-crust Boston” for many, and affixed her as “a most improbably, and thus supremely compelling, guide to the geography of hell.”\textsuperscript{166} Dix appeared uniquely equipped for her mission.

\textbf{3.11 Social Control and Stigma}

Without question, Dix proved successful in her efforts to sway legislatures and rally public support. Many of the hospitals she helped launch still operated over a century later. One in North Carolina bore her name until it closed after one hundred and fifty years of service. Whether the system of institutional care that she helped propagate benefitted the insane and society, however, was debated in the next century as conditions

\textsuperscript{163} Grob, 50.
\textsuperscript{164} Ibid., 46.
\textsuperscript{165} Gollaher, 6.
\textsuperscript{166} Ibid., 2.
in mental asylums once again came under scrutiny. Bursting at the seams, the poor care, squalid conditions, and persistent incurability in the nation’s mental hospitals were far from Dix’s vision. The optimism that once surrounded care for mental maladies slowly faded—first among physicians, and then in the public. Abhorrent conditions at asylums too large and crowded to offer humane care prompted one vein of criticism.

An additional line of critique surfaced in the twentieth century. Some surmised that in their efforts to make society better, nineteenth century reformers sought homogeneity. Such homogeneity required that citizens deemed abnormal, like the mentally ill, be moved out of sight. Coercive power they argued, not a quest for humane treatment, motivated the growth of asylums and other social institutions. Society appeared more productive and more advanced when its deviant members were locked away. That darker motivation of the quest for institutionalization remained outside the conscious, Christian motivations of Dix and others, but it warrants consideration.

Cotton Mather viewed madness as a part of every human. With the rise of asylums, social theorist Michel Foucault argued that “madness had become a thing to look at: no longer a monster inside oneself, but an animal with strange mechanisms, a bestiality from which man had long been suppressed.”

That European and American asylums became places for Sunday excursions to view mentally ill patients offers support of Foucault’s assertion. Rather than sick citizens in the process of being healed, the insane were treated as public spectacles. With madness an external reality—something present not in oneself, but instead in unfortunate others—insanity became easier to fear and more imperative to try to resist. After the Enlightenment, citizens viewed madness

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168 Ibid., 70.
not as an inevitable consequence of human incarnation, but as something dangerous, something needing to be avoided. The insane were deemed worthy of confinement because their illness demonstrated the dreaded power of unreason. With such logic, madness was dehumanizing, not a mark of humanity as Mather assumed. For Foucault, those like Dix, reformers who fought for the construction of asylums, were not “liberating heroes,” but “agents of bourgeois repression and conformity” motivated by “capitalist development.”  

It seems unlikely that Dix would have affirmed, that line of thinking, but it is worth considering how such notions may have shaped her work and the actions of her contemporaries. With the rise of scientific medicine, and the increasing ability to prevent and cure disease, maladies that lingered drew suspicion. Were defects of character to blame for incurable madness? Perhaps. Foucault argued that Pinel and Tuke’s removal of physical restraints was replaced by the constraints of moral culpability. Whether or not Foucault’s assessments held true, by the late nineteenth century, Americans increasingly believed that those that remained ill might be responsible for their illness, or at least for not working adequately for its cure. Suspicions of individual guilt gave rise to deepened social stigma.

Eventually, changing conceptions of mental maladies in the antebellum period surrounded the afflicted with disgrace. The effect was far from intentional, but with heredity deemed as a likely cause, and with notions of irregular behavior as predisposing factors, the chronically ill seemed doomed, unable, or unwilling to control their own fates. In addition, while scientific discoveries ushered in assurances of solving physical

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169 Tomes, 9. Tomes outlined the work of other social control theorists. While each assessment varied slightly, all saw the asylum as “an instrument of class domination.” Ibid., 10.

170 See Foucault, 246-250 for a discussion of individual and corporate responsibility for illness.
illnesses, cures for mental maladies remained undiscovered. That allowed suspicions of demonic possession or sin and moral wrongdoing to persist. Early institutions hoped to restore patients to health and return them to the community, but that became impossible as hospitals grew crowded and dedicated treatment transitioned into custodial care. Once hopeful retreats, asylums turned into institutions that left a taint on those admitted.

Public crusading, even when well intentioned, sometimes failed to bring desired results for Dix and other Christians. Regardless of the conscious and subconscious motivations for the establishment of asylums, their deterioration shaped the experiences of a later Protestant, the Rev. Anton Boisen. By the time the mentally ill Boisen found himself hospitalized, American asylums had veered far from Dix’s vision of gentle, curative, restful institutions.

3.12 Conclusion
As Dix crisscrossed the country, hospitals with friendly superintendants became her favorite resting places. In October of 1881, at age seventy-nine, Dix visited the New Jersey State Lunatic Asylum. While there, she fell ill, complaining of a severe chill and a pain in her lung. For the next six years, she convalesced at the asylum, only sometimes feeling well enough to write and entertain visitors. Dix died at the hospital in July of 1887, and was buried in Mount Auburn cemetery in Boston, just yards from the tomb of William Ellery Channing.171 Throughout her public career, Dix was heralded as a “national symbol of benevolence.”172 After her legislative triumph in Tennessee, for example, she declined the offer by “twenty-five society matrons” to have a sculptor portray her in “a permanent and pleasing form a countenance expressive at once, of

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171 Brown, 344.
172 Ibid., 143.
feminine delicacy, and heroic firmness, sensibility and strength, compassion and courage.\textsuperscript{173}

Dix lived as a Christian motivated by a need to discern her unique way to serve God, by the perfectionism she learned from her Methodist father, and by a desire to tend to the afflicted she gleaned from Unitarian outreach. She invoked public responsibility by relaying graphic details of her visits to public institutions. She appealed not to Protestants directly, but to legislatures, the bodies with the power to do something about the problem as she identified it. She cooperated with politicians and medical professionals, yet bore full responsibility for her own mission. Indirectly though, Dix appealed to all Americans to do their part, to fulfill their Christian duties to care for the least of these. By advocating on behalf of sufferers, Dix exemplified the faith of one who knew she could change the world.

\textsuperscript{173} Ibid., 146.
4. Anton Boisen: Pastor and Patient in the “Little Known Country” of Mental Illness

The physician, as a result of his empirical method and his careful, systematic study of living men and women, has thus in very truth become a physician of souls, while the traditional ‘physician of souls,’ clinging to his traditional methods, has become merely the custodian of the faith.

-- Anton Boisen, 1923

In many of its forms, insanity, as I see it, is a religious rather than a medical problem, and any treatment which fails to recognize that fact can hardly be effective. But as yet the church has given little attention to this problem.

-- Anton Boisen, 1960

4.1 Introduction

In the fall of 1920, the Presbyterian clergyman Anton Theophilus Boisen found himself a patient at the Boston Psychopathic Hospital. Committed after exhibiting strange behavior, he transferred a few months later to Westboro State Hospital, the asylum that was the subject of Dorothea Dix’s plea the Massachusetts legislature a century earlier. Diagnosed with schizophrenia, over the next fifteen years, Boisen experienced five more severe psychotic episodes and hospitalizations.

Boisen (1876-1965) referred to mental illness as a “little-known country,” visited by a minority of Americans and understood by even fewer. His own periods of psychosis provided—both literally and figuratively—a vision for his life’s work. While sick, he conceived that he had “broken an opening in the wall which separated medicine and religion.” In that opening, the clergyman found a “new mission” for his life. In 1921,

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3 Ibid., 91.
just a few months after emerging from his first psychosis, and still hospitalized, he named
his hopes in a letter to a colleague. “My present purpose” he reflected, “is to take as my
problem the one with which I am now confronted, the service of these unfortunates with
whom I am surrounded.” Boisen’s hospitalizations turned his attention to the plight of
those suffering with mental maladies, the complexity of illness, and made clear to him the
church’s responsibility. Later, he served as one of the first full-time chaplains in a mental
hospital, and trained others to do the same. For the minister, illness provided a personal
cause with a distinctly “pastoral dimension.”

Undertaking his mission, Boisen
encountered the theological and medical systems established by Protestant clergy and
physicians of prior centuries. He found neither one adequate to bring healing, but
believed that the combined insight of religion and medicine could enable cures.

In the decades between Dix’s advocacy and Boisen’s hospitalization, much
changed for the nation’s mentally ill. Cures proved as elusive as ever and the quality of
institutional care degenerated. Religious attention to mental maladies waned. New social
theories touted the promise of human progress and decried the dangers of dependency.
Combined, those forces generated powerful social stigma toward the mentally ill that
stymied Christian responses. Boisen’s work offered an influential correction.

Based on his experience, the pastor/patient felt sure that recovery—for himself
and for others—depended on a new understanding of the relationship between mental

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4 Ibid., 113.
5 Vision From a Little Known Country, 2.
6 Boisen’s illness shaped his life’s work, but stigma about mental illness meant that he kept the
depth of his illness quiet until his 1960 autobiography, Out of the Depths. Boisen’s early recounting of his
first committal, for example, indicated that despite the severity of his initial delirium, it disappeared as
quickly as it arrived. “Only a few days later,” he recalled, “I was well again.” Anton T. Boisen, The
Exploration of the Inner World: A Study of Mental Disorder and Religious Experience (Chicago, New
illness and religious experience. He insisted “that many forms of insanity are religious rather than medical problems and that they cannot be successfully treated until they are so recognized.” Proper treatment started with correct diagnosis. As he redefined some illnesses as spiritual problems instead of medical concerns, he challenged prevailing medical theory.

While he brought new insight, Boisen drew on the work of Protestant forbearers that had shaped the country’s approach to mental maladies. In some ways, his thought offered a return to the reasoning found in the work of colonial clergyman Cotton Mather. Both saw a religious dimension in emotional disturbance and found illness purposeful in the spiritual life. Unlike Mather, or the physician Benjamin Rush, however, Boisen claimed no direct authority in medicine. Though he possessed medical knowledge, much more important to him was the authority of experience, a claim made possible by the newly developed disciplines of psychology, the psychology of religion, the emergence of liberal theology, and his own struggles. Dix too had relied on experience to fuel her advocacy, but her authority came as an observer, not as patient or social scientist.

Like Mather, Rush, and the Dix before him, though, Boisen felt a divine call to alleviate the distress of others. Success navigating his illness gave him confidence that he could remedy Protestants’ lapsed attention. “The problem seems to me,” he argued, “one of great importance not only because of the large number who are now suffering from mental ailments but also because of its religious and psychological and philosophical aspects.” “I am very sure that if I can make to any contribution whatsoever

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7 Boisen wrote frequently about “religion” and “religious experience.” While he used generic language, it is clear that Christianity, and specifically Protestantism, was the norm he assumed when talking about religion. Reflecting Boisen’s descriptions, I use the terms interchangeably. While he spent little analytic effort on other religions, nowhere does he seem dismissive of non-Christian traditions. See, for example, a mention of the mystical experiences of Hinduism in Vision From, 73.
[to the problem of mental illness] it will be worth the cost.” Drawing from his experiences, Boisen encouraged a deep investigation of the human condition and a reconfiguration of clergy training. Those changes, he hoped, would help ministers to attend to a wide range of suffering. That focus became Boisen’s mission for the next four decades.

The pious Presbyterian could enter the story of American Protestantism and mental illnesses from several perspectives, and that multiplicity demonstrates his importance to the account. Most significant, Boisen knew firsthand the pain of mental disorder. He also brought professional expertise to bear. As an ordained minister, he served several local parishes. He had studied religion and psychology at Andover Theological Seminary and Harvard University, worked as a chaplain in mental hospitals, and pioneered the creation of clinical training for seminary students. In 1924, Boisen was appointed to the faculty at Chicago Theological Seminary, where he taught for nearly twenty years. He published extensively about mental illness, the psychology of religion, and the intersections of medicine and religion.

Boisen’s story demonstrates three developments in the relationship between Protestantism and mental illness from 1865 to 1930. First, he reflected theologically as one who experienced mental maladies. Mather and Rush had ruminated about mental distress, but not firsthand. To be sure, Dix lived in fear of illness and experienced depression, realities that likely informed her advocacy, but she never publically drew connections between her suffering and the plight of those she sought to help. Boisen’s experience as a patient fueled his work.

8 Boisen, The Exploration, 7.
Second, Boisen called for a restoration of clergy and church authority in attending to mental maladies, authority that ministers had ceded to medical professional in the prior half-century. His efforts brought changes not only in clerical training, but also in psychiatric practice and in medical-ecclesial relationships. The pastor/patient remained sure his insights could improve not just clerical, but also clinical, care. He “concluded that the gap between professionals had widened in the twentieth century. He set in motion a movement of clinical training and case study that would bring together pastors and physicians in a common enterprise that would deal more effectively with those who may be afflicted emotionally as well as physically.”

Boisen felt the church gave far too little attention to mental illness, and knew that properly trained ministers could reclaim their rightful position at the bedsides of those enduring mental distress.

Third, with clerical authority reasserted, the clergyman’s work encouraged Protestant leaders to reconfigure their attention to mental maladies by deploying social scientific methods in combination with religious insights. Dix had done her part as a layperson by ensuring the creation of asylums. Boisen argued that believers must do more. Instead of handing off care to institutions—public or private—Christians, particularly clergy, needed to work directly with those hospitalized, both to attend to their spiritual needs, but also to understand better suffering. Many American church bodies listened to his plea. They updated training requirements for ordination and expanded fields of ministry. While he did not intend to do so, his work shifted the course of theological education and clergy training. Key for Boisen was adding “first-hand study of human experience—what he called a reading of the ‘living human documents’” to

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supplement classroom-based theological education. His work not only established Clinical Pastoral Education (CPE) and mental health chaplaincy, it also paved the way for the new discipline of pastoral theology. Claiming religious authority and medical insight (gained both as a chaplain and as a patient), Boisen’s work helped cultivate a period of cooperation between many Protestants and medicine.

All told, Boisen’s story signals that something had shifted dramatically in the two centuries since Cotton Mather’s reflections on illness. Boisen’s hospital stays followed six decades of sweeping changes in institutional life and in the profession of psychiatry. Perhaps in no other period did care for America’s mentally ill evolve so rapidly. Public views of mental maladies changed too. If religion still played the primary role in defining mental maladies and in directing care, Boisen could have remained silent. Instead, he felt something had gone awry with how America’s Protestants perceived and attended to mental distress. In addition to abdication of care to medical professionals, during this era, the social stigma affixed to mental illness grew more intractable. Boisen longed to remedy those problems, and in the process make his suffering purposeful.

While healing concerned him, Boisen contended that “sanity in itself is not an end in life.” Instead, “the end of life is to solve important problems and to contribute in some way to human welfare.” Awakening to his opportunity to contribute, he shared that “if there is even a chance that” improving human welfare “could best be accomplished by going through Hell for a while, no man worthy of the name would hesitate for an instant.” Sensing a divine call and an urgent need to help, he served gladly.

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10 *Vision From*, 1.
4.2 Well Educated and Wandering

It took decades—and the experience of illness—for Boisen to settle into a career. Born in Bloomington, Indiana, he came from a family dedicated to higher education and experienced in church leadership. His maternal great-grandfather and grandfather had each served as ministers in Reformed Presbyterian churches. His maternal grandfather taught as a professor of mathematics at Indiana University for forty-six years and as the university’s president.\(^{13}\) His father, Hermann Boisen, had earned a doctorate and taught botany and modern languages at Indiana University. His mother, one of the first women enrolled there, taught for a year at the University of Missouri before marrying. Both parents valued education and his father passed on his interest and skill in scientific inquiry. He idealized his father and his influence persisted even though he died of heart failure when Boisen was just seven years old. After his father’s death, Anton, his mother, and siblings lived with his maternal grandparents in their strict Presbyterian household.

As a young adult, Boisen tested several career paths. After graduating from Indiana University, he briefly taught high school. In 1902, despite having started graduate work in modern languages, he decided to become a forester. Memories of his father’s love of the outdoors, a desire for adventure, and a growing sense of restlessness influenced the career shift. In 1908, his vocational plans changed again. While studying at Yale Forestry School, he experienced a call to ministry. He matriculated at Union

Theological Seminary in New York City, where he focused on the psychology of religion.\textsuperscript{14}

Ordained as a Presbyterian in 1912, the trained minister initially failed to secure a church appointment. Without a parish to tend, he combined his interests in science and religion and conducted surveys (of economic, sociological, and religious factors of geographic areas) for the Presbyterian Board of Home Missions. After completing that work, he finally was appointed to a series of rural Congregational churches in Iowa, Kansas, and Maine.\textsuperscript{15} During World War I Boisen served as a chaplain with the Overseas Y.M.C.A. and then returned to conduct religious surveys for the Interchurch World Movement. Like Dorothea Dix, at age forty, his most important work had yet to begin.

Also like Dix, Boisen’s life included personal difficulty, although of different sorts. Beginning in adolescence, Boisen had “felt shame and guilt for his inability to control sexual feelings.”\textsuperscript{16} Similar ideas troubled him throughout his life and triggered his first severe depression at age twenty-two. Unrequited romantic infatuations also plagued Boisen and contributed to his mental distress. For decades, starting in 1902, he maintained a one-sided love affair with Alice Batchelder, who he met when she spoke on behalf of the Y.W.C.A. at Indiana University. Obsessed with the never married-woman, Boisen made career choices to try to prove to her that he would be a worthy husband. He

\textsuperscript{14}“Boisen self-identified as a liberal Protestant and lived out his professional life in the context of a network of Progressive reformers, social science professionals, and liberal Christians. At one point, he declared himself a ‘disciple’ of liberal clergyman Harry Emerson Fosdick. He embraced the fundamental importance of science, believed in the possibility of the transformation of human beings through moral striving, and stressed the importance of making some kind of contribution to the social good.” Susan E. Myers-Shirk, Helping the Good Shepherd: Pastoral Counselors in a Psychotherapeutic Culture, 1925-1975 (Baltimore: Johns Hopkins University Press, 2009), 17.

\textsuperscript{15}Following his scientific and psychological training, Boisen “made sociological surveys of his parishes, and spiritual/psychological inventories of his parishioners,” research that led to a number of published articles. Powell, 8.

\textsuperscript{16}Vision From, 4.
pursued the uninterested, but occasionally friendly, Batchelder until her death thirty-three years later. His perceived failures in that relationship, and a sense that “he was not good enough for her,” led to at least two, possibly three, of his mental breakdowns. In 1930, the death of his mother precipitated another breakdown and hospitalization. Five years later, after hearing the news that Alice Batchelder suffered from terminal cancer, he underwent a third major psychosis.

Yet, the hospital system that Boisen experienced was far different from the idyllic haven imagined by Dix and others in the prior century. By the close of the nineteenth-century, asylum-based care fell short of the ideals of earlier Christian reformers because of overcrowding, underfunding, and the continued elusiveness of cures.

4.3 Understanding Insanity after the Rise of Institutions

Medical, social, moral, and religious understandings of mental illness combined with institutional conditions to shape the care offered to patients like Boisen. They also determined the willingness to access treatments. Laity, clergy, and medical professionals shared some conceptions, but also differed.

4.3.1 Psychiatric Views

In the nineteenth century, medical professionals took the lead in defining illness, drawing on both medical and moral rationale. They viewed mental illness primarily as a “somatic disease that involved lesions of the brain.” Belief in such lesions, though, involved a leap of faith given that no diagnostic tools were available to confirm their

\[\text{17} \] Ibid., 5. Despite the centrality of the one sided love affair to his life, Boisen shielded it from public view and refrained from writing publically about it until his 1960 autobiography, *Out of the Depths.*

\[\text{18} \] In 1813, Benjamin Rush offered a basic categorization of mental maladies. Psychiatrists did not publish an updated classification system until the early twentieth century.
presence, at least in living patients. As a result, physicians suspected inherited and psychological causes in addition to physical ones.

In most cases, they assumed, mental maladies involved “the violation of the natural laws that governed human behavior.” While not all mental illnesses were “self-inflicted,” doctors held that “by ignoring the laws governing human behavior, people” risked succumbing to disease. Given that understanding, and despite belief in somatic origins, psychiatrists focused as much on behavioral prevention and cures as on physical treatments. They found presumed moral causes of insanity—“intemperance, overwork, domestic difficulties, excessive ambition, faulty education, personal disappointments, jealousy, pride, and…the pressures of an urban, industrial, and commercial civilization”—easier to identify and treat than organic ones.19

The focus on behavioral causes, and presumptions about human responsibility, formed part of the deepening stigma associated with mental illness. No longer did Americans view mental maladies as no-fault illnesses caused by the legacy of original sin. Suspicions of personal responsibility intruded into all cases, particularly incurable ones.

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19 Gerald N. Grob, The Inner World of American Psychiatry, 1890-1940: Selected Correspondence (New Brunswick, NJ: Rutgers University Press, 1985), 3. Views about the links between masturbation and insanity offer an example of the presumed connections between behavior (and prevailing morality) and mental illness. In 1835, Samuel Woodward, superintendent of the Worcester State Lunatic Hospital, wrote, “No Cause is more influential in producing Insanity, and, in a special manner, perpetuating the disease, than Masturbation.” Alongside intemperance, Woodward found masturbation the “most frequent cause of insanity,” and usually incurable, “since the vice was almost impossible to give up.” Mary Ann Jimenez, Changing Faces of Madness: Early American Attitudes and Treatment of the Insane (Hanover, NH: University Press of New England, 1987), 83. Protestants too linked masturbation and intemperance to insanity. See Jimenez, 88 for a discussion of how “the meaning of insanity” is “refracted through the moral imperatives” of a particular society.
4.3.1.1 Treatments

Physicians’ views of illness dictated treatments. In the nineteenth century, most formal care for mental illness took place in asylums. While care varied significantly among institutions, the majority of late nineteenth century alienists tried to restore a normal balance to patients through a combination of diet, exercise, fresh air along with tonics and cathartics, approaches that continued the practice of moral treatment adopted earlier in the century.\textsuperscript{20} Sedatives and hypnotics including opium and morphine became common remedies for calming patients. Restraint systems—created to prevent patients from harming themselves or others—remained controversial; some understood them as protective, others saw nothing but repression.\textsuperscript{21} Treatment proved an inexact science.

Debate about treatment methods emerged, but professional optimism in the curative potential of institutions prevailed, at least during the period of institution building. From the 1830s through the 1870s, reports of high recovery rates fueled demand for asylum care. In 1834 and 1841, the annual reports of Samuel B. Woodward of the State Hospital in Worcester, for example, indicated recovery rates between 82% and 91%.\textsuperscript{22} Other antebellum superintendants claimed similar results.

\textsuperscript{20} Physicians working in asylums identified as alienists, and often served under the title of superintendent. With the professionalization of the field, this group of physicians came to be known as psychiatrists. I use the terms interchangeably.


\textsuperscript{22} Pliny Earle, “The Curability of Insanity,” \textit{American Journal of Insanity} 33, no. 4 (1877), 498-9. Grob noted that although success rates were “undoubtedly exaggerated, there is some evidence that early nineteenth-century mental hospitals achieved some striking success.” He attributed that success to the closely controlled “internal environment” of the earlier hospitals paired with the “charismatic personalities” of the first generation of superintendants. Grob, \textit{The Inner World}, 4.
Asylum physicians considered mental maladies even more treatable than other ailments. In 1835, for example, Woodward pronounced, “in recent cases of insanity, under judicious treatment, as large a proportion of recoveries will take place as from any other acute disease of equal severity.”

Throughout the middle of the nineteenth century, high cure rates helped legitimize the care hospitals provided and prompted continued government funding for treatment.

After 1851, growing professional coordination among alienists meant that care for patients began to be formalized. One of the first measures of the recently formed Association of Medical Superintendents of American Institutions (AMSAI) was the publication of guidelines for design and construction of mental hospitals. The 26 standards included recommendations for site selection, room size, lighting, and a basic architectural plan. The document advised a rural setting and a central administrative building flanked with long wings of patient wards on each side. In those spacious facilities, physicians lived on site with their families, affording them direct, daily access to patients and tight control of all aspects of their institutions.

4.3.2 Lay Perceptions of Behavior and Institutionalization

Human behavior, not medical definitions, dictated lay perceptions of insanity. Historian Nancy Tomes used correspondence between patient family members and Thomas S. Kirkbride, the superintendent of the Pennsylvania Hospital for the Insane in

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23 Samuel B. Woodward quoted in Earle, 497.
24 As noted, this group of superintendents, from thirteen asylums, formed in October 1844.
West Philadelphia, to assess common views of mental illness. She classified four categories of behavior that led families to suspect insanity: 1) a loss of cognitive faculties including the inability to speak coherently or remember the past, 2) a disturbance in basic living habits such as dramatic changes in eating, sleeping and working habits, 3) debilitating mental states and moods (excitement, melancholy, irritability), and 4) delusions and bizarre beliefs. Not all strange behavior drew suspicions of insanity, though. If present from birth, families labeled odd behavior idiocy; when present only during fever they considered it delirium. Only when a “great change in natural disposition and bearing” appeared and persisted did family members fear a more serious problem.

While uncertain of exact causes, families assumed that insanity stemmed from disorder in the nervous system. They concluded that stressful events—physical or emotional—shocked the system and affected normal brain function. A severe physical sickness might lead an individual toward insanity; so could common bodily processes like constipation, menses, and menopause. At times, families suspected the habitual use of alcohol and tobacco in their relative’s distress. They described psychological causes including “grief, anxiety over the sick, business losses, intense application to work or study,” and “unrequited love.” Severe trauma might also precipitate insanity, as in the case of an uncle who never recovered from the “great shock” of witnessing the

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27 Ibid., 102.
assassination of Abraham Lincoln at the Ford Theater.\textsuperscript{28} Regardless of the suspected cause, disruptive, odd behaviors worried family members.

While openess to institutional care expanded with asylum construction, families still made the decision to commit loved ones reluctantly, and only after exhausting other options. Relatives considered kin that acted bizarrely simply eccentric, but persistent behavior that interrupted normal life routines or turned violent, forced families to consider a more significant problem. Only after failing to squelch odd behavior did the family call their doctor. Local physicians deployed an assortment of cures including age-old remedies like bleeding, purging, and blistering. Doctors also tried morphine, chloroform, and other drugs. When physical treatments failed, family physicians recommended committal. The more controlled asylum environment, they reasoned, might help. Even then, families that could afford to do so sent men and women for extended stays at health resorts and spas before resorting to mental hospitals.

In time, the inability to provide care at home coupled with the carefully cultivated presentation of the asylum’s capabilities by superintendants helped ease decisions to institutionalize. Though committal remained a last resort, violent, self-destructive behavior and suicide attempts accelerated decision-making. Anxiety and guilt usually accompanied the decision to commit a relative, even when the asylum seemed the best hope for peace at home and recovery for the patient. Yet, eventually, many families trusted institutions to bring healing they could not.

\textsuperscript{28} Ibid., 94.
4.3.4 Clerical Perceptions of Maladies and Treatments

With secular treatment options growing more prevalent, nineteenth-century clergy no longer served as lone experts about mental distress. A reflection by the physician D. A. Gorton showed the ground physicians had claimed from clergy. While affirming that mental health always interested physicians, only in the middle of the nineteenth century did doctors move beyond their “disinclination to intrench [sic] upon a department of study which the custom of centuries has wrongfully confided exclusively to the profession of theology.” Gorton saw religion as good and true, but found medical professionals more qualified to deal with matters of the mind. Many ministers and laity agreed.29

Though “the overwhelming majority of clergymen left no record of their opinions about mental illness,” a few voiced their views. The historian Norman Dain isolated three categories of reactions from Christian leaders.30 The first group, mostly those that ministered in asylums or campaigned for reforms, viewed illness as alienists did. Mental maladies, they agreed, were conditions requiring treatment from medical professionals. The Rev. D. S. Welling’s 1851 *Information for the People; or, The Asylums of Ohio, with Miscellaneous Observations on Health, Diet and Morals, and the Causes, Symptoms and Proper Treatment of Nervous Disease and Insanity* exemplified this approach that yielded authority to asylum physicians. With his approval of institutional care, Welling, who served as the chaplain at a state asylum in Columbus, Ohio, even relaxed his usual

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30 Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick, N.J.: Rutgers University Press, 1964), 184. From “1825 to 1865 more than seventy articles…about insanity and related topics appeared in leading Protestant journals” and religious leaders also addressed insanity in at least two books dedicated to the topic, in one pamphlet, and in four other books. Dain noted that articles were especially frequent in journals sponsored by Quakers and Presbyterians. This section relies on Dain’s eighth chapter, “Religious Opinion.”
stance on vice and virtue in support of activities that aided patient recovery. Dancing and card playing—typically activities that could generate “great evil” or even induce “mania”—he considered “very proper for lunatics in an Asylum to engage in” because they offered the possibility of recovery, if not cure.\textsuperscript{31} Clergymen like Welling trusted the authority of asylum doctors in defining cures, and even let medical prescriptions trump their usual spiritual counsel.

Clerical endorsement of psychiatric techniques allowed asylum superintendents and religious men to work cooperatively. That relationship proceeded most smoothly, though, when ministers ceded final authority to physicians. Ministers in the community sought advice from superintendents when they faced parishioners acting strangely (advice that the family minister had dispensed a century earlier). Starting in 1840, some asylums hired part time chaplains or allowed local clergy to preach Sunday sermons. Despite the Protestant heritage and practice of most of the nineteenth century alienists, they remained wary that clergy “would weaken their authority or disturb their patients.” Concern (and professional debate) about the role of Christian ministers in hospitals notwithstanding, many annual reports from asylums noted, “religious services aided greatly in therapy.”\textsuperscript{32} Medical and clerical cooperation proved possible under some circumstances.

While the first category of ministers ceded virtually all authority to alienists, a second group called for separate jurisdictions. This group included “academic moral philosophers” that turned their attention to “human psychology” instead of medicine. The Congregational clergyman, and president of Yale University, Noah Porter, for example, authored a textbook on \textit{The Human Intellect}, and wrote, “it is no part of our


\textsuperscript{32} Dain, 184-185. See 255 n5, n9 for the professional controversy surrounding hiring chaplains.
duty to give a scientific theory of insanity.” Such clergy remained “interested in the mind-body relationship and in psychology,” but they “considered psychiatry out of their purview.”\textsuperscript{33} That second group of clergy helped the ministerial ranks retain some authority on mental diseases despite the growing professional power of asylum physicians. In 1840, Harpers and Brothers commissioned the Rev. Thomas C. Upham, professor of mental and moral philosophy at Bowdoin College, to author a text about mental disease.\textsuperscript{34} Writing for “popular reading,” Upham hoped to show that the “public mind is but little informed, certainly much less than it should be, in relation to the true doctrines of regular or normal mental action; but it is, undoubtedly, much more ignorant of philosophy of defective and disordered mental action.”\textsuperscript{35} Upham noted that most writing about mental disorder proved complex, and not designed for “popular circulation.” As a clergyman and professor, he claimed authority to translate the topic for popular consumption. Even with separate jurisdictions, clergy retained some authority by making medical thought accessible for the masses.

A final class of clergy primarily professed interest in theological aspects of insanity. This group, like the first, supported most asylum practices, but “in dealing with such controversial problems as causation of insanity, moral responsibility, and the origin of religious melancholia and mania, they often sought to counter” what they viewed as “dangerous psychiatric ideas.” Of particular importance to them was defending Christianity against charges that it could cause insanity. As will be detailed below, few clergymen thought insanity stemmed from demon possession. Many, including the Rev. Thomas C. Upham, \textit{Outlines of Imperfect and Disordered Mental Action} (New York: Harper & Brothers Publishers, 1855), iii.

\textsuperscript{33} Ibid., 186.
\textsuperscript{34} Ibid.
Joseph H. Jones, a Presbyterian minister in Philadelphia, granted that possession remained a “theoretical possibility,” but doubted that it caused any of the cases he encountered.\textsuperscript{36} While their ruminations were largely theological, even those religious leaders held that medical treatment, not spiritual care, formed the correct response to mental distress.

Undoubtedly, ministers continued to counsel the distressed, but in their public discussions and debate, clerical attention to mental maladies in this period proved more of an intellectual exercise than an exploration of the best methods for the direct provision of pastoral, congregational, or public care.

\textbf{4.3.5 Religion’s Role in Precipitating Insanity}

Medical professionals, laity, and clergy all pondered whether religious belief and practice could cause insanity. Many laity suspected that non-normative religious beliefs and practices might trigger mental illness. Tomes’s exploration showed families suspected that religious behavior could bring insanity. “At a time when universal salvation, the innate goodness of human nature, and the harmony between spiritual and secular concerns were becoming dominant themes in mainstream American Protestantism” relatives assumed that “too pessimistic or otherworldly beliefs” and “unwarranted convictions of sin and damnation” might precipitate delusion instead of piety. Letters also claimed “overzealous religious practices, such as excessive Bible reading, too exacting observance of Lent, and adoption of old-style Quaker dress” brought “mental instability.”\textsuperscript{37} Religious practice outside of customary limits, they argued, could cause illness. While they may have suspected it, family correspondence

\textsuperscript{36} Dain, 87.
\textsuperscript{37} Tomes, 99.
gave no indication of a primary role for personal sin or the supernatural as attributed cause of illness, a claim more common in the prior century. Instead, a variety of non-supernatural, behavioral explanations now seemed most plausible.

While few psychiatrists thought that religion actually caused mental illness, they agreed that “excessive religious zeal” could be “responsible for precipitating the disease in persons who were predisposed.” Superintendents also posited a role for misguided clerical action. They feared “depressing or condemnatory sermons” might further disturb patients. That understanding fed the reluctance of some to allow clergy to serve institutions. They feared ministers would preach sermons that were “too austere, denunciatory, and prone to dwell on the ‘terrors of the law’” instead of offering consolation and comfort in the face of suffering.

Ministers, on the other hand, felt sure that Christian belief brought solace, not illness. For example, Frederick A. Packard, an editor of Sunday school publications argued, “properly revealed religion warded off insanity by engendering obedience to God through fear and love.” Like the public, clergy remained “virtually unanimous that irreligion threatened insanity.” They assumed “a disposition to deny the truths of religion deprived the mind of ‘all rational and stable views in regard to the mysteries around and within us, [and] sets it afloat without chart or compass.” Religious belief, ministers argued, was necessary for mental health, and popular morality played a role in

38 Dain, 187.
39 Abraham Brigham, in ibid., 187-188.
40 Ibid., 188.
41 Ibid., 191.
42 Ibid., 192 (my italics).
that assessment. Without religion to ground morality and tame free will, people might lose touch with moral truths, leading to insanity or, more likely, to sin.\footnote{Clergy proved reluctant to excuse immoral behavior on the grounds of “moral insanity,” preferring to name wrongdoing as sin. “Moral insanity,” a specific diagnosis that came into vogue for a period in the middle of the nineteenth century, and that was offered frequently by psychiatrists through the Civil War, declared that illness, and not sin, was at the root of some wrongdoing. That logic allowed criminals—with the aid of physicians—to plead insanity in courts of law. The anthropologist James C. Prichard, who coined the English use of the term “moral insanity,” noted that in some cases patients lost “the power of self-governance” but not the ability to reason “upon any subject proposed to him.” That definition served as a “catchall” for a variety of forms of mental illness, particularly when sufferers failed to follow social moral norms. Earlier, Pinel used the same term in a different way. See ibid., 73-76.}

Nineteenth-century revivalism and views of the role of Scripture prompted two sets of disagreements among ministers. In the first set, those opposed to revivals linked them with insanity. Correlating the increase in asylum populations and with the rise of religious revivals, the liberal clergyman Otis A. Skinner pronounced, “something like one sixth [of the insane] are made crazy by gloomy views of religion” and revival preaching. Even supporters of revivals feared that the hysteria, catalepsy, and epilepsy that sometimes accompanied them could prove dangerous to those prone to mental illness.\footnote{Ibid., 190. Catalepsy involved the lapse into a catatonic state.}

Others, like the revivalist Charles G. Finney, simply assumed that the future of religion and the conversion of souls made some risk of insanity worthwhile. “It is very desirable” he argued “that the church should go on steadily…without these excitements. Such excitements are liable to injure the health. Our nervous system is so strung that any powerful excitement, if long continued, injures our health… this spasmodic religion must be done away….But as yet, the state of the Christian world is such, that to expect to promote religion without excitement is unphilosophical and absurd.”\footnote{Finney, quoted in ibid., 191.}

Ministerial affinities or aversions to revivalism informed assessments of its dangers.\footnote{For an extended historical exploration of “a class of seemingly involuntary acts alternately explained in religious and secular terms,” (including debate among religious communities), see Ann Taves,
In the second instance, disagreement stemmed from the willingness of more liberal Protestant clergy to agree “with the growing tendency of medicine and psychiatry to view insanity as a physical illness—that is, a disorder whose symptoms and perhaps even sufficient causes were mental but one that was essentially somatic, possibly a dysfunction of the brain.” 47 Alternately, those committed to a more conservative, literal interpretation of the Bible proved reluctant completely to discount “demonic possession and miracle healing” as realities relegated to the past. Conservatives appeared more likely than their liberal counterparts to claim individual sin as a cause of insanity and thus repentance and redemption as the primary cure. “Many liberal clergymen, influenced in part by the higher criticism of the Bible, abjuring fundamentalism and talk of the devil, and eager to keep up with current scientific trends, came to ignore the subject of insanity altogether as a religious theological issue.” 48 Instead, they gladly handed over authority on medical matters to medical professionals. Those basic differences appeared for the next century. Later, we will see Boisen sought a middle ground.

In short, many ideas swirled around in forming understandings of mental illness in the final half of the nineteenth century, and no one point of view proved dominant. In the face of mental maladies, the public looked to educated leaders for definitional help and treatment, but more than in the past, medical professionals, and not clergy, proved the more trusted sources of authority on healing. After the rise of asylum medicine, never again did clergy hold lone expertise for care of mental maladies. Even ministers

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48 Ibid.
that recommended only spiritual cures needed to offer critiques of medical treatment options. By Boisen’s time, the normative presumption about responsibility for mental illness had shifted firmly to the medical realm.

4.4 From Salvation to Squalor: Asylum-Based Care

4.4.1 Approval of Asylum Care

Decades before Boisen’s hospitalization, asylums had emerged as the widely-approved location for treating mental illness. In the three decades after 1860, the United States population doubled. In the same time, the population of America’s mental institutions increased nine fold and demonstrated that the assumed proper locale of treatment had shifted from the home and community to the public asylum.49 “By 1860 there was virtually no disagreement with the principle that society had a moral obligation toward the mentally ill,” and institution building continued through the end of the nineteenth century.50 A decade later, responsibility for insane persons increasingly fell into the hands of state agencies, not local jurisdictions or church institutions.51 Spurred by the legacy of Dix’s efforts, by 1880, nearly 140 public and private institutions offered care to nearly 41,000 mentally ill patients.52 Those institutions “provided restorative

49 Baxter, 51.
51 Ibid., 319.
therapy for curable cases” and also offered basic care (food, shelter, clothing) to those unable to survive outside of intuitions.\textsuperscript{53}

Though impressive institutional growth coupled with the emerging professionalism of psychiatry seemed to indicate widespread success in asylum care, problems emerged. Those troubles contributed to the deepening stigmatization of the nation’s mentally ill population and prompted Boisen’s plea for renewed religious involvement in care giving.

4.4.2 Strained Institutional Care

The presence of more mental hospitals (and almshouses and prisons) failed to prevent illness and dependency, nor were those hospitals able to provide adequate treatment to all in need. Overcrowding contributed. The 1851 recommendations of AMSAI suggested each institution house between 200 and 250 patients. Low numbers enabled superintendants and their staffs to offer attentive, personal care, but shifting legislative funding shaped definitions of mental illness, which created new patients. “When states assumed full responsibility for the care and treatment of the mentally ill, for example, local officials saw advantages in redefining insanity to include aged and senile patients, thereby making possible their transfer from almshouses to hospitals and shifting the fiscal burden to the state” and contributing to inpatient population growth at state facilities.\textsuperscript{54} The number of patients at individual hospitals grew quickly and exceeded

\begin{footnotesize}
\textsuperscript{53} Grob, \textit{The Inner World}, 2. Initially, alienists argued that chronic and acute patients were best treated in the same institutions. In 1880, superintendant Thomas S. Kirkbride noted that “What is best for the recent [patient]…is best for the chronic [patient].”
\textsuperscript{54} Grob, \textit{Mental Illness}, 74.
\end{footnotesize}
manageable levels. By 1875, “state and urban asylums founded before 1870 had an average resident population of 432,” and a “third had between 500 and 1300 residents.”

Larger institutional populations required alterations to treatment approaches. The practice of moral treatment, popularized in the nation’s first institutions “assumed that hospitals—like families—would remain small, and that superintendants—like firm but loving fathers—would have the ability and flexibility to shape the environment in order to arrest and then reverse the course of mental disorders.” Overcrowded asylums made that approach untenable. Instead, hospitals needed to exert “rigid and coercive” control. Maintaining order took precedence over providing cures and personal care for each patient from physicians proved infeasible. Packed asylums forced superintendants to take on more administrative roles, leaving daily treatment, if it even occurred, to attendants with less medical training. Exacerbating crowded facilities, hospitals built shoddily by penny-pinching state governments offered inadequate treatment facilities. Writing to Dix in 1880, J.P. Brown, superintendent of the Taunton hospital in Massachusetts, complained that political battles reduced funding, “cheapening everything” and limited “the expenses of our Hospital to Poor House Rates.” Finally, a growing percentage of chronic cases, including senile residents, made it difficult for caregivers to devote as much attention to acute and less severe cases. As a result, many went without treatment. As early as 1862, Dix had lamented, “no State Hospital provision has been adequate to the needs of the insane.” “Old cases,” she noted “are removed at present of a hard necessity to make place for recent and probably curable

55 Grob, The Mad Among Us, 91.
56 Ibid., 91.
57 Grob, Mental Institutions, 300.
As institutions became more custodial than curative and discharged patients before they were restored to health they could no longer promise relief from mental maladies.

National and professional politics also prompted changes in institutional life. In the decades before 1900, the country changed dramatically. While only 11 percent of the population lived in urban areas in 1840, that figure grew to 20 percent in 1860 and 40 percent by 1900. Population growth (from 31,443,000 to 75,992,000 in the same period) sparked by massive immigration fueled much of the urbanization. With a greater population density in cities, problems of illness and dependency grew more prominent and coordinated efforts to combat them appeared. Massachusetts, for example, centralized its welfare efforts with the 1863 establishment of the Board of State Charities. Five more states followed suit by 1869 and others followed soon thereafter. As the complexity of the nation’s bureaucracy increased, public funding and decision-making took place at a greater distance from those experienced with the care of the poor, dependent, and ill. That trend diminished the authority of institutional superintendents over their domains, shifting their duties from the medical to the administrative.

Increasingly, Americans viewed mental hospitals as welfare institutions instead of medical facilities. Reports such as the 1854 *Report on Insanity and Idiocy in Massachusetts*, commissioned by the state and led by the physician and statistician Edward Jarvis, contributed to suspicions of mental illness as a problem of social

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58 Brown, 324.
61 See Chapter 7 of ibid., for discussion of how state mental institutions were swept up in larger welfare reform efforts.
dependency. Jarvis reported a “higher incidence of insanity, idiocy, and crime among poor and pauper groups than among” others. He traced both poverty and insanity to the same origins, an “‘imperfectly organized brain and feeble mental constitution.’” Jarvis also linked mental disease to class and ethnicity, saddling those that suffered with the social stigma attributed to immigrants and the poor. As state welfare systems developed, the result was “to further enmesh mental hospitals in an ambiguous system that alternated between compassion and hostility for dependent groups.”63 While physicians diagnosed mental maladies as illnesses, increasingly, they were also viewed as a social problem.

As the result of shifting patient populations and changing bureaucratic control, by the end of the century, life inside asylums resembled care in the almshouses Dix once sought to eradicate. To be sure, many patients benefitted from hospitalization, even if institutions failed to live up to earlier ideals. But, because of larger patient populations, strained facilities, less attentive care, and weary professionals, insane asylums resembled warehouses more than hospitals.

4.4.3 Professional Optimism Wanes

Problems for the nation’s mentally ill expanded beyond crowded facilities and deteriorating physical plants as professional confidence in the ability of asylums to cure illness also diminished. Hopeful alienists had produced exaggerated cure rates. In December 1876, Pliny Earle, the superintendent of the State Hospital for the Insane in

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62 Ibid., 260, 291. Massive immigration in the late nineteenth century also shaped perceptions. Nativism grew sharply in the final decades of the century. Foreign-born citizens were assumed prone to illness, poverty and degeneracy. As the number of “foreign” patients rose in mental hospitals, ethnic stereotypes affected care. Physicians professed to find “native” populations more receptive to treatments as the result of perceived higher intelligence and better personal habits. The race, class, and gender of patients all affected treatment. Patients were segregated by these factors, and their therapeutic care often differed by their perceived station in life. See Grob, The Mad Among Us, 86-90.

63 Grob, Mental Institutions, 341.
Northampton, Massachusetts exposed inconsistencies and errors in the calculation of recovery statistics. In what Earle diagnosed as a “period of apparent struggle for the largest numerical symbols,” physicians reported increased treatment effectiveness, but he and others voiced concerns that statistics could mislead as easily as they could prove success. Addressing his peers at the New England Psychological Society, Earle urged them to reconsider recovery rate calculations. Offering his colleagues the benefit of the doubt about their reports, he pointed to the desire of superintendants to “look upon the bright side of things” rather than statistical incompetence as accounting for exaggerated cure rates.\textsuperscript{64} Sanguine physicians simply believed that new, moral treatments would prove effective given enough time, and their reporting reflected this optimism. Efforts to heal by altering patient behavior, though, brought limited success, and Earle’s exposé of dubious calculations contributed to growing professional skepticism about non-medical, moral treatment and doubts about the “eminent curability” of mental diseases.\textsuperscript{65}

Earle’s suspicions proved true. While mid-century accounts from superintendants professed high, sometimes universal, cure percentages, a 1877 study of American and British institutions found that for every 100 patients admitted, only thirty-four recovered by year-end. Twenty-nine died, and thirty-six showed no progress or grew worse. Of the thirty-four reported recovered, many relapsed.\textsuperscript{66} Such evidence shattered earlier optimism about the effectiveness of treatments and the possibility of universal cures. Reported recovery rates plummeted in the final quarter of the nineteenth century, and given lingering suspicions of personal responsibility for incurable illness, the public ascribed fault to patients as much as to medical professionals or inadequate facilities.

\textsuperscript{64} Earle, 496.
\textsuperscript{65} Ibid., 493.
\textsuperscript{66} Grob, \textit{Mental Illness}, 14-15.
4.4.4 The Devaluation of Asylum Medicine

In addition to reassessments of recovery rates, as the century drew to a close, hope for medical cures for mental disorders waned. That proved true despite the emergence of scientific medicine and improvements in other medical specialties. By 1900, changes in general medicine colored mental institutions as remnants of the past and a pall of disrespectability tainted both patients and asylum physicians.

4.4.4.1 Changes in General Medicine

By the time Boisen was hospitalized, the paths of general medicine and attention to the mentally ill—long part of the same story—diverged. While the earliest alienists were simply general physicians that chose to work in institutions, changes between 1860 and 1920 left them detached from the medical mainstream.

A general professional reconfiguration of medicine followed a period of disorganization and lowered public confidence in all medical practitioners. “By the mid-nineteenth century…medicine had for many Americans degenerated into little more than a trade, open to all who wished to try their hand at healing.” Medical schools proliferated and medical sects flourished. In 1830, the country counted twenty-two medical schools, twice the number in similarly sized European countries. By 1860, the number of schools had doubled. While each institution granted diplomas, the quality and length of instruction varied widely, as did the skills of graduates. Most states required only a M.D. degree as proof of competency, independent of the granting institution, and “unhampered by legal prejudice, healers of every stripe assumed the title

68 Ibid., 52. Stevens reported, “in 1800 there were only 4 functioning medical colleges” in the nation. “Between 1810 and 1840, 26 new medical schools were founded; between 1840 and 1876, 47; and in the great wave of immigration at the end of the century (1873-90) 114 new schools were established.” Stevens, 24.
doctor and hung out their shingles.\textsuperscript{69} As part of that diversity, homeopaths, Thomsonians, more orthodox European trained physicians, and countless other sectarians and charlatans promoted diverse medical systems. Uncoordinated and contradictory treatment options dampened public confidence in all practitioners, including asylum physicians.

As a result of that fragmented professional landscape, physicians worked to regain credibility. Reforms to the practice of medicine began with a focus on medical education and the reinstatement of legal barriers to entry. Top schools extended training periods to three years, far longer than the many institutes whose coursework spanned weeks or months, and not years. Entrance requirements also increased with more than twenty schools requiring two years of college by 1910.\textsuperscript{70} In addition, between 1874 and 1900, every state in the union had passed medical licensing acts, reversing the reluctance earlier in the century to regulate the practice of medicine. Those acts, combined with the 1888 Supreme Court decision, \textit{Dent v. West Virginia}, that upheld “the authority of the state medical examining board to deprive a poorly trained eclectic physician of the right to practice” fostered standardization. In addition, curricula improved as medical schools aimed to prepare students for licensing exams.

Scientific medicine and medical advancements emerged, but in specialties other than psychiatry.\textsuperscript{71} “The specific germ theory of disease and the growing importance of

\textsuperscript{69} \textit{The Professions in American History}, 55.
\textsuperscript{70} Ibid., 58.
\textsuperscript{71} Thought the vast majority of physicians remained generalists serving rural populations through the Civil War, slowly, new professional specialties and societies formed. Alienists had declared the first specialized guild, but others followed. Among others: American Ophthalmological Society, 1864; American Otological Society, 1867, American Neurological Association, 1875, American Gynecological Society, 1876; American Dermatological Association, 1876. Stevens, 46. General hospitals were part of that expansion; so were the first non-asylum specialty hospitals treating the eyes, the ears, and skin diseases. Ibid., 31.
bacteriology gave rise to a faith that understanding the etiology and course of disease was both possible and empirically verifiable, and that effective therapies would surely follow." Inventions in anesthesia, the invention of stethoscopes (1819), ophthalmaoscopes (1851), and laryngoscopes (1855), and the use of radiology revolutionized diagnosis and treatment and helped attend to physical, but not mental, ailments. While such improvements failed directly to affect care of mental disease, they did encourage many psychiatrists to seek "scientific research rather than care or custody." As they attempted to shift their focus to "disease rather than patients," they directed curative and preventative measures toward all of society not just those in the confines of mental institutions.

Finally, urbanization and immigration sparked the development of general hospitals, which then became the "foci for the institutionalization of medicine." Charitable hospitals had developed in the colonial era, but a more widespread expansion of general hospitals began in the 1880s. The earlier facilities offered care for mostly indigent patients; new hospital catered to more affluent groups that could afford new methods of care, and that provided higher incomes for their physicians. Those facilities became the seats of scientific study and physician training. Once viewed as the nation’s most innovative and curative institutions, asylums suffered a loss in prestige when compared to the new general hospitals.

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72 Grob, The Mad Among Us, 145.
73 Stevens, 39.
74 Grob, The Inner World, 9.
75 Stevens, 34.
76 Ibid., 10.
77 Grob, Mental Illness, 31.
After the turn of the century, the professionalization of general medicine evolved with more force. Membership in the American Medical Association grew rapidly as the organization coordinated with local medical associations, allowing it to exert more control over care. As the authority of “regular” physicians grew, it did so at the expense of medical sectarians, nurses, and pharmacists. Also left behind were psychiatrists and even further behind, clergy. To be sure, rivals to orthodox medicine remained, with Christian Science, osteopathy, and chiropractic care appearing as the twentieth century dawned, but non-psychiatric physicians had established their dominance.

Once drawing the interest of the nation’s best physicians, tending to mental maladies lost appeal for later generations of caregivers. Challenging conditions and a sense that the rest of medicine had abandoned them pushed asylum physicians—now more commonly called psychiatrists—out of institutions in droves. They sought to reclaim public and professional respectability and to find new venues to ply their trade.78 “In 1895 virtually all members [of the American Psychological Association] had been in hospital practice. By 1956 only about 17 percent...were employed in state mental hospitals or Veterans Administration facilities; the remainder were either in private practice or are employed in various government and educational institutions, including community clinics.”79 Their flight reinforced negative public images of asylums (and the insane) and simultaneously diminished the quality of care received by institutionalized Americans. As psychiatrists ventured beyond asylum walls, “they were less and less

78 The name change of their professional organization shows the specialty’s movement beyond institutions. In “1885 the Association of Medical Superintendents of American Institutions for the Insane (founded in 1844) modified its membership requirements and permitted assistant physicians to become ex officio members. Seven years later, it changed its name to the American Medico-Psychological Association (AMPA). These changes, which culminated in 1921 when the AMPA became the America Psychiatric Association (APA), represented a fundamental shift in focus.” Grob, The Inner World, 7-8.

79 Ibid., 11.
prone to act—as their nineteenth-century predecessors had acted—as the representatives of the institutionalized mentally ill,” particularly seemingly chronic cases.  

### 4.4.4.2 External Critique and Internal Disagreement

As the nineteenth century closed, asylum care and its practitioners drew criticism from several quarters. One line came from other physicians. The neurologist S. Weir Mitchell’s 1894 address to the American Medico-Psychological Association exemplified attacks on asylum medicine from other physicians. He declared psychiatry deficient and too isolated from other medical specialties. “You were the first of the specialists,” Mitchell declared, “and you have never come back into line. It is easy to see how this came about. You soon began to live apart, and you still do so. Your hospitals are not our hospitals; your ways are not our ways. You live out of range of critical shot; you are not preceded and followed in your ward by clever rivals, or watched by able residents fresh with the learning of the schools.” Drawing a distinct line between psychiatry and scientific medicine, Mitchell claimed that mental hospitals failed to foster scientific inquiry, deployed distrusted therapeutics, and disregarded responsibility for educating the public about treatments and prevention.

External critique also emerged. A few vocal former patients decried forced committal and the treatment they received. Mrs. E. P. W. Packard, for example, led a public attack on legal incarceration after being institutionalized by her Protestant

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80 Ibid.  
clergyman husband for three years in the Illinois State Hospital for the Insane. “In a trial that received national publicity, Packard was declared sane” and then spent “nearly two decades campaigning for the passage of personal liberty laws that would protect individuals and particularly married women from wrongful commitment to and retention in asylums.”

Asylums throughout the country faced writs of habeus corpus that freed wrongly committed patients and generated negative publicity and suspicion about committal procedures. Alongside such public exposés, increased government bureaucracy meant that superintendants faced constant queries of their methods and approaches from state boards of charity. Citizens perceived—and professed—that something was wrong with treatment of mental disorders.

Attacked by both medical doctors and patients, internal disagreements also weakened professional cohesion and deepened external criticism. With institutional crowding, for example, superintendants differed about whether states should establish separate institutions for the incurably insane (hospitals that provided custody but not treatment). Some argued that move would improve care in “therapeutic” hospitals and use public funds most effectively. Others worried that distinguishing between curable and incurable disease invited error and that preventing the abuse of patients in custodial institutions would prove difficult.

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82 Grob, The Mad Among Us, 84. See also Grob, Mental Institutions in America, 263. Committed to Worcester hospital with “brain fever” in 1935, Packard married four years later. Grob reported an unhappy marriage was exacerbated by sharp religious differences: “Elizabeth Packard adhered to a liberal theology, while her husband was a devout Calvinistic [sic] who accepted the total depravity of humanity. When Packard refused to play the role of an obedient wife and expressed religious ideas bordering on mysticism, her husband had her committed in 1860.”

83 Grob, Mental Institutions, 269.
84 Ibid., 305.
Despite some disagreement, most asylum superintendants held fast to the hope for cures. As all doctors administered drugs more commonly in the final decades of the century, younger asylum physicians that experimented with medical cures and adopted purely somatic view of illness increasingly criticized moral treatments as unscientific and ineffective. Adopting a “therapeutic nihilism,” some younger psychiatrists even claimed that mental illness would prove incurable until medical advances appeared.\textsuperscript{85} They remained certain that cures lay just around the corner, but believed they would stem from somatic solutions, and not asylums. In his 1917 presidential address to the American Medio-Psychological Association, Charles G. Wagner predicted that the hard work of a variety of approaches would, “within the period of a decade or two…result in a much better understanding of the etiology, pathology, diagnosis and treatment of mental diseases.”\textsuperscript{86} Such hopefulness, though, bypassed the chronically mentally ill to the extent that psychiatrists focused treatments on those outside of asylums.

As the result of different treatment approaches, the field of psychiatry fragmented in the early twentieth century. In addition to more diverse practice inside and outside of institutions, some professionals “explored the physiological and biological roots of mental disease; some developed a more analytic psychiatry that incorporated Freudian insights; some attempted in integrate psychological and physiological phenomena to illuminate the inner workings of abnormal minds.” A number even reached beyond customary medical jurisdiction to shape human behavior as part of the mental hygiene movement.\textsuperscript{87}

\textsuperscript{85} Ibid., 315.
\textsuperscript{86} Wagner, cited in Grob, \textit{The Inner World}, 8.
\textsuperscript{87} My Chapter 5 discusses the divisions in psychiatry and mental hygiene initiatives.
With the professionalization of medical science, “proponents of a ‘physiological’ view of insanity were poised to make a withering onslaught against the ‘metaphysical’ interpretation” of the founding fathers of the American Association of Medical Superintendants and early asylum advocates.\(^88\) As a result, no longer could someone like Dorothea Dix or religious leaders claim comprehensive authority over public asylums or mental illness. In 1898, Franklin B. Sanborn, the secretary of Massachusetts’s Board of State Commissioners of Public Charities reflected that Dix “lacked ‘the special knowledge and discrimination required’ to lead modern reforms.” Medical expertise and adeptness in public administration trumped Christian charity as public leaders rejected the “religious principles of moral treatment.”\(^89\) Reforms at asylums, however, were far from complete.

While mental institutions in years of Dix’s campaigns had offered the country’s most dedicated care, improvements and changes in medicine largely bypassed asylums. Just as reported cure rates for mental illnesses plummeted, other medical fields claimed success. Alienists remained specialists, but now detached from general medicine rather than being beacons of innovation. Without scientific advances in the care of mental illness, and because they continued to serve a socially and economically diverse population, a sense emerged that psychiatry and institutional care were “vestigial remnants of a pre-modern age” and leftovers of “an earlier social order.”\(^90\) Treating mentally ill patients not only became more onerous, it proved a less appealing

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\(^{88}\) Brown, *Dorothea Dix*, 328.
\(^{89}\) Ibid., 329.
profession.\textsuperscript{91} Those realities were a dramatic reversal from the optimism that had fueled Dix’s advocacy just a half century earlier.

4.5 Religious and Social Change

4.5.1 The Role of the Church

How did Protestants weigh into that debate about care for mental maladies? Those at the helm of early nineteenth-century medical institutions had been motivated, at least in part, to pursue careers in medicine by their Protestant morality, but little evidence exists that Protestants in the ante- and post-bellum eras considered advocacy for the mentally ill of prime ecclesial importance. In general, Christian belief influenced social action, but not all problems received equal attention. To be sure, clergy continued to attend to parishioners and tout the call to care for the least of these, but the majority of Protestants in the middle and late nineteenth century focused elsewhere.\textsuperscript{92}

Following the revivals of the Second Great Awakening, America’s Christians saw unprecedented diversification and growth. They focused on launching new congregations and denominations. Social causes including temperance, literacy, prison

\textsuperscript{91} Grob, \textit{The Inner World}, 11. The creation of psychopathic hospitals accompanied the growth of general hospitals. The former appeared after 1890 as alternatives to asylum care. Those “reception” hospitals (and, similarly, psychiatric wards in general hospitals) located in urban areas offered inpatient treatment for acute cases, sometimes as a first step before committal to an asylum. Grob, \textit{The Mad Among Us}, 147-8. Psychopathic hospitals (versus asylums) developed from Progressive reform efforts around the turn of the twentieth century. They provided outpatient, short-term inpatient, and preventative services in local communities. They were also intended to help reduce the stigma of mental illness attached to asylum patients. Reality fell short of intentions, and the facilities served largely as the first step to institutionalization at the larger asylums and efforts in them focused on processing chronic patients more than treatment and prevention of acute cases. For a thorough assessment of psychopathic hospitals, see David J. Rothman, \textit{Conscience and Convenience: The Asylum and its Alternatives in Progressive America} (New York: Aldine de Gruyter, 2002), 309-370.

\textsuperscript{92} At a time when the nation’s professionals were vying for authority, perhaps an attempt to hold onto or regain legitimate authority among other professions, in part, distracted clergy from attending to the needs of men and women as earlier generations of ministers did. The rise of modern medicine and the authoritative control of asylums by superintendents meant clergy ceded control of particular forms of suffering. Growing social stigma attached to mental illness may have also played a role. Caring for the nation’s mentally ill seemed hopeless, and clergy may have been happy to let other professional carry the load.
reform, the equality of women, and the abolition of slavery won attention too.\textsuperscript{93} After the Civil War, some Protestants—like Boisen—embraced the ideas and approaches of German theological liberalism. Those attracted to the high anthropology and general optimism of that movement assumed their efforts to prompt social change would help usher in the Kingdom of God.\textsuperscript{94}

\subsection*{4.5.2 Social Progress and Stigma}

Religious changes took place among larger societal shifts. A spike in immigration, labor unrest, economic panics, and fears of degeneracy and widespread illness caused unease. Nonetheless, hopefulness persisted. Citizens assumed that solving the nation’s problems was possible with hard work and the right scientific discoveries. That outlook, in fact, was central to an emerging sense of what it meant to be an American. The historian Donald Meyer argued, “the quest for American identity had assumed that that identity was to be found in purposes, aspirations and achievements, and further, that whatever these purposes were, they were served by energy-packed questing

\textsuperscript{93} See Jennifer Graber, \textit{The Furnace of Affliction: Prisons and Religion in Antebellum America} (Chapel Hill: University of North Carolina Press, 2011). Protestant involvement in prison reform offers a contrast to their participation in asylum care. The historian Jen Graber documented Christian influence in nineteenth century prison reform. Unlike involvement in asylum building, which Protestants advocated, but then turned over to medical authorities, Protestant prison reformers remained integral to shaping the philosophy and daily life in correctional institutions. Asylums and prisons, while often treated by scholars alongside one another because they involuntarily housed citizens, differed in their aims and approaches. Asylums sought to restore patients to health. Prisons hoped to reform and redeem criminals. While some may have suspected mental illness resulted from individual sin, a legal declaration of wrongdoing marked prison inmates. Asylums aimed to alleviate suffering; prisons imposed suffering as part of the reformation process. Heroic treatments and restraint at asylums, however, bore some resemblance to the methods of inflicted suffering at prisons and made public conflation of such institutions understandable. Both aimed to bring a new state of being through pain or isolation, but nineteenth century Christians shaped life inside of prisons in ways they did not inside asylums.

\textsuperscript{94} That high anthropology (rooted in a trajectory that began with Immanuel Kant and made its way into Protestant liberalism through Frederick Schleiermacher) placed trust and authority in human experience.
Enthusiastic and capable Americans hoped to solve the problems of a changing society.

Progress seemed to pass some by, however. Mentally disturbed patients in the care of the state hardly fit the American ideal; they were “not quite right.” In addition, the deterioration of institutional care meant that people viewed those facilities—and sufferers within them—as outside of “normal” American society. Social stigma plagued both asylums and patients. Separation exacerbated stigma. Asylums were located on the outskirts of increasingly urban American life. Patients received treatment away from their families in rurally situated, fortress-like institutions, which only fed stigma’s growth.

All told, despite the work of many, care for the mentally ill proved no further along at the end of the nineteenth century than one hundred years earlier. The afflicted still suffered; facilities were inadequate; cures were far from guaranteed; professional debate raged. Many worked with good intentions but the results remained dismal. Decades of deterioration in asylum life, changes in general medicine, shifts in psychiatric care, and deepened social stigma all shaped Boisen’s experience in the “little known world” of mental illness and prompted his critiques of the care he received.

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96 An 1880 statement by the American neurologist E.C. Seguin explains the stigmatized status of those declared mental ill: “It is fair to say that in the present state of psychiatry in America, to be pronounced insane by physicians, by a judge, or by a jury, means imprisonment for months, for years, or for life. To put it another way, there is a disease which reduces its victims to a level with persons accused of crime, and exposes them to loss of liberty, property and [to] unhappiness.” Quoted in Gerald N. Grob, “The Transformation of American Psychiatry: From Institution to Community, 1800-2000,” in History of Psychiatry and Medical Psychology, ed. Edwin R. Wallace and John Gach (New York: Springer Science + Business Media, LLC., 2008), 540.
4.6 Boisen and Sickness of the Soul

Boisen began his 1936 *Exploration of the Inner World: A Study of Mental Disorder and Religious Experience* on an autobiographical note. He observed, “to be plunged as a patient into a hospital for the insane may be a tragedy or it may be an opportunity. For me it has been an opportunity.” What he named as his “brief but extremely severe period of mental illness” allowed him to witness the widest range of human experience, from “the bottommost depths of the nether regions to the heights of religious experience at its best.” The sympathetic pastor’s immersion in an institutional milieu provided a ready field of study that prompted him to deploy theological insights alongside social-scientific methods to bring healing, for both himself and others.

While Dix experienced depression and sought recovery in Europe, Boisen experienced healing in a system of institutions shaped by her work, but marred by a half century of unhappy change. Boisen’s first hospitalization came in 1920 as he struggled to rewrite of a Statement of Faith for the New York Presbytery in hope of a pastoral placement. His hope to land a ministry position stemmed from a continued desire to earn the love and attention of Alice Batchelder. While writing, he found himself obsessed with “a coming world catastrophe.” His visions of destruction and evil frightened his friends and family, who eventually took action. On October 9, 1920, six police officers “came marching into the room” at home where Boisen worked. After announcing that he “had better come quietly or there would be trouble,” they whisked him away to Boston Psychopathic Hospital.

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97 Boisen, *The Exploration*, 1, ix-x.
98 Ibid., 1.
99 *Vision From*, 5.
During this first hospitalization, Boisen’s severe psychosis included violent delirium, hallucinations, and delusions. One vision held lasting significance. In what biographer Robert C. Powell termed a “prophetic delusion,” Boisen conceived that he had “broken an opening in the wall which separated medicine and religion.” Though “patently delusional” at the time, the vision focused his attention, not only during time in the hospital, but for the rest of his life. Powell argued that “in view of the extremely productive course Boisen’s life took” after his vision, “there is perhaps some justification for agreeing with an assertion he made in a letter written soon after the gross disturbance cleared: ‘The cure has lain in the faithful carrying through of the delusion itself.’” As Boisen delved into the meaning of his experience, he became convinced that healing required a new understanding of the relationship between medicine and religion. He felt a divine call to make it a productive reality.

4.6.1 Defining Mental Illness

Four months after his initial hospitalization, Boisen transferred to Westboro State Hospital. While often lucid, he occasionally relapsed into psychosis. When his acute symptoms subsided, Boisen drew on his knowledge of social scientific methods and explored the institution’s character, procedures, and patients. As part of that study, he concluded that most of the other men were hospitalized with “spiritual or religious difficulties” rather than organic illnesses. He also observed that purely physical treatment methods failed to address their problems.

102 Vision From, 6. Boisen published details about his illness only decades later in his autobiography. Of his first hospitalization, he recalled, “Throughout this entire period I was in a violent delirium and spent most of the time reposing in cold-packs or locked up in one of the small rooms on Ward 2, often pounding on the door and singing.” Boisen, Out of the Depths, 87.

103 Boisen, Out of the Depths, 91.

104 Powell, 8.
Boisen defined two “main classes” of mental illness, “organic” and “functional.” As he surveyed fellow patients and thought about his own illness, he concluded that in the one case there is some organic trouble, a defect in the brain tissue, some disorder in the nervous system, some disease of the blood. In the other there is no organic difficulty. The body is strong and the brain in good working order. The difficulty is rather in the disorganization of the patient’s world.

He assumed his illness was of the functional variety. Such a malady, he argued, resulted when something has happened which has upset the foundations upon which his ordinary reasoning is based. Death or disappointment or sense of failure may have compelled a reconstruction of the patient’s world view from the bottom up, and the mind becomes dominated by the one idea which he has been trying to put in its proper place.\(^\text{105}\)

In a 1926 article for *Christian Work*, Boisen relayed that two-thirds of the cases at Worcester hospital lacked explainable physical origins and that diminished intelligence or reason did not explain illness.\(^\text{106}\) Rather than a medical problem, Boisen understood many functional mental illnesses as acute spiritual problems in need of religious ministrations.

Unlike late nineteenth and early twentieth-century physicians that routinely presumed physical causes, even if they could not identify them, Boisen posited a different explanation. He believed that conflict caused functional mental illness, conflict stemming from an individual’s personality seeking a reintegration about one’s purpose in life.\(^\text{107}\) According to this view, he contended functional mental illnesses were

\(^{107}\) Anton T. Boisen, “Concerning the Relationship Between Religious Experience and Mental Disorder (1923),” in *Vision From*, 16.
disorders of emotion and volition, of belief and attitude, rooted not in cerebral disease nor in the breaking down of the reasoning process but for the most part in the age-old conflict which the Apostle Paul so vividly describes, the conflict between the law that is in our minds and that which is in our members.  

Boisen diagnosed such inner conflict as precipitating his first hospitalization.

Boisen’s illness was characterized by “distinct psychotic episodes” that “came and departed very quickly.” “For long period in between episodes [he] was free from” symptoms. While ill, he experienced grandiose and religious delusions. He envisioned, for example finding “most sacred relics” wrapped in “white linen” that were “connected with the search for the Holy Grail” and heard beautiful voices that he professed were “the celebration of the Last Supper.” At times, he also experienced symptoms of depression (“It was a beautiful day, but there was no sunshine for me, and no beauty—nothing but black despair.”) and mania (“I was tremendously excited. In some way, I could not tell how, I felt myself joined onto some superhuman course of strength.”). Boisen recorded his experiences, and published them near the end of his life in Out of the Depths, his autobiography.

Mental breakdowns caused by functional mental illness, he believed, could serve a creative, healing role. They were efforts “at a new synthesis of life,”…attempts “to become reconciled with the ‘Man Above’ in order thereby to become reconciled with one’s fellows.” While “some forms of mental illness serve a curative, problem-solving

108 Boisen, “Theological Education Via the Clinic (1930),” in Vision From, 26.
109 During his first hospitalization, Boisen received the diagnosis of schizophrenia, and used that label to describe his symptoms throughout his life. Later assessment of the variety of Boisen’s self-reported symptoms led some to assess his illness as a different ailment, bipolar affective disorder. Carol North and William M. Clements, “The Psychiatric Diagnosis of Anton Boisen: From Schizophrenia to Bipolar Affective Disorder,” in Vision From, 217-227.
110 Boisen cited in Powell, 14.
function for the individual,” Boisen observed that, not all conflict resolved “happily.”

Some sufferers remained in a state of psychosis.

Although he lived at a time when the spheres of medicine and religion divided firmly, Boisen, like Cotton Mather two centuries earlier, blended his knowledge of the two realms to explain illness. Combining religious and medical terminology, he compared successfully resolved mental illnesses to conversion experiences: “Such conflicts, when they result happily, as in the case of Augustine, George Fox and John Bunyan, we recognize as religious experience. When they result unhappily, we send the sufferer to a hospital for the mentally ill and speak of him as insane.”

Some types of mental illness, he argued, appeared “essentially a desperate struggle for salvation, a manifestation of nature’s power to heal which is analogous to fever or inflammation in the body.” For some sufferers, traditional religious conversion—“hit[ting] the sawdust trail’ at the meetings of evangelists like Billy Sunday,”—brought resolution, but other individuals suffered in a way that required a different sort of conversion.

Any illness caused by spiritual distress, Boisen surmised, appeared curable. “It came over me like a flash,” he recalled, “that if inner conflicts like that which [the apostle] Paul describes in the famous passage in the seventh chapter of Romans can have happy solutions, as the church has always believed, there must also be unhappy solutions which thus far the church has ignored.” While some, like himself, managed to steer through those difficulties after their “inner world(s) had come crashing down,” others remained ill. He understood his ailment as “at once mental disorder of the most profound

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111 Vision From, 1.
and unmistakable variety and also…of unquestionable religious value.” Religion, he concluded, could help bring healing even in the worst cases of functional mental illness, ones formerly considered incurable. In a letter to his mother during his first hospitalization, Boisen wrote: “In many of its forms, insanity, as I see it, is a religious rather than a medical problem, and any treatment which fails to recognize that fact can hardly be effective.” With that newfound insight, it frustrated Boisen that his physicians possessed “neither understanding nor interest in the religious aspects” of experiences like his.

Claiming not only personal experience, but also clerical authority and medical knowledge, Boisen saw a clear distinction between religious distress and organic mental disease. He noted, though, that psychiatrists often failed to “recognize with sufficient clearness the sharp contrast between them.” When psychotic visions seemed specifically religious, like many that he observed (and experienced), Boisen sought to discern the presence of God, and not presume delusion. Such experiences, he argued, were “mystical experiences in so far as they give the sense of identification with the larger fellowship presented by the idea of God.” Reflecting on the ability of some psychotic hallucinations to heal, he noted, “perhaps, we…need to learn…that all auditory hallucinations do not necessarily come from the devil but may represent the operations of the creative mind.” In doing so, Boisen “challenged the idea that mentally ill people

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114 Boisen, The Exploration of, 11.
115 Ibid, 8, 48.
116 Ibid., 5.
117 Boisen, “Concerning the Relationship,” 16.
119 Anton T. Boisen, “Inspiration in the Light of Psychopathology (1961),” in Vision From, 122. There Boisen noted that medieval mystics had to learn that some of the “ideas which came surging into their minds could hardly have come from God” and might have come from the devil.
were depraved,” and instead suggested, “the individual who suffered from functional mental illness was actually the most sensitive in moral and ethical matters.” Given those insights, throughout his career, Boisen encouraged reconsideration of mental maladies and drew clergy attention to an area he felt they held rightful expertise.

4.6.2 Claiming Pastoral Authority

Boisen’s interest in suffering and religion had blossomed long before his first hospitalization. After enrolling in Union Theological Seminary in 1908, he studied the psychology of religion, finding an affinity with the work of the psychologist and philosopher William James. With James, “Boisen ‘believed that sickness of soul might have religious significance,’ and with him he ‘proposed to employ the methods of science in attacking the problems involved.’” At Union, Boisen continued his exploration of the psychology of religion with George Albert Coe, from whom he learned the importance of the “living ‘human document’” as an object of theological study.

His illness prompted further study. In 1922, while still an outpatient at Westboro State Hospital, and with the approval of his mother and his physician, Boisen enrolled at Episcopal Theological School in Cambridge. He also took courses at Andover Theological School and Harvard. In additional to theological topics, Boisen explored social ethics and abnormal psychology. He used those new tools to prepare case studies, almost forty of them, from his observations of his fellow patients. Documenting the

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120 Myers-Shirk, 17.
121 Boisen observed, “In every mental hospital therefore, we find patients who believe that God has spoken to them, that he has given them some important mission to perform and that they have some important role to act out. Among these there may be some potential George Fox or John Bunyan or some Saul of Tarsus who has it in him to change the course of history. It is therefore a matter of first importance to be able to recognize and give a helping hand to the moulding genius and to have our eyes opened to the significance of such experiences.” Boisen, “Inspiration in the Light,” 114. Boisen draws no connection to his own religious visions.
122 Powell, 7.
human condition amidst suffering served as a first step in Boisen’s theological assessment of mental distress. Additional study prepared him to share that revelation with religious and medical professionals. Both groups needed his insight.

4.7 A Call for Physicians of the Soul

As a patient at Westboro, Boisen attended weekly religious services. Initially hopeful that the local clergy leading those worship services might become conversation partners, he discovered that while they “might know something about religion…they certainly knew nothing about” mental maladies. Recalling a minister from the neighboring village who preached on the text, “If thine eye offend thee, pluck it out,” he feared that “one or two of my fellow patients might be inclined to take that injunction literally.”

In Boisen’s view, though willing to lead a formal worship services, clergymen failed to understand both the suffering experienced by patients and the role they could play in healing. With his understanding of mental illness as partly a religious problem, came the realization that Protestants had failed to understand mental distress. As a result, Boisen observed, “as yet the church has given little attention to this problem.” He sought to fix the oversight, and hoped churches would come to see things differently.

As Boisen continued to develop that thinking about mental illness and its significance in the religious life, he corresponded with the Rev. Elwood Worcester, an

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123 Boisen, The Exploration of, 6.
124 Boisen cited in ibid., 48.
125 Boisen found healing in “religion,” but assumed that clergy mediated, enacted, and led congregations and ministered one on one to parishioners. Individual healing formed Boisen’s ultimate interest, and changing clergy awareness and practice formed the route he pursued to effect change.
Episcopal clergyman and professor of psychology and philosophy. His second letter to Worcester included hope “for the day when cases of mental trouble which are not primarily organic in origin will be recognized and treated as spiritual problems, and that the church will develop physicians of soul of a type whose work will be based upon sound and systematic study of spiritual pathology.” After recovering, Boisen’s first task was to prepare himself for such a position.

4.7.1 The Church’s Failure

Studying the religious symbolism in his delusions helped Boisen heal, and he hoped to share that insight. As he touted the healing role that believers could play, he admonished fellow clergymen for failing to apply such care. The church had failed to attend to mental maladies despite its attention to other sufferers. “It seems not inaccurate to say” he argued, “that if a man has a broken leg he can be cared for by the church in a church institution. But if he has a broken heart he is turned over to the state, there to be forgotten by the church.” Protestants, the former patient asserted, cared for the sick in church-affiliated general hospitals, but took “no interest in cases of pronounced mental disorder.” Of 381 hospitals, Boisen identified only three that focused on mental maladies. As a result, the care of the mentally ill, many of whom Boisen understood to suffer from spiritual, not physical problems, were “left practically without Protestant religious ministration.” “The one chief piece of machinery that the Protestant Church has worked out for dealing with the man who is sick of soul,” Boisen observed, “is the

126 Worcester founded the Emmanuel Movement, an effort to “bring people to health by using psychotherapy in a process of reconciling patients with Christ while at the same time attempting to alleviate their symptoms.” Dain, “Madness and the Stigma,” 78.
127 Boisen. Cited in Powell, 9. By spiritual pathology, Boisen referred to documenting in patients, the types of religious experiences he found outlined in the work of Augustine, George Fox, Paul Bunyan, the apostle Paul, and others. He hoped clergy (and physicians) would attend not only to physical and behavioral symptoms, but also to the progression and struggles inherent in spiritual journeys.
‘revival meeting,’ and it is an open question whether this method in practice does not do almost as much harm as good.”

Boisen found it “truly remarkable” that “a church which has always been interested in the care of the sick” confined “her efforts to the types of cases in which religion has least concern and least to contribute, while in those types in which it is impossible to tell where the domain of the medical workers leaves off and that of the religious worker begins, there the Church is doing nothing.”

Having identified the problem, Boisen diagnosed its origins.

The church’s failure to respond, he argued, stemmed from an inadequate understanding of the human condition. The minister observed that clergy “have made little attempt to study the human personality either in health or in sickness” even though “the human personality [was that] with which it was…[the pastor’s] task to work.” Clergy must undertake this work in order “to bring to bear…the forces of healing and of power which lie in Christian Religion.”

Alongside this assertion, he scolded clergy for abdicating their authority for the care of souls to physicians: “The physician, as a result of his empirical method and his careful, systematic study of living men and women, has thus in very truth become a physician of souls, while the traditional ‘physician of souls,’ clinging to his traditional methods, has become merely the custodian of the faith.”

Boisen bitterly lamented the loss.

Despite “waning [clerical] influence,” Boisen listed items of “fundamental importance” that ministers could bring to the treatment of mental illness. First, religion,

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129 Boisen, “Concerning the Relationship,” 18.
130 Boisen, “The Challenge to,” 20-21. There Boisen noted that “according to the Interchurch Survey of 1919, 381 hospitals are supported and are controlled by the Protestant churches of America, only three of these hospitals, so far as I have been able to discover, are especially concerned with the problem of mental disorders, and even in these three the approach is almost wholly medical.”
131 Boisen, in Powell, 11, n73.
132 Boisen, “Concerning the Relationship,” 17.
as mediated by clergy, provided a sense of the “ultimate realities of life,” which offered comfort, hope, and strength to the afflicted. Because he understood that functional mental illness resulted from being “out of adjustment” with one’s conceived purpose in life, he asserted benefits from prayer and the inclusion in a Christian community, a “wholesome environment” for those in distress. Given those benefits, Boisen also cited a preventative role for religious workers—their participation with individuals might help work through problems before they became severe enough to require hospitalization.\(^{133}\)

Using social scientific methods of participation observation, Boisen felt sure that clergy could gain insight about human nature and suffering that would enable them to bring healing that medical professionals could not.\(^{134}\)

Writing near the height of the Fundamentalist-Modernist controversy, Boisen spared neither Fundamentalist nor Liberal Protestants in lambasting the church’s efforts. On one hand, conservatives, with their focus on saving souls, undoubtedly brought comfort to many through a hope in a “new purpose in life” and a fellowship with other believers. But ultimately, conservative evangelical Protestant response to mental illness was simply “treatment without diagnosis,” for fundamentalism “has no clear idea of what salvation means nor of what people need to be saved from.” And, Boisen feared, “its hell is a future affair and it has been blind to the hell which was right before its eyes.” Liberals, on the other hand, “supply neither treatment nor diagnosis…for the soul that is sick they have no gospel of salvation.” Distracted by their focus on religious education and social reform, liberals “are all too ready to turn” the mental patient “over to the

\(^{133}\) Ibid., 17-18. Similar preventative impulses fed clerical and lay participation in the mental hygiene movement.

\(^{134}\) See Myers-Shirk, 18-20 for a discussion of Boisen’s adoption of scientific methods.
doctors and then forget about him.” Boisen hoped to inspire changes in practice for all Christians.

4.7.2 The Root of the Problem and a Solution

Boisen faulted seminaries for allowing the abdication of authority to medical professionals. After studying the course catalogues of theological schools, he discovered that most focused on the traditional disciplines of scripture, church history, systematic theology, philosophy of religion, and preaching with very little focus on “the human personality either in health or in sickness, or the social forces that affect it.” He argued that clergy needed training beyond the seminary classroom, training that deepened their attention to human experience. Few current pastors, he observed, possessed the skills for such work, but supplementing training with clinical experience in mental hospitals could enrich that basic preparation. The clergyman hoped, “through the empirical approach, to call attention back to the central problem of theology and the central task of the church – the problem of sin and salvation’….’What is new,’ he reminded his fellow clergymen, ‘is the attempt to begin with the study’” of human experience.

The “person in difficulty,” Boisen argued, served as the proper focus of theological training and practice. Mental hospitals, full of such individuals, proved a perfect location for a new form of education because students encountered complex human experience and suffering firsthand. That experience helped bring about what Boisen understood as “the potential power of the church to contribute to the solution of this problem.” If theological students witnessed “struggles in their dramatic

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136 Ibid., 22.
137 Boisen in Powell, 20. Boisen frequently used the term “living human documents.”
138 Boisen, “Concerning the Relationship” 18.

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vehemence, in their nakedness of panic and despair” at mental hospitals, then they “might be more sensitive to the little hints and small signs by which” their parishioners indicated a “need for help and salvation.” 139 Clear about the problem, Boisen was optimistic about a solution.

4.7.3 Call for Reconfiguration of Professional Authority

In 1924, Boisen persuaded William A. Bryan, the superintendent of Worcester State Hospital to hire him as a full-time chaplain. 140 Bryan’s interest was therapeutic, not religious. The physician, Boisen reported, was not a “churchman,” yet he allowed that spiritual care might help patients recover. While Bryan received “a good deal of chaffing from his fellow superintendents” for permitting a full-time chaplain, he countered, saying “that he would be perfectly willing to bring in a horse doctor if he thought there was any chance of his being able to help the patients.” 141 And so, Boisen gained entry to the asylum, but this time as a professional instead of as a patient.

Though hospitals had employed clergy to lead worship services, Boisen’s role proved novel. 142 He offered religious services but also worked directly with patients “in which the religious problem...[was] an outstanding feature.” 143 Serving as a chaplain offered both “a contribution toward the solution of the problem of insanity and the service of the class of unfortunates,” like himself, that suffered from mental maladies. 144

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140 Alongside work at Worcester, Boisen taught at Chicago Theological Seminary, spending the fall quarter of each year there.

141 Boisen, The Exploration of, 9.

142 Chaplains had served at other institutions, such as prisons, for more than a century, but Boisen forged a new role as a full time chaplain at a mental hospital. Graber, 48, 61-2, 73-74.

143 Powell, 12.

144 Ibid., 9.
His goal remained making changes not only in institutions, but beyond. He focused on “charting and exploring the little-known country in which [patients] wander,’ and with gaining ‘some degree of mastery in the difficult art of helping the mind distressed,’ for ‘then and only then may we speak with authority in regard to the laws of spiritual life which affect us all.’”\textsuperscript{145} He saw spiritual distress as a universal condition.

Boisen staked a claim for role of clergy in the lives of the mentally ill as part of the overall caring process. He asserted, “only as mental disorder and religious experience are studied the one in the light of the other will it be possible to understand and to deal intelligently with either.”\textsuperscript{146} Another of Boisen’s recurring delusions—“his notion of a ‘family of four’—suggested a definite ‘plan of collaboration between medical and religious workers’” for the benefit of patients.\textsuperscript{147} Cooperation with medical professionals was essential, with each professional deploying different expertise. “The functional group of mental disorders are of peculiar interest to the religious worker; those with religious authority should attend to such inner conflict in hopes of ‘happy’ resolutions.” But, he also professed that in places, such as the care of mental illness, “the provinces of religious and medical workers overlap.” Attending to spiritual care was the only way to assure full healing. In addition, observation of the human condition by the theologically trained deepened the understanding the human condition for medical personnel to benefit from. Admitting that clergy had ceded care for sickness of the soul to medicine, Boisen

\textsuperscript{145} Ibid., 14.
\textsuperscript{146} Ibid., 11, n75.
\textsuperscript{147} Ibid., 21. Boisen did not assume, however, that clergy would adopt and use principles of psychotherapy. Medical and religious workers were to cooperate by using their individual competencies and sharing insight. Myers-Shirk, 39.
acknowledged the religious worker functioned as a “mere beginner.” But, they needed to step forward and claim the authority that was rightly theirs.\footnote{Boisen, “The Challenge to,” 22.}

Boisen’s passion extended beyond assessment of the religious significance of suffering and how religion and medicine should influence each other. He remained attentive to specifics of the life of faith, including how suffering and worship intersected. Aware of the “therapeutic significance” of Christian worship, his work included \textit{Hymns of Hope and Courage}, first published in 1937. He edited the hymnal for use in worship services at mental hospitals. Boisen hoped it anchored individuals in their faith, helping them find healing in Christianity, but he carefully avoided topics and tropes that might have proven harmful to the therapeutic purpose of worship. Reminders of the love and forgiveness of God, courage and action, and consciousness of sin alongside aspiration for a better life helped the sufferer. He avoided allusions to enemies, hearing voices, magic, and things that might intensify helplessness, isolation, and fear. Popular for many years, the hymnal’s fourth and final edition was published in 1950.\footnote{For Boisen’s discussion of his hymnal, Boisen, “The Service of Worship in a Mental Hospital: Its Therapeutic Significance (1948),” in \textit{Vision From}, 89-96.}

\textbf{4.7.4 Practicing what he Preached}

Once established in his work at Worcester State Hospital, Boisen trained others. In 1925, he recruited four seminary students for a program of clinical training. Participants worked ten-hour shifts, serving most of their time as attendants on the hospital’s wards. They also ran recreational program, observed patients experiences, and attended regular staff meetings. The students “used those encounters to observe patient behavior and draw conclusions about how religious experience figured in mental...
Five years later, thirty-five students had served as interns at Worcester. Most then entered parishes after graduation, which pleased Boisen. While he extolled the virtues of the mental hospital as a place of learning, the patient turned teacher remained convinced that the lessons learned there proved useful in congregational ministry. He felt that a “clinical year” for clergy was equally important, as the time physicians spent training in general hospitals before beginning private practice. Only with adequate training—including deep study of human suffering—could clergy minister effectively.

4.8 Legacy

Boisen recalled that during his first hospitalization some of his friends thought, “it was my duty to remain in the hospital as a patient for the rest of my life. Others assumed that something in the nature of simple manual work was all that would now be open to me.” Hopeful and determined, he proved them wrong. Despite, or perhaps because of, his experience with mental illness, Boisen never stopped reflecting on the religious meaning and the social context of human suffering. The optimistic clergyman hoped that Christians, especially ministers, learned to read experience with the “same reverence, respect, and depth, with which they read biblical texts. [That] “empirical theology” marked his teaching and writing, and shaped a generation of theologians and caregivers.

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152 Boisen, The Exploration of, 7.
153 Vision From, 9.
Boisen and his first students expanded clinical pastoral training. In January 1930, the Council for the Clinical Training of Theological Students (CCT) formally organized and developed standards for Clinical Pastoral Education (CPE). In 1932, he moved to Illinois to serve as the chaplain of Elgin State hospital, and to be nearer to Chicago Theological Seminary and Alice Batchelder. In 1938, Boisen left his chaplain duties at Elgin to teach and write fulltime about religion and mental illness. He returned as chaplain at Elgin for three three-year stints between 1942 and 1955. During that time, he consulted with clinical training centers around the country. In 1960, he finally shared his “own case record” and the depth of his suffering in his autobiography. He offered it as “a case of valid religious experience which was at the same time madness of the most profound and unmistakable variety.” In it, he attested that “the purgatorial fires of a horrifying psychosis” had allowed him to “set foot in his promised land of creativity” and thereby help others.

As a pastor and a patient, Boisen’s life experiences shaped his theological research. “He did not want to believe that his mental illness was organic or physiological and thus, by the medical standards of the time, incurable. Nor did he wish to believe that he was somehow morally degenerate or corrupt—the other possible explanation for his illness. He spent a lifetime arguing the opposite,” using both theological insight and scientific methods. His work convinced modern religious leaders that mental maladies

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154 The Rev. Dr. Seward Hiltner, a pastoral theologian at Princeton Theological Seminary and ordained Presbyterian clergyman, was one of Boisen’s first students at Elgin State Hospital.
155 Powell, 18-20.
156 Boisen, Out of the Depths, 9.
157 Ibid., 208.
158 Myers-Shirk, 21.
should be part of the church’s purview, and that in cooperation with medical professionals, that the spiritual and medical care of mental disease could improve.

That Boisen’s authority came directly from his illness, proved problematic for some. His three-week psychotic break in 1930 persuaded some of his CCT colleagues of his “unfitness to be involved in the Council’s training programs.” Despite that loss of confidence, over the course of the next few years, his productivity continued with nine articles, a revision of his hymnal for mental patients, and a book analyzing 173 case studies published. He continued to serve as a chaplain, publish, and teach. After his 1935 psychotic break, he was never again hospitalized.

Boisen wrote and taught for decades. His most significant influence stemmed from insight gained during his hospitalization and recovery, in a system that failed to provide for his needs. He felt impelled to change the system. Like Dorothea Dix, his final resting place was beside the patients to which he devoted his life. In 1965, his friends buried Boisen at Elgin State Hospital cemetery after an “unremarkable state hospital funeral.”159 His students helped found the Association of Mental Health Clergy, and at a gathering of that group decades later, Robert C. Powell, a professor of history and medicine, offered an overview of Boisen’s life and work. Powell hoped his account would remind a later generation of clergy attending to mental maladies of Boisen’s influence as their “founding father.” He called for his fellow mental health workers to take Boisen “completely seriously, and holistically, delusions and all.”160

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159 Vision From, 12.
160 Powell, 21.
4.9 Looking Forward

Boisen never wavered from the belief that treatment for mental distress must change. Many ministers benefitted from the additional training he pioneered, but as Boisen feared, pastoral use of psychological methods became the focus instead of more thorough theological reflection. Eventually, Clinical Pastoral Training expanded beyond mental hospitals to general medical centers. Some saw this as a productive widening; others knew it shifted the focus from the problems of mental illness. Perhaps social stigma affixed to mental maladies made general hospitals more palatable locations for ministerial training than asylums.¹⁶¹ As the twentieth century progressed, the mental hygiene movement and world wars brought some attention to mental maladies. For most Protestants, though, persistent stigma made it all too easy to focus attention elsewhere.

¹⁶¹ Even Boisen’s work proved vulnerable to stigma. The historian Norman Dain noted an inconsistency in his efforts. The Presbyterian clergyman hoped to help “the ‘worthy’ insane, those struggling to resolve problems of life and death and of instinctual drives (mainly sexual).” Boisen implied that those were the “kind of people whom religion can help; by implication they would tend to be educated and therefore middle or upper class,” individuals like Boisen. Absent from the pastor’s work were the unworthy, that he deemed beyond help. Dain noted “the idea that certain patients either deserved or could benefit better from treatment, religious or psychiatric, than other patients was of course not confined to the religious but was widespread in the psychiatric profession and society at large….The pious individual who became insane might be freed from blame and minimally stigmatized by his or her disorder; the reprobate was likely not to be thus spared.” Dain, “Madness and the Stigma,” 79.
5. Karl Menninger: Psychiatrist and Classical Protestant Moralist

“Rescue the perishing, care for the dying,
Snatch them in pity from sin and the grave;

...  
Rescue the perishing, duty demands it;
Strength for thy labor the Lord will provide.”
-- Fanny Crosby, 1869\(^1\)

“It is doubtless true that religion has been the world’s psychiatrist throughout the centuries.”
-- Karl Menninger, 1938\(^2\)

“The basis of all religion is the duty to love God and offer our help to His children—and psychiatry, too, is dedicated to the latter duty.” Karl
-- Menninger, 1964\(^3\)

5.0 Introduction

For the sake of those suffering with mental illnesses, the Rev. Anton Boisen sought cooperation between Christianity and medicine, and many took up the charge. After 1930, Dr. Karl Menninger, the most revered American psychiatrist of the twentieth century, led the way. A life-long Presbyterian, the Kansas physician’s advocacy spanned seven decades and, in many ways, exemplified the mainstream Protestant approach to mental illness in the twentieth century.\(^4\) For the betterment of the world, Menninger drew together scientific knowledge, deep compassion, a Calvinist sense of vocation, and a dose

\(^1\) From the hymn, “Rescue the Perishing,” by Fanny J. Crosby, in The Hymnal, ed. The General Assembly of the Presbyterian Church in the United States of America (Philadelphia: The Presbyterian Board of Publication and Sabbath School Work, 1921), 730.

\(^2\) Karl A. Menninger, Man Against Himself (New York: Harcourt, Brace, 1938), 449.


\(^4\) See the Introduction for a discussion of my use of the terms mainstream and Mainline. My use in this chapter follows my earlier practice and captures the group of Protestants that could be named as culturally normative. In this chapter, I attend to what came to be known, by the middle of the twentieth century, as the Protestant Mainline. (I exclude the groups labeled Evangelical or Fundamentalist.) Here, use the terms Mainline and mainstream to refer to the same group of believers. This chapter characterizes those who read The Christian Century, for example, and not the readership of Christianity Today.
of Christian realism. Tireless, he offered an active Christian witness in the face of mental maladies. Few Protestants, though, achieved Menninger’s level of involvement, even if they aspired to.

As comfortable talking to the readers of *Ladies Home Journal* and *The Saturday Evening Post* as to members of the American Psychiatric Association, “Dr. Karl’s,” commitment to help others took him around the globe as he treated patients, debated colleagues, trained professionals, and campaigned for his version of holistic psychiatric care. As a physician, Menninger attended to the suffering of the afflicted, and as a well-respected one, he was able to influence colleagues and the public as he raised awareness about the nature of mental illness and the need for proper treatment. In doing so, he saw little need to keep psychiatry and religion at a distance. For Menninger, they formed part of the same whole, responding faithfully in the face of suffering.

Menninger’s resume brimmed with accomplishments. In 1941, he served as president of the American Psychoanalytic Foundation. As a scientific consultant during World War II, he toured the European theater of operations to assess the need for psychiatric care among soldiers. In 1952, the trainer of physicians co-published a textbook, *A Manual for Psychiatric Case Study*. In 1965, the American Psychiatric Association awarded the doctor its Distinguished Service Award. That same year, he founded The Villages, Inc., a nonprofit organization that provided homes for children declared wards of the state, hoping to prevent their fall into delinquency. In 1979, along with his father and youngest brother, he was pictured in the Wilson Memorial Window of
Healing Arts Window of the Washington National Cathedral in Washington D.C. In 1981, President Jimmy Carter granted Menninger the Medal of Freedom, the nation’s highest civilian honor. Along the way, he published more than ten books and dozens of articles and gave countless lectures that delivered his opinions to psychiatrists, psychologists, social workers, clergy, and homemakers.

Menninger earned a living in medicine, but a sense of Christian vocation animated his endeavors. As a result, some heralded him as a “classical Protestant moralist.” Well into his old age, he “spoke out every chance he could against individual and social evil,” including “the abuse of children, [the care of] prisoners, [treatment of] Native Americans and the environment.” Menninger, like Mather, Rush, Dix, and Boisen before him, was a pious Christian, feeling God called him to attend to suffering and injustice. While never hiding his religious identity, Menninger’s claim to public authority came primarily from his training and practice as a medical man, not his faith. Regardless, Menninger used the national stage to advocate for the wellbeing of others, and of central interest to him was the welfare of those afflicted with diseases of the mind.

Other twentieth-century Christians held similar concerns. In the decades after World War II, many imagined roles for themselves in caring for mental maladies. As they investigated ways to help, Protestants readily accepted scientific solutions for mental illnesses. While psychiatry had experienced a lull in confidence around the turn of the

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5 Barnes Bart, “Cancer Stills Psychiatrist Karl Menninger at Age 96,” Houston Chronicle, July 19, 1990. Besides Albert Schweitzer, Karl was the only living subject represented in the cathedral’s stained glass windows.


twentieth century—both from the public and from their medical peers—the specialty reclaimed its respected position during the World Wars. With renewed approval, and with men like Menninger at the helm—figures that combined scientific expertise with Christian morality—willingness to let medical men lead the way in attending to sick minds seemed logical.

Although Mainline Christians ascribed nearly unqualified authority in matters of mental health to medical professionals, they hoped to cooperate with physicians to bring healing. Clergy sought advice from medical men and added psychological insights to their ministerial toolkits. Laity advocated for quality institutional care and helped launch new hospitals. Yet, by the 1960s, when individual believers sought help with severe—or even minor—mental distress, they found themselves more comfortable in medical offices than in clergy studies.

Many social issues occupied twentieth-century Protestants. Only for a short time, though, did mental illness appear a top concern. In the decade after World War II, support for mental health initiatives (more so than any other public health concern) filled the pages of *The Christian Century*, the publication that best reflected the Mainline ethos. By 1970, however, despite the past hopes of Mather, Rush, Dix, and Boisen, and notwithstanding Karl Menninger’s best efforts, other pressing public needs occupied clergy and laity. Perhaps, the authority of medical science was too entrenched and the social stigma that affixed to mental illness too powerful. By the century’s final decades, Protestants undertook other causes. And, when they did consider mental illness, they relegated themselves to caring from the sidelines.
The forces that shaped care for mental maladies in the nation evolved dramatically in the twentieth century. With attempts at professional cooperation came new wartime insights about mental distress, the popularization of psychoanalytic theory, national legislation of mental health provision, massive mid-century deinstitutionalization of mental hospitals, and the development of grassroots advocacy groups in support of sufferers. The voice of Karl Menninger proved audible throughout those changes and amidst the development of twentieth-century Protestant engagement. Using his story as a guide, this chapter explores the cooperative, optimistic, but ultimately detached, Christian response to mental illness from World War II through 1980.

5.1 A Faithful Son of Topeka Earns National Attention

Medicine and faith shaped the life of Karl Augustus Menninger (1893-1990), the first of three sons born to Charles Frederick and Flo Menninger. Five years before Karl’s birth, his parents moved to Topeka, Kansas, where Charles established a medical practice. That eastern Kansas town was home for generations of their descendents. Church involvement was central for the Menningers, and the family matriarch molded their devotion. Reared by Prohibitionist Mennonites, Flo Menninger found her way to the Presbyterian Church after teaching Bible classes there. In 1891, she convinced her husband to depart from his German Evangelical and Catholic roots and join Topeka’s First Presbyterian Church. For decades thereafter, the family was deeply involved in the church’s educational programs and worship life.⁸

Christian discipleship in the Menninger home proved a combination of study, devotion, and action. From his mother, who patterned a life of Christian reflection and

⁸ Flo Menninger taught Sunday school for decades and attracted a large following in Topeka. In 1935, the congregations’ Menninger Bible Classes, dedicated a memorial rose window in memory of her service and teaching.
service, Karl gained a “commitment to missionary benevolence” and a sense that the Bible should be understandable and “practical” in daily life. Flo also led the family’s “tradition of social service.” As part of their religious inculcation, she taught her young sons to sing the Fanny Crosby hymn, “Rescue the Perishing” and put her convictions into practice as she welcomed long-term boarders into the family’s home. In many ways, Flo’s approach to faith prefigured Karl’s future.

5.1.1 Finding a Vocation

The Menninger’s oldest son did not set out to become a psychiatrist, but the wishes of both parents eventually influenced that decision. As a young adult, he entertained religious vocations. Exploring that possibility, and to defray the costs of his undergraduate studies, Menninger preached at Sunday church services in nearby rural towns while enrolled at the University of Wisconsin. The pious college student also participated in the Student Volunteer Movement for Foreign Missions. In 1914, he attended the organization’s national convention where he pledged to put his talents to missionary use. Given his college activities and his mother’s influence, a ministerial or

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9 Lawrence Jacob Friedman, Menninger: The Family and the Clinic (New York: Knopf, 1990), 29. Karl Menninger felt the same way about medical insight – that it should be practical for use in daily life.

10 Ibid., 23, 26. The text of Rescue the Perishing demonstrates a sense of Christian discipleship focused on serving one’s fellow humans, with help and strength to do so provided by God: “(1) Rescue the perishing, care for the dying, Snatch them in pity from sin and the grave; Weep o’er the erring one, lift up the fallen, Tell them of Jesus, the mighty to save. (Refrain) Rescue the perishing, care for the dying, Jesus is merciful, Jesus will save. (2) Though they are slighting Him, still He is waiting, Waiting the penitent child to receive; Plead with them earnestly, plead with them gently; He will forgive if they only believe. (3) Down in the human heart, crushed by the tempter, Feelings lie buried that grace can restore; Touched by a loving heart, wakened by kindness, Chords that were broken will vibrate once more. (4) Rescue the perishing, duty demands it; Strength for thy labor the Lord will provide; Back to the narrow way patiently win them; Tell the poor wand’rer a Savior has died.” The Hymnal, 730.

missionary career called. Yet despite her evangelistic impulses, Flo found ministry “insufficiently practical” and hoped her son would pursue a career in business. Karl’s father held other dreams. Longing for company to quell the loneliness of serving as a sole medical provider (and with the Mayo family’s Minnesota Clinic as his inspiration), Charles pictured launching a family medical practice.

Karl’s eventual occupational pursuit pleased both parents. A career in medicine appeared an acceptable alternative to ministry for his mother and an answer to prayer for his father. While it was a secular career, faith still played a role in the choice. Karl’s sense that “the central purpose of each life should be to dilute the misery in the world” shaped even this more “practical” vocational path. As much as an occupation or job, medicine formed a vocation—a Christian mission and a “solemn responsibility”—for the oldest Menninger son.

While medicine led to Menninger’s renown, his Protestantism remained an influence. Menniner and his youngest brother William were lifelong members of the same Kansas congregation discovered by their parents before the turn of the twentieth century. As adults, Karl served on the church’s session and Will led the congregation’s

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12 *The Encyclopedia of Positive Psychology* First ed. (Malden, MA: Wiley-Blackwell, 2009), s.v. “Menninger, Karl.” (This quotation of Menninger’s is oft cited, but without attribution to a specific work.)

Boy Scout troop to national recognition.\textsuperscript{14} For many years, the elder brother taught a weekly Sunday morning class at the family’s hospital to adult patients that professed interest in theology, philosophy, ethics, and biblical study. And, although nurtured in Topeka, Karl’s Christian service extended beyond the walls of his home city—he lectured at seminaries and spoke at churches around the country. Protestant faith and practice served as an anchor throughout Karl’s life.

5.1.2 An Obligation-Imbued Lifestyle: Dr. Karl's Religious Beliefs

Menninger gladly identified with his “fellow Presbyterians” and was happy to talk about his religious beliefs. He professed belief in God and prayer, yet in public statements, lived-faith seemed of higher importance to him than particulars of Christian doctrine. Writing in the \textit{Journal of Presbyterian History} in 1981, the Menninger Foundation professor, Dr. Paul Pruyser, painted Menninger as a devout, intellectually curious believer. To locate him in the American theological landscape, he listed the doctor’s long-held periodical subscriptions to \textit{The Christian Century}, \textit{Theology Today}, \textit{Commonweal}, and \textit{The Biblical Archeologist}.\textsuperscript{15}

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\item[\textsuperscript{14}] First Presbyterian Church of Topeka, “History of First Presbyterian” http://www.fptopeka.org/docs/History_of_First_Presbyterian.pdf (accessed January 4, 2012). See also Pruyser, 70.
\item[\textsuperscript{15}] Pruyser, 60. The oldest Menninger worked and worshiped in an increasingly diverse Protestant landscape. His beliefs and practices—not to mention his subscriptions to Christian periodicals—placed them squarely in the Protestant Mainline. Those twentieth-century believers were located in denominational clusters including the American Baptist, Congregational (UCC), Disciples, Episcopal, Lutheran (ELCA), northern Methodist, Reformed, and Presbyterian (PCUSA) churches. Descending from early twentieth-century Protestant liberalism, in the face of a rapidly changing world, Mainline Protestants viewed God as transcendent and at work in and through history and nature. They understood Christ as a radical incarnation of God, the Bible as the source of faith (although not infallible), and culture as (at least) selectively normative.

Protestants like Menninger shared an “openness, if sometimes cautious, to new ideas in the scientific, social and ethical realms.” They tolerated diversity “regarding theological, social, and political opinions among clergy and membership,” and viewed social progress as beneficial. Similarly, they understood creation—all of creation—as inherently good and given by God to humanity. Mainline Protestants, however, did find sin and evil in the world. They recognized sin in both individuals and institutions and understood it as contrary to God’s ordering of creation. To combat evil and to enact their
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The fact that Christian convictions shaped the psychiatrist’s medical work was no secret. Pruysr indentified three main influences of Presbyterian faith in Menninger’s life. First, he refused to shy away from the presence of evil in the world. As a Calvinist, he revered the Old Testament for its thundering laments, lyricism, prophetic voice, and especially its “realistic portrayal of evil.” Menninger, Pruysr argued, was “both theologically and psychologically first of all a realist who knows...that man has an uncanny proclivity toward an unduly flattering self-perception, and worse: toward vice, crime, violence, hatred, vengeance.”

Pruysr speculated that that Calvinist assessment of sin and evil “almost certainly aided [Menninger] in embracing with great vigor,” Sigmund Freud’s controversial thesis that “a death instinct must be postulated to account for otherwise puzzling phenomena of self-destructiveness.” Later in his career, that inclination spurred Menninger to write his 1973 lament, *Whatever Became of Sin?*, where he decried the disappearance of sin as a category deployed in religious and public life.

Second, alongside a recognition of evil, love animated Menninger’s thinking. The doctor was a realist, but Pruysr argued that “his Calvinism, insofar as it derives from the Pauline writings (especially 1 Corinthians 13),” prepared Menninger “for seeing love not only as a desirable condition, but as a forceful cosmic reality.” Menninger held that love should dictate the shape of human relationships, including the relationship between physicians and mental patients. He saw the tension between love and hate as what “made human life so ambiguous, so turbulent, so contradictory.”

Belief in the power of love

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16 Pruysr, 63.
17 Ibid., 64.
18 Ibid.
19 Ibid.
allowed him to remain full of hope despite his ready acknowledgement of evil and suffering in the world.

Finally, Pruyser argued that the “two Calvinist motifs” of vocation and curiosity shaped Menninger’s “obligation-imbued lifestyle.” While Pruyser relayed no knowledge of Menninger’s specific views on the doctrine of election, he observed in the whole Menninger family “a sense of being elected, if not to God’s grace then to the shouldering of duties.” Karl, his parents, and his brother Will “acted as if they were called, not only to perform meliorative work, but to do so with initiative and zest, even with a degree of pleasure in overcoming obstacles.” That sense of energy-infused divine vocation came with the compulsion to produce change in people’s attitudes, a mission Pruyser equated with “the smashing of idols.” Menninger’s intellectual ability and knack for framing situations innovatively aided that undertaking. For example, at times when the culture around him looked with “fear, hopelessness and…pity at the seriousness” and irreparability of mental illness, “Menninger call[ed] attention to the healthiness of the patients’ struggles” and asserted that health and illness existed on a spectrum and that all humans were ill to a degree.20

As a Mainline believer, Menninger presumed God was at work in the world, but he spoke mostly about the benefits of religious involvement rather than divine activity. For example, Menninger valued worship—for himself and others. For those living with mental maladies, the doctor noted the therapeutic value of ritual, hymn singing, and prayer.21 Thinking of patients and his colleagues, he asserted, “going to church appeals

20 Ibid., 66.
to many psychiatrists as a prescription for patients, if not for themselves.”

Using psychological language to profess the value of worship (which he referred to as “group assemblage and some kind of formal ritual”), the doctor commended the “mutual stimulation, reinforcement, and encouragement” present in congregational worship. He found “singing together” had “great and obvious a value in furthering interpersonal linkages and enthusiasm in a common purpose.”

According to Menninger, routine religious practice aided emotional health. The call of faith and the inspiration of Christian hope proved ever-present in the Menninger family’s life and in Karl’s work.

5.1.3 A Career Comes into Focus

Flo Menninger’s Christian outreach inaugurated not only her oldest son’s faith, but also his medical specialty. Many of the individuals Flo welcomed into the family home were “mentally unbalanced” and Karl saw the effects of mental distress first hand.

Later, formal study provided scientific tools for attending to the suffering he witnessed as a child. While a student at Harvard Medical School, a lecture about Freud’s ideas given by Louisville Emerson, a founding member of the Boston Psychoanalytic Society, deepened his interest in matters of the mind. An internship at the Kansas City General Hospital, just after his graduation, cemented his vocational pursuit. Menninger felt drawn to patients with neurological ills, many of them “derelicts” brought to the hospital by police because they proved unable to survive without assistance. In 1918, he

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23 Ibid., 11-12. Menninger went on to cite the work of Alfred B. Haas, professor of practical theology at Drew University who wrote about “the therapeutic value of hymns” in Pastoral Psychology. In that article, Haas pointed out “that, because of their rich emotional associations, hymns reduce anxiety, alleviate a sense of guilt, strengthen inner resolves, bring comfort, and divert self-preoccupation.”
24 Friedman, 29.
returned to the Atlantic seaboard and put his interests and skills to use in the residency program in neuropsychiatry at Boston Psychopathic Hospital.\textsuperscript{25}

The newly minted doctor’s stay on the east coast ended shortly thereafter, and in 1919, he returned to Topeka to enter medical practice with his father. A year later, Charles Menninger’s dreams for a family medical practice came true when he and Karl formed the Menninger Diagnostic Clinic for the practice of general medicine and psychiatry. At first, the clinic treated a variety of ailments. A broad reach allowed both men to earn a living, but Karl continued to seek out cases of mental distress, and travelled around Kansas to treat patients in need of neuropsychiatric care. While carving out a new specialty, not all Topekans welcomed the junior Menninger’s interests. In the first years after the clinic’s launch, “alarmed citizens went to court to stop him from operating a ‘maniac ward’ at the local hospital.” Undeterred, for a time the eager young physician smuggled in patients, often “disguising them under erroneous diagnoses.”\textsuperscript{26} Despite early reticence, decades later, the clinic emerged as one of the largest employers in town and a source of local pride.

While settling in in Topeka, Menninger continued to feel the tug of missionary service. In 1921, he reflected, “I am not altogether relinquishing the hope that I may sometime develop neuropsychiatric work in China.”\textsuperscript{27} Eventually, though, demands in Kansas and around the country satisfied his vocational goals. Six years after returning to Kansas, he formalized efforts to care for mentally ill patients when the clinic opened a residential psychiatric hospital, the Menninger Sanitarium. Situated on a twenty-acre

\textsuperscript{25} Ibid., 29-30. After his return to Boston, Menninger met his mentor, the Dr. E. E. Southard and worked with the psychoanalysis Smith Ely Jelliffe.


\textsuperscript{27} Friedman, 44.
farm on Topeka’s northwest side, the new facility admitted thirteen men and women suffering with “nervous and mental diseases” and provided optimistic and attentive psychiatric care, not merely sequestered institutionalization.²⁸ In 1925, the facility branched out to serve another population with the opening of the Southard School for emotionally disturbed children. That same year Menninger’s youngest brother Will joined the family practice.

Karl held that mentally ill Americans deserved good care. He found it “painful,” and “paradoxical” that in America, a “rich, busy, idealistic, sympathetic, growing country, that the physically ill garnered more compassion than the mentally distressed, despite their “ofttimes greater suffering.” “Let a man be taken to a hospital because he has a broken leg, crying out with pain when he tries to walk,” Karl observed, “and he will be surrounded by nurses, physicians, and technicians and within a few hours, his suffering eased and his leg so held that it can begin to mend.” But, he reflected, “let a man’s mind begin to wander or his memory to fail, his perceptions to become confused or his fears to overwhelm him, and he is likely to be conveyed in a dilatory fashion through the county jail…to the wards of what was once called the ‘asylum.’” About the plight of the mentally ill, Menninger lamented, “few know, few care, and fewer do anything about it.”²⁹ That injustice motivated his efforts.

5.1.4 Growth and Prominence

A passion for helping spurred further institutional growth. In 1933, the American Medical Association approved the Menninger Sanitarium as a provider of psychiatric residency training, and in the following decades, the Menningers launched educational

²⁹ Menninger introduction to Deutsch, 16.
initiatives for a wide range of professionals. From 1940 to 1951, for example, their facility operated training programs in clinical psychology, social work, marital counseling, and pastoral care and counseling. In 1935, Fortune recognized the clinic as one of a small group of new, innovative facilities. Among the way, the family physicians recruited other professionals to join their treatment team.

Karl’s publications contributed to the clinic’s prominence. His first book, The Human Mind (1930), for example, proved popular both among medical professionals and with the public. The text defined mental illness, discussed symptoms, considered causes, recommended treatments, and advocated for the broader usefulness of psychiatric theory for a “healthier-minded” humanity. In a review of the volume’s second edition, the University of Kansas professor of psychology J.F. Brown noted that with nearly two hundred thousand copies in circulation, it “must have been read by nearly all members of the [psychological] profession since it’s appearance” eight years earlier. Broad scholarly readership was impressive for a text created out of class lectures on mental hygiene given to freshman at Washburn College, but the book’s accessible tone meant that the Literary Guild selection became the best-selling mental health volume in American history. Karl continued to publish for decades, and, whether writing about psychiatry or social issues, his writing kept the doctor in the public eye.

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30 Friedman, xi.
31 During the Nazi era, many Jewish European psychoanalysts who had fled their home countries settled in Topeka to work at the clinic.
32 J. F. Brown, “The Human Mind,” Psychological Bulletin 35, no. 1 (1938), 50. Brown also named the text as a “popularization of contemporary psychiatry, conceived with artistry and executed with accuracy and grace,” 52. By 1940, in addition to his work at the University of Kansas, Brown served as Chief Psychologist at the Menninger Clinic.
33 Friedman, 56.
34 Karl next two books, Man Against Himself (1938) and Love Against Hate (1942) outlined his sense of Sigmund Freud’s “most important message—man’s tragic intrapsychic struggle.” Ibid., 120. Friedman argued that as a result of his optimism, Karl failed to understand fully the darkness and depth of
Faithfulness, not fame, motivated the oldest Menninger son’s work. Though he garnered international notice, attending to suffering retained a larger purpose. When he toured east coast psychopathic hospitals in the 1910s and 20s, the care provided there impressed him. Steep fees, however, meant that the hospitals served only a small number of wealthy patients. Menninger hoped to offer top-notch care, but to a much wider population. And, by all accounts, he succeeded. In 1935, he “boasted that his own hospital lacked the expensive physical facilities of his private competitors but that his staff development and treatment programs were better.” That same year, despite the impact it had on profitability, he opened a free clinic for needy Topekans. In 1941, father and sons formed the Menninger Foundation, giving their individual assets to the Foundation in order “to be of greater service to the nation and the world.”

In response to a sense of Christian vocation, Menninger and his family developed competencies that fostered worthy care for as many as possible.

The aftermath of war opened avenues for additional expansion. Following World War II, many veterans sought psychiatric services, and the Menninger Foundation filled the need. In 1946, working with the federal Veteran's Administration, Menninger established a psychiatric training program at a former Army hospital in Kansas. Within a

Freud’s “death instinct.” With his stress on the power of love, Menninger also departed from Freud’s focus on the pervasive influence of “libidinal sexuality.” See ibid., 121-2. The Vital Balance (1963) “argued for the replacement of rigid psychiatric classifications with more dynamic perspectives.” Ibid., 310. Moving toward more general social advocacy, his The Crime of Punishment (1968) explored the nation's criminal system and examined what he saw as the “strange paradox of social danger, social error, and social indifference.” There he also challenged the incompetence of the nation’s justice system, arguing, “the punishment of incarceration in our penal system is a crime in itself...because it is self-defeating and not socially protective.” Robert Wallerstein, “Karl A. Menninger, M.D.: A Personal Perspective,” American Imago 64, no. 2 (2007), 217.

35 Friedman, 41.
36 Ibid., 142. The Menningers then turned the free clinic over to the city of Topeka, but Karl complained, “in our actual work we labor with a few rich individuals...whose personal salvation or lack of salvation will not make very much difference.” He had hoped his efforts would reach more broadly.
few years, internal estimates indicated “5 percent to 7 percent of all the psychiatrists in the U.S. and Canada were trained at Menninger,” and by the mid-twentieth century, “the Menninger School of Psychiatry became the largest training center in the world.”\(^3^8\) In 1949, 100 of the 800 psychiatric residents in the country had trained in Topeka.\(^3^9\) What began as a spark of faith around the family dinner table grew into a wide reaching medical organization.

5.2 Twentieth Century Mental Institutions and Treatments

5.2.1 Public Facilities and the Burden of Chronic Patients

Though a handful of private clinics for mental patients, like the Menningers’ Kansas hospital, emerged in the first decades of the twentieth-century, nearly ninety-eight percent of the nation’s institutionalized patients remained in public facilities. By 1940, state mental hospitals housed 410,000 Americans, and 59,000 additional patients lived in veterans’, county, and city hospitals.\(^4^0\) While founded as restorative institutions, those facilities were rarely—any longer—sites of productive therapeutic care. States continued to fund asylums, though, because no alternatives appeared to “meet the needs of [that] disabled population.” Deteriorating physical plants and insufficient staffs meant that for most, hospitalization brought containment more than a cure.\(^4^1\)

\(^3^8\) Ibid.

\(^3^9\) Wallerstein, 214. The Menningers’ facilities earned a loyal following, not only among patients, but also with employees. Seventy-five years after father and son began their joint medical practice, the state-of-the-art Menninger Foundation and Clinics employed over 1,000 in Topeka and Kansas City. Reflecting on his twenty-five year career as a psychologist at the Menninger Clinic, the Dr. Ira Stamm noted, “the commitment many staff made to [the Menninger Clinic] was akin to a religious or missionary calling. Menninger staff would settle in Topeka, raise their families here and devote their careers to the care of those with mental illness who sought treatment at Menninger.” Given their clear vision, the Menninger men easily recruited others to join in their cause. Ira Stamm, “Menninger Has a Distinguished Past but what is its Future?,” The Topeka-Capital Journal Online http://cjonline.com/indepth/menninger/stories/010602_bus_menninger.shtml (accessed February 14, 2012).


\(^4^1\) Grob, The Mad Among Us, 165-166.
In the first four decades of the century, the majority of the patients admitted to state hospitals were severely mentally ill, diagnosed with ailments like schizophrenia and manic-depression. Those suffering from paresis (the third stage of syphilis, which brought neuropsychological symptoms) also occupied hospital beds, as did sufferers with somatic conditions including epilepsy, alcoholism, mental deficiency, and pellagra (a disorder caused by a deficiency of niacin). Still others were institutionalized as the result of behavioral symptoms without identifiable somatic causes. Through the end of World War II, the nation’s mental institutions also accommodated a growing number of chronic and elderly patients, citizens relegated to hospitals when alternative methods of care, like almshouses, disappeared. In 1920 in New York, for example, 18 percent of first admissions to state mental hospitals were diagnosed as psychotic because of senility or arteriosclerosis. By 1940, that category accounted for nearly 31 percent of all first admissions. By the 1930s, chronic and aged patients occupied nearly 80 percent of the beds in American mental hospitals. With few exceptions, causes and cures remained as elusive as they had for centuries. To be sure, some patients in public facilities fared well, but more often than not, sufferers experienced impersonal care at best, and abusive treatment at worst.


43 Eventually, paresis and pellagra proved treatable. “The former was the tertiary stage of syphilis in which massive damage to the central nervous system and brain resulted in insanity; the latter, a disease of dietary origins, in many cases caused bizarre and abnormal behavior.” See Grob, The Mad Among Us: A History of the Care of America’s Mentally Ill, 144.
5.2.2 Public Exposés

In the 1940s, details of horrible conditions reached many Americans. In May of 1946, the journalist Albert Q. Maisel’s, “Bedlam 1946,” exposé in *Life* magazine compared the conditions in two state institutions to those in Nazi concentration camps. Shoddily clad or naked, patients, he revealed, were fed “starvation diets” and crammed into “hundred-year old firetraps” where some were forced to sleep on the floor. Others were restrained by “thick leather handcuffs” and in poorly lit rooms “reeking with filth and feces.”44 Similarly, when the journalist Albert Deutsch visited the Philadelphia State Hospital for Mental Diseases, he found it housed 6,100 patients, seventy-five percent over its normal capacity. Although the American Psychiatric Association standards called for 1,100 attendants for a patient population of that size, only sixteen served. The rest of Deutch’s account in *The Shame of the States* (1948), sounded eerily similar to Dorothea Dix’s observations a century earlier. Buildings swarmed “with naked humans herded like cattle and treated with less concern.” A “fetid odor so heavy, so nauseating that the stench seemed to have almost a physical existence of its own” pervaded the filthy, bug-infested hospital.45 More than just a muckraker, Deutsch advocated for reform and voiced his concerns to local and national legislators hoping to bring change by restoring institutions as sites of therapeutic treatment, and not just custodial care.

Occasionally, media coverage pointed to bright spots amid harsh realities. In 1946, for example, Mike Gorman, a reporter for the *Daily Oklahoman* and health lobbyist contrasted poor conditions in Oklahoma state hospitals with the superior care provided at

44 Albert Q. Maisel, “Bedlam 1946: Most U.S. Mental Hospitals are a Shame and a Disgrace,” *Life*, May 6, 1946, 103.
45 Deutsch, 41-42.
That same year the writer Mary Jane Ward’s *Snake Pit*, an autobiographical novel about a young woman hospitalized after a nervous breakdown, described her miserable stay at a state institution but did so alongside hope in professional competence to treat mental disease. Nonetheless, stagnating hospital populations and deteriorating conditions proved debilitating for both patients and physicians.

5.2.3 Hopefulness amid Despair: New Physical Treatments

Notwithstanding the realities of subpar care, in the years after World War I, a “spirit of therapeutic innovation” generated some optimism. Newly discovered treatments including malaria fever therapy, insulin and metrazol shock therapy, and prefrontal lobotomy warranted hope for some patients. Early twentieth-century psychiatrists also deployed new drugs—paraldehyde, sulphonal, trional, veronal, chloralhydrate, bromides, hyoscine, and morphene—to calm and restrain agitated patients.

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47 *The Snake Pit* was released as a motion picture of the same name in 1948. Starring Olivia de Havilland, in 1949, it won one Oscar and was nominated for five more.
48 Fever therapy developed from the observations of the Austrian psychiatrist, Julius Wagner-Jauregg, who found that “mental symptoms occasionally disappeared in patients ill with typhoid fever.” By the 1930s, fever therapy (caused by infecting patients with malaria and other viruses) became dominant in the treatment of paresis. Shock therapy, introduced by the Viennese physician Manfred Sakel, and refined by Sakel between 1933 and 1935, involved injecting patients with large enough doses of insulin to induce a hypoglycemic state, which seemed to improve the mental condition of patients. At the same time, Hungarian physician Ladislas von Meduna, having observed that epileptic patients were rarely schizophrenic, began inducing convulsions with camphor and then metrazol. Both forms of shock treatment gained popularity in the U.S. between 1937 and 1940. See Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 294-299.

Even such harsh treatments, with unknown effectiveness, seemed worth using on patients otherwise destined for a lifetime of institutional care and by physicians in search of worthwhile medical innovation. By 1940 electroshock therapy, because it appeared to minimize the risk of injury to patients, began to replace insulin and metrazol shock therapy. Lobotomy involved severing “fibers of the prefrontal areas from the rest of the brain” through the removal of a small piece of skull. The procedure seemed to reduce symptoms, but also brought lasting side effects, including the loss of “some spontaneity, some sparkle, [and] some flavor of the personality.” See ibid., 304-305 for a fuller discussion of the development of, and objections to, prefrontal lobotomy.
patients. Those therapeutic and pharmaceutical interventions not only offered hope to patients, but also promised doctors treating mental maladies the ability to keep up with their medical peers that specialized in biological ailments. The promise of cures through new treatment, however, failed to bring lasting change. Used only sporadically, and without standardization in treatment protocols (in part because psychiatrists disagreed about their effectiveness and safety), new medical technologies largely failed to improve care for the mentally sick. And, innovations proved difficult to deploy extensively in overpopulated hospitals.

5.2.4 Moral Treatment Abandoned

By 1943, with public funds diverted to support war and recovery from economic depression, care had worsened. Staffing levels in state institutions dropped again and physical plants deteriorated further. As a result, use of the “moral” treatments popular in the prior century, therapies that “involved the creation of a new environment in order to alter the circumstances that had given rise to mental disease and its physiological manifestations,” faded. Dispensing such personal and labor intensive care proved unmanageable, at least in large, public facilities. Menninger and his family, however, tried to balance principles of past moral treatment with new medical theories.

49 Ibid., 292. Other novel treatments emerged, including the “focal infection theory of mental illness” in which “patients had allegedly infected teeth removed or underwent tonsillectomies” to improve their mental health. Protestants spent little time, at least in the Christian Century, discussing pharmaceutical treatments.

50 Ibid., 291.

51 A 1946 study by the Group for the Advancement of Psychiatry found doctor-patient ratios of 1 to 500 and nurse-patient ratios of 1 to 1,320. Grob, The Mad Among Us, 170-171.

52 See my chapters 3 and 4 for discussions of “moral” treatment, which names a standard of humane care, and not an explicit attempt to inculcate morality. For Karl Menninger’s explanation of moral treatment, see Karl A. Menninger, The Vital Balance: The Life Process in Mental Health and Illness (New York: Viking Press, 1964), 67-71.
5.2.5 The Menninger Treatment Protocol

Menninger broke medical ground in his first years of practice. He identified, for example, the reversibility of depressive and schizophrenic illnesses triggered by influenza. And, as he treated his first patients in Kansas, the doctor realized that biological treatments helped many patients suffering emotional distress, but not all of them. Victims of the later stages of syphilis, for example, benefitted from the newly discovered drug known as Salvarsan and 606. Cases with no detectable organic origins, however, presented a challenge. Having “prodigiously” studied the theories of Freud and read the works of Freud’s adherents, Menninger found hope for those patients in emerging psychoanalytic techniques. With the right care, he was optimistic that nearly all patients could recover, and the “passage of years and the extension of experience” only deepened his hopefulness.53

Although Menninger held firm opinions about treatment protocols, in time, his brother William most strongly influenced that Menninger Clinic’s approach to care, but always with his older brother’s approval, or at least acquiescence.54 The historian Lawrence Friedman found four distinct elements that shaped William’s, and thereby the family clinic’s, holistic formulation of mental health care. First, William Menninger deployed the moral treatment approaches of his nineteenth century predecessors including Dorothea Dix, Thomas Kirkbride, and Samuel Woodard. Menninger

53 Friedman, 46-47, 52. Karl Menninger met with Freud, briefly, during a 1934 trip to Vienna. Despite his devotion to Freud’s theories, Menninger thought the Austrian mistreated him by being dismissive and failing to recognize Menninger’s grasp and use of Freud’s work. Ibid., 110-111. Karl A. Menninger, The Human Mind, Second ed. (New York: Alfred A. Knopf, 1942), vii. In 1945, Menninger visited the Buchenwald concentration camp just twelve days after it was liberated, and the horror what he saw tempered his enthusiasm for full-scale adoption of European psychoanalytic theory. Friedman, 130-1.

54 As Karl’s speaking schedule increasingly kept him away from Topeka, managing the day to day operations of the Clinic transferred to William. I discuss details of Karl’s theory of the origins of mental illness below.
operations remained small enough for that attentive, individualized approach to care to succeed. In a well-controlled hospital environment like the Menninger Clinic, for example, patients “could learn to cope with the past associations” that contributed to mental illness. Working closely in trusted relationships with staff, patients “would learn to master” their emotions in a “protected, instructional setting.”

Second, drawing on the work of the Swiss-born psychiatrist Adolf Meyer, Will Menninger rejected assumptions that mental illness stemmed from hereditary defects or from cerebral lesions. Instead, Meyer’s “psychobiological” methods took into account the relationship between the patient and his detailed social environment.

Third, the importance Charles Menninger placed on working with good medical assistants undergirded William’s sense of the importance of interpersonal relationship in the provision of care.\(^{55}\) Finally, suspicion of the new pharmaceutical and surgical treatments led William, like Karl, to favor psychoanalytic approaches based on Freud’s theories.\(^{56}\) Altogether, those influences shaped a scientifically informed, community-like “milieu therapy” at the Menninger Clinic. With a treatment protocol established, their earlier religiously based missionary drives made their clinic a “missionary outpost within the ‘new psychiatry,’” and a counterpoint to custodial care.\(^{57}\)

### 5.2.6 Christian Institutions

Karl Menninger took part in a larger conversation. He and his family were not the only Protestants to provide alternatives to public institutions. While the majority of

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\(^{55}\) The therapeutic philosophy articulate in William Menninger’s “Guide to the Order Sheet” “committed everyone to being part of the treatment, including housekeeping staff, aides, cooks, and groundsmen. Treatment was a 24-hour-a-day process that involved every employee,” and not just physicians. Roy W. Menninger, “The Legacy of Menninger,” *Bulletin of the Menninger Clinic* 66, no. 4, 354.

\(^{56}\) Friedman, 62-65.

\(^{57}\) Ibid., 90.
mental patients received treatment in public facilities, private hospitals—including some of the nation’s original, church-founded intuitions—also offered care.

### 5.2.6.1 Alternatives to Secular Care

Less burdened by chronic populations and motivated by religious convictions, a handful of Christian asylums retained a focus on moral treatment methods. Pine Rest Christian Hospital in Cutlerville, Michigan serves as an example. Founded in 1910 by members of the Dutch Reformed tradition, Pine Rest’s small size and commitment to “Christian mercy” enabled its adherence to moral treatment. Based on the conviction that “Christ’s concern for undeniable dependents—widows and orphans, together with the blind, deaf, and demonically plagued—signaled a clear and continuing obligation to nurse and, if possible, cure such unfortunate people,” church leaders felt called to provide an alternative to the secular care provided in state hospitals.\(^{58}\)

A church-run hospital that included “spiritual counseling” as part of treatment efforts, Pine Rest offered an alternative to the incomplete and “neglectful care” reported in state facilities.\(^{59}\) The hospital admitted twenty patients in the summer of 1912, and by 1940, it accommodated 270. True to the philosophy of moral treatment, patient regimens included occupational therapies ranging from housekeeping to maintenance of the hospital’s 220-acre farm; the routine also included weekly worship and pastoral counseling. Sure that “all disease and suffering originated in humanity’s corporate

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\(^{59}\) Despite largely falling out of favor, suspicions of demonic influence lingered. With plans for Pine Rest underway, the Dutch Reformed clergyman, Jon Keizer concluded that “mental problems…frequently resulted from spiritual anxieties—fears of having sinned beyond the power of God’s forgiving grace.” Such “a weakened state,” he held, made “the patient especially vulnerable to the work of Satan.” Ibid., 13, 15. Marking some instances of mental distress as religious in nature, and thus the responsibility of the church (and not medicine), was a pronouncement similar to that offered by Anton Boisen.
rebellion against God,” but equally certain that “God’s grace and Christ’s example demanded his disciples exert every effort to alleviate the consequences of sin,” believers responded with alacrity.60

5.2.6.2 Mennonites Act, Protestants Cheer from the Sidelines

Though motivated by different circumstances, American Mennonites forged a similar path, and one commended by other believers. As pacifists, Mennonites declared conscientious objector (CO) status during World War II and served as aides in public mental hospitals as an alternative to combat duty. In the institutions where 1,500 Mennonite COs labored, they observed “damp and peeling plaster walls and dripping ceilings, rotten plumbing, filth-soaked wooden floors, dungeon-like bedrooms, inadequate sanitary facilities” that were “the normal situation” in such hospitals.61 They also encountered overworked and undertrained staff members that were negligent and violent in their provision of care. Mennonite COs doubted those realities maximized the chances of patients regaining health.

Horrified by deplorable conditions and compelled by their faith, Mennonites responded quickly. During the War, they worked to improve conditions in state hospitals, and post-war they opened church-run facilities. Elmer Ediger, a founder of the

60 Other religions groups continued or launched similar care efforts. The Christian Sanatorium in Patterson, NJ opened in 1917 after deacons from Reformed and Christian Reformed congregations hoped to “create a facility that would be guided by Christian principles and provide physical, mental, and spiritual care for those with mental afflictions, regardless of ability to pay.” See, “Our History”, Christian Health Care Center http://www.christianhealthcare.org/our_history.html (accessed February 23, 2012). The Seventh-Day Adventist and psychiatrist, George T. Harding, II, after years of private practice, opened the Indianola Rest Home for women in 1916. In the 1930s, he launched the Harding Sanitarium. Harding staff members were influenced by Karl Menninger’s writings and trained at the Menninger Clinic. See George T. Harding IV, "Adventists and Psychiatry - A Short History of the Beginnings," Spectrum 17, no. 3.

Mennonite Mental Health Services, explained that, in the face of suffering, COs felt called by God to respond, sensing that “if God has exposed us to this need and we don’t do anything, how can we expect anyone else to do so?" They understood their response to the plight of the mentally ill as peaceful, loving, and Christ-like. Other Protestants took note of the work of those COs, and urged all of “Christian America” to take up the work they had begun “in behalf of the mentally ill.” While Mennonite efforts garnered praise from more mainstream believers, their witness failed to inspire institution building by other denominations.

5.2.7 Protestant Advocacy

Some Protestants, though, turned their attention to patients in state facilities, an impulse that matched Karl Menninger’s desire to attend to suffering. Albert Q. Maisel’s *Life* feature, which included pages of “ghastly photographs,” prompted Protestants to claim, “with continued publicity of this sort, an aroused public opinion is certain to demand sweeping changes.” Christians, and especially clergy, should be aware of

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63 Mennonites opened seven additional mental health centers between 1949 and 1967. Planning for the first Mennonite hospital, Brook Lane, began in 1946. It opened in 1949, located on a farm outside of Hagerstown, MD. See ibid. The third Mennonite hospital, Prairie View, opened in Newton, Kansas in 1954. “They discovered,” a correspondent for the *Century* reported, “that mental patients responded to their care, and that Christian love was a prerequisite which had apparently been lacking in the care and treatment” at other facilities. “Mennonites Aid Mental Therapy,” *The Christian Century*, May 5, 1954, 566.

64 “Invite Churches to Aid Mentally Ill,” *The Christian Century*, April 24, 1946, 517.


66 Similarly, the editors of the *Christian Century* argued, “in the light of these current revelations, no Christian minister with a member of his congregation in a mental institution should rest until he knows what the conditions are in that institution and whether or not they call for reform.” The editorial urged clerical action: “In the light of these current revelations, no Christian minister with a member of his congregation in a mental institution should rest until he knows what the conditions are in that institution and whether or not they call for reform.” “Growing Outcry Over Mental Hospitals,” *The Christian Century*, May 15, 1946, 611-12.
needed changes and, more important, take action. Public institutions, after all, were well within the purview of presumed Protestant responsibility.

Demonstrating that sense of ownership of state-run medical institutions, a 1946 *Christian Century* article titled “State Hospital Scandal” began with reference to “our state psychiatric hospitals.” Both mistreated patients and overworked staff members drew the concern of the author, the Rev. John M. Gessell, an Episcopal priest and later professor of Christian Ethics at The University of the South. Outraged, he lamented the “general indifference to the plight of these unfortunates” and implored concerned readers to “insist that state legislatures make sufficient appropriations for the care of the mentally ill.” Gessell rooted his deep concern in two places. He pointed first to the societal cost of inadequate care measured in broken homes, ruined businesses, and the loss of gainful employment. Only after expressing those more secular concerns did he cite direct religious motivation, reminding his readers, “our Lord demonstrated repeatedly his concern for mental health,” and thus, so should modern believers. The clergyman also hinted at an “intimate relationship between religion and mental well-being.”

In addition to advocating individual action, Gessel called for congregations to play a role in “fostering understanding of mental health in the community” and in advocating alongside secular organizations for adequate care. In his desire to see hospitals transformed into “places of refuge,” Gessell pointed readers toward involvement with advocacy organizations such as the National Mental Health Foundation.67 Offering education and a means for getting involved, those groups

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67 Gessell, 1245-1247.
provided a logical locale for Christian participation. While not acting from religious motivations exclusively, Protestants like Gessell urged advocacy, education, and direct involvement in care in the face of mental illness. Less clear, however, was the breadth of response that such pleas motivated.

A number of public health concerns attracted Protestant attention in the twentieth century, including polio, leprosy, tuberculosis, and alcoholism. Measured by frequency of coverage in flagship periodicals, however, none garnered as much interest as mental health. Mentally ill patients, they observed, occupied more than half of the nation’s hospital beds. Acknowledging the vast number of portrayals of mental illness in literature and drama, Protestants pointed to the “responsibility of gigantic proportions for the church and ministry” to attend to those ills before they reached “epidemic” proportions.

A few Protestants organized to take action. The year after Gessell’s plea, the Chicago Church Federation “launched a campaign to bring about action by the state legislature to remedy the deplorable conditions” in state institutions. The group lamented crowding, inadequate staffing, and insufficient state funding. Christians were encouraged to send away to the commission to receive materials that would prepare them to be knowledgeable advocates. The Federation’s work also brought the plight of Illinois’s mentally ill population into Chicago pulpits. “Almost with exception,” a correspondent reported, “Protestant pastors last Sunday called upon their congregations to unite in

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68 Similarly, an April 1946 Christian Century editorial advocated support for the same organization and lauded the U.S. House of Representatives for passing the National Mental Health Bill. “Invite Churches to Aid Mentally Ill,” 518.
demanding correction of the deplorable conditions in the nine state hospitals for the mentally ill and the two institutions for the mentally deficient.”

Protestants, at least a few in Illinois, heeded calls to action.

Others advocated care outside state hospitals. Instead of “casting off” sick Americans to far away institutions, they argued that “church people,” more than any others, bore responsibility for the “welfare of mortal beings” and should work with public agencies to find local alternatives to the “vestige of the Dark Ages” of institutional care. The Greater Minneapolis Council of Church Women stepped up to help. Partnering with the state departments of Vocational Rehabilitation and Public Welfare, they formed the “Church F Club” at Wesley Methodist Church, to create a “circle of friendship” that promoted the continued health of discharged mental patients. Similar initiatives sprouted up around the country, and in the wake of public exposés of conditions at public facilities, the decade after 1945 proved a time of heightened Protestant attention to mental maladies, and in some pockets, action.

5.2.8 Closing Thoughts on Institutional Care and Treatment

Though riddled with problems, public institutions persisted as the most common venue of treatment for the severely mentally ill. By the early 1960s, though, national and

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74 “Church Club Helps Discharged Mental Patients,” *Presbyterian Life*, December 15, 1959, 31. Support for public relief agencies and efforts persisted over the next two decades. In 1966, for example, an article entitled “Mr. Goldwater Talks Sense,” in the *Century* pointed to an “unexpected boost” (and a “shocking rebuke” for the “lunatic fringe of the radical right”) from Barry Goldwater, an ultra-conservative 1964 presidential candidate. In a speech as the campaign chair of a local Arizona mental health association Goldwater had called for a “turn-around on our outlook on mental health,” expressed dismay at the lack of knowledge of mental illnesses and called for support for local mental health agencies. *Century* editors were pleasantly surprised by Goldwater’s support for such efforts, and noted “So, if the extreme right leaves him [as a result of his stand] – good riddance.” Inherent in that commentary about Goldwater was a continued call for support, and an affirmation of the value of local, secular mental health agencies by the Mainline. “Mr. Goldwater Talks Sense,” *The Christian Century*, July 20, 1966, 905.
state policies began to shift to favor community-based care options. A massive deinstitutionalization of public facilities ensued. Before 1965, “patients spent years, if not decades, in asylums.” After 1970, “length-of-stays” more likely measured in days or weeks, with still unstable patients left to find continued treatment elsewhere. Patient populations decreased dramatically. “The number of in-hospital beds in public mental hospitals fell from 413,000 in 1970 to 119,000 in 1986.” Community mental health providers though, failed fully to “assume the burdens previously shouldered by state hospitals” and as a result, many former patients ended up homeless. They cycled in and out of prisons and the psychiatric wards of general hospitals. The period also saw the discharge of chronic, aged patients from mental hospitals, and “during the 1960s the population of nursing homes rose from about 470,000 to nearly 928,000.” Those changes eliminated large public mental hospitals as a focal point of interest and advocacy and coincided with a shift in Protestant focus from the plight of sufferers to the adequacy of preparation of clergy to prevent and attend to mental distress. Menninger’s publishing, speaking, and training supported that transition.

Though some hope surfaced for the treatment of mental illness in the twentieth century, overall, it is difficult to describe anything but a troubled system of care. As many Americas as ever lived with mental distress but locating good care proved difficult. Notwithstanding the desire to help and a handful of church-run institutions, in the twentieth century congregations and church leaders had little sustained involvement in public mental institutions. Nor did they participate actively in deinstitutionalization efforts or in the provision of community-based care. Despite clarion calls to advocacy

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early in the century, Protestant efforts had much more limited influence that the advocacy of Dix a century earlier might have inspired and that Menninger hoped for. Most believers simply cheered care giving efforts on from the sidelines.

5.3 Medical Theory Evolves: The Lasting Impact of Wartime Insight

The experiences of war not only created avenues for expansion of Menninger facilities, they also changed approaches to treatment and provided new opportunities for Protestants to attend to mental distress.

During the war, the government recruited a large number of physicians, many without prior training in psychiatry. Initially hired to screen potential recruits for neuropsychiatric disorders that made them unfit for service, attention turned quickly to attending to “high battlefield neuropsychiatric casualty rates.” With the “unfit” presumably screened out, and men still suffering, physicians concluded that environmental stress and the horrors of war—and not the preexisting structure of the personality—could precipitate mental illness. Will Menninger, then chief of the army’s Neuropsychiatric Division and the first psychiatrist named Brigadier General, played a key role in publicizing those discoveries.77 As a result of the findings, prevention became the focus: leaders limited combat time, they added “measures to promote group cohesion,” and mandated “regular rest periods.” Military psychiatrists also discovered that when environmental stress in war zones contributed to “mental maladjustment…purposeful treatment in non-institutional settings produced favorable outcomes.”

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77 Wartime needs grew the ranks of psychiatrists and expanded the setting of their work beyond the asylum. In 1940, the American Psychological Association had 2,295 members, two-thirds of whom worked in mental hospitals. In World War II alone, 2,400 physicians served in psychiatric roles. Ibid., 193-194, 196.
Similar tools soon became part of the broader psychiatric arsenal. After the war, as physicians shifted from military to civilian practice, their combat zone experience shaped a new system of thought. They began to argue, “early identification of symptoms and treatment in community settings could prevent the onset of more serious mental disorders and thus obviate the need for prolonged institutionalization.” Undergirding that assumption was a belief that mental health (and illness) existed along a spectrum. Preventative and restorative measures helped reorient ailing individuals toward health.78

5.3.1 Post War Psychiatry
The science behind wartime discoveries built on the new, “dynamic psychiatry” that gained popularity after 1900. That model of disease “suggested that behavior occurred along a continuum that commenced with the normal and spanned to the abnormal.” The approach “elevated the significance of the life history and prior experiences of the individual” and called for psychiatric involvement well before mental disease became acute.79 As medical professionals searched for clues to causes of illness in life histories, psychiatric practice outside of asylums was a logical result. In the years after the war, “a shift in psychiatric thinking fostered receptivity toward a psychodynamic and psychoanalytic model that emphasized life experiences and the role of socioenvironmental factors.”80 Karl Menninger played a leading role in the professional adoption of that new psychology, which he described as “an articulate science of human

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78 This section relies on ibid., 191-194. Wartime efforts significantly increased demand for psychiatric professions, particularly so because the military used psychiatrists to screen out men deemed unfit for military service. “The military feared in particular that the inadvertent recruitment of homosexual males would have a devastating effect on the armed forces.” Ibid., 192. The condition soldiers suffered was named, “combat exhaustion,” and not formally diagnosed as mental illness (another indicator of ongoing stigma).
79 Ibid., 142.
80 Grob, From Asylum to Community, 4.
in 1944, he chaired the American Psychiatric Association’s Special Committee on Reorganization. While new physical treatments were used, committee members favored a turn to psychodynamic approaches. Menninger endorsed Freud’s theories, and credited the Austrian thinker with allowing mental illness finally to begin to yield to science. Like earlier medical “discoveries” of internal organs and later, technologies to view and diagnose them (the dissecting scalpel, microscope, and X-ray), he argued, Freud’s discovery of the “vast organization of mental functioning of which our conscious experiences are only a small part” and his methods for “looking behind the surface of conscious thinking” helped diagnose and treat “malfunctioning personalities.”

Yet, not everyone greeted Freud’s psychodynamic theories and the committee’s work warmly. Conflict emerged in the century-old American Psychiatric Association (APA). More traditional “heirs of institutional psychiatry” who were “committed to a somatic pathology and organic and directive therapies,” rejected both Freud’s theories and responsibility for broad social concerns, and focused on severe patients in hospitals. The younger wave of psychiatrists, including the Menningers “believed that institutional psychiatry,” at least as it had been practiced, “was obsolete.” They “favored psychodynamic and psychoanalytic concepts, and endorsed community treatment and social activism.” In the 1950s and 60s, proponents of psychodynamics dominated the APA and most university departments of psychiatry, and the approach of the Menningers

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81 Menninger, The Vital Balance, 66.
82 Menninger, “Religio Psychiatri,” 14. Freud’s psychodynamic theory assumed psychological, not organic, forces shaped human behavior. Psychoanalysis, then, sought to uncover those psychological forces in both conscious and unconscious thought.
prevailed. Yet, despite heated internal debate, and jockeying for position, psychiatrists worked to keep their arguments in the family, lest their public image, once again, suffer.83

5.3.2 A New Mission: Mental Hygiene

Notwithstanding professional disagreements, wartime success of “local” (on the battlefield) treatments meant that efforts turned to reducing environmental stressors in civilian life through mental hygiene initiatives. To be sure, psychiatrists still cared for acutely ill patients, but their interests had broadened. Wartime experiences, however, accelerated the both professional and public interest in prophylactic care. Protestants too paid attention.

The focus on mental hygiene figures into the history of Protestants and mental maladies for three reasons. First, it shaped public perceptions of illnesses, particularly lingering and chronic ones. Second, mental hygiene efforts provided an easy access point for lay Christian engagement in combating mental maladies. Finally, involvement hinted at links between Christianity and deepening stigma.

Theories of mental hygiene changed over time. Nineteenth-century prevention efforts had “reflected a world view based on an older religious tradition that emphasized natural law, free will, and individual responsibility.” A “synthesis of Protestantism, Scottish moral philosophy, and Baconian science” linked mental and physical disease to individual behaviors. While professionals could educate patients about the connections between behavior and disease, individuals held ultimate responsibility for their choices.84 The twentieth-century mental hygiene movement, in contrast, grew from the assumption

83 Grob, The Mad Among Us, 101-102. By 1957, only seventeen percent of 10,000 APA members worked in state asylums or VA facilities. A century earlier, membership was restricted to asylum physicians.
84 Grob, Mental Illness and American Society, 1875-1940, 144.
that disease was “a product of environmental and hereditarian deficiencies” and that “its control and eradication required a fusion of scientific knowledge and administrative activity.” As a result, newer mental hygiene efforts addressed not just mental illness, but also feeblemindedness, alcoholism, juvenile delinquency, crime, prostitution, and dependency, all conditions thought to be influenced by environmental and hereditarian factors.

Preventative measures proved popular with psychiatrists seeking work outside of institutions and sounded beneficial to the public. Psychiatrists took the lead to prevent and treat “pathological behavior.” By doing so, they hoped to “create a better society” and enhance “the welfare and happiness of all citizens.” They quickly attracted other professionals (social workers, occupational therapists) and lay people to their cause. Optimistic about the progress of the nation, and with professionals leading the way, Americans assumed they could eliminate weak traits and ensure the country’s continued success.

5.3.2.1 Menninger on Mental Hygiene
A proponent of the broadened role for psychiatric care, Menninger supported many mental hygiene initiatives. In his 1930, *The Human Mind*, he commended the

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87 Coordinating many mental hygiene efforts was the National Committee for Mental Hygiene (NCMH), which formed in 1909. The former mental patient turned advocate for the insane, Clifford Beers founded the organization, with the support of the Swiss-born psychiatrist Adolf Myers and psychologist William James. The NCMH hoped to “protect the public’s mental health; promote research into and dissemination of material pertaining to the etiology, treatment, and prevention of mental disease; enlist the aid of the federal government; and establish state societies for mental hygiene.” Ibid., 153. See Grob’s Chapter 6 for additional detail about the formation and development of mental hygiene efforts. pp. 144-178. Grob argued, “hygienic goals seemed certain to attract broad support from a public increasingly fearful of the seeming rise in venereal diseases, alcoholism, and a variety of other aberrant behaviors that fostered illness, dependency, and crime.” Mental hygiene efforts allowed Americans to address their worries about other citizens. Grob, *The Mad Among Us*, 154.
88 Menninger, though, rejected hereditarian theories of mental disease. See discussion below.
work of the National Committee for Mental Hygiene.\textsuperscript{89} He appreciated that mental hygiene philosophies assumed that “the distress of a personality struggling with an environment is simply struggle and not a matter of devils and witches, sin and ‘‘orneriness,’ or yet of a feeble intellect or feeble will.” The goal of those efforts, he concluded, assumed “mental health is attainable,” and that “failure to attain it and retain it is to some extent dependent upon our ignorance of general principles.” Education formed a vital component of mental hygiene efforts, and much of Menninger’s own work fell under an educational umbrella.

The doctor also lauded work preventing “unhealthy-mindedness” in a world that, while attentive to physical health, seemed to ignore mental well being. “Few people,” he reflected, “give any attention to…brushing their mental teeth or to giving their minds a bath or their memories a cathartic.” He found attention to the prevention of mental distress particularly important for children. “The teeth, the tonsils, the eyes, and the ears of thousands of schoolchildren are meticulously examined each year…and much clatter and fuss are made over elaborate statistical reports of the damage found, repaired, or averted.” “Meanwhile,” he asked, “how much thought is given to the examining of the minds of these same children? Are teeth and tonsils more important than minds?”\textsuperscript{90} For many psychiatrists, mental hygiene provided an opportunity to distance themselves from institutions and the care of chronically ill adults. The same did not prove true for Menninger, who while endorsing mental hygiene efforts, continued to assert a central role for institutional care and attended to all types of mental distress.

\textsuperscript{90} Ibid., 14, 359.
5.3.2.2 Protestant Support for Mental Hygiene

Menninger encouraged Protestant promotion of mental health initiatives. Mental hygiene proved an easy point of entry to attend to the prevention of disease and human suffering. In 1940, for example, the parents’ group of the Presbyterian Park Central Church in Syracuse, New York sponsored a series of six lectures on “Mental Hygiene in the Family.” An average of 150 individuals attended each lecture. Similar events took place around the country, often jointly sponsored by congregations and mental hygiene organizations. Together church leaders and public officials hoped to train parishioners to spot and treat nascent emotional troubles before they worsened.91

Some congregations claimed great success. In 1950, for example, the First Community Church in Columbus, Ohio, touted that of the “646 men and women from the church who were in the armed services during [World War II,] there was not one instance of mental breakdown.” They credited that victory to their mental hygiene efforts that began before “the child is born.” Premarital counseling was followed by careful monitoring for “deviation or abnormality” in the church nursery school and psychological testing of adolescents. In the case of military service men and women, the church kept in close contact during deployments and after their return home through letters and clergy visits.92 Menninger praised the work of First Community Church, calling it “the best example of organized mental hygiene that” he knew of, or had ever seen.

5.3.2.2.1 A Darker Side

While optimistic, mental hygiene efforts also revealed a darker side of the American, and the American Protestant, ethos. Some, fearing “that an alleged increase in

91 “Church Offers Courses on Mental Hygiene,” The Christian Century, March 27, 1940, 427.
92 “Great Churches of America: XII. First Community Church, Columbus, Ohio,” The Christian Century, December 20, 1950, 1515.
degeneracy in general and mental illness in particular threatened the biological well-being of the American people,” promoted “interventionist measures, including marriage regulation, immigration restriction, and involuntary sterilization.” Those individuals pronounced that the cost of “eugenic,” preventative measures eliminated the need to spend money housing and caring for “degenerates” later. Between 1907 and 1940, the eugenics movement resulted in the surgical sterilization of more than eighteen thousand patients in state hospitals. While members of the psychiatric profession and the public held mixed views of the value of eugenics, those approaches shaped, and perhaps reflected, public perceptions of mentally ill Americans.

While fears of the “socially undesirable” always existed, historian Grob asserted that in prior eras “a religious based optimistic activism and faith that individual will and volition could surmount character imperfections” mitigated those concerns. But, as a new century dawned the “version of Darwinian biology” that assumed hereditary instead of environmental flaws spurred some to limit the multiplication of “unfit” Americans. Some Christians weighed in against those efforts. The Roman Catholic Church, for example, opposed voluntary and involuntary sterilization as a violation of natural law, but wider public concerns failed to appear until “revelations about the use of sterilization in Nazi Germany because public” during World War II. Not all mental hygiene initiatives led to drastic measures, but such efforts deepened suspicions about those that differed from an American ideal.

As the theological ethicist Amy Laura Hall demonstrated, eugenic impulses shaped “scientific” efforts often endorsed by Protestants believers. To be sure, not all

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94 Ibid., 173.
95 Ibid., 177.
clergy and laity supported drastic practices that sought to make the world a better place, but Hall’s account suggested a cultural pervasiveness and lasting impact of eugenic thought among Christians. That trajectory began even before the changes brought by World War II. In 1926, for example, the American Eugenics Society sponsored a Eugenics Sermon Contest. The third place winner, the Reverend George Huntington Donaldson, a Methodist from New York City argued, “the strongest and best are selected for propagating the likeness of God and carrying on his work of improving the race.”96 The contest winner, the Reverend Phillips Endecott Osgood, rector of St. Mark’s Unitarian Church in Minneapolis, claimed that Jesus “was superlatively concerned to better the qualities of human living” and urged Christians to take up the responsibility of “refining” the human race through the sterilizing of criminals and responsible reproduction. Instead of the impulse of Protestants before him to attend to suffering, Osgood proposed creating a more perfect humanity by weeding out those whose handicaps meant the human race remained impure.97

In Hall’s assessment, Protestants like Donaldson and Osgood interpreted the “scriptural story of salvation in the Old Testament” as “God’s refining, purifying, and selecting in order to produce a stronger, heartier stock of humans.” Menninger, who never hinted at approval of eugenics or sterilization, likely would have refrained from venturing that far in his assessment, but in the hands of some, “Jesus’ parables regarding the kingdom of God swiftly became parables for the eugenic separation of human wheat from human chaff.”98 Among the “chaff” were those deemed inferior because of race,

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97 Ibid., 261-262.
98 Ibid., 265.
poverty, moral laxity, or mental illness. Because such assessments required acceptance of Darwinian notions of evolution, eugenic views resonated with many modernist, mainstream Christians who were supportive of scientific advancement.\textsuperscript{99}

With a prevalent sense that Americans, and Christians in particular, had a responsibility to demand that “every child born is worthy of a place in our midst,” those admitting to mental distress or institutionalized were considered defective.\textsuperscript{100} Menninger supported many mental hygiene efforts, but, as we’ll see, he lamented that the movement deepened stigma for those that remained outside of the perceived healthy norm.

5.4 Modern Perceptions of Mental Maladies

Amidst a struggling system of care, evolving treatment protocols, and growing stigma, how did twentieth-century Americans think about mental maladies and those that suffered from it?

5.4.1 Menninger’s Voice

Given his prominence, Menninger played a lead role in shaping both public and professional views of mental distress. The doctor described illness—whether physical or mental—as “pain, disability, bodily deformity or disintegration.” He saw it as “an adventitious state of being which impairs or hurts or threatens to destroy us” because it “interrupts, to some extent, the ordinary, ‘normal’ course of life.” Illness, he argued, “impairs or threatens to impair comfort, effectiveness, and even life continuance.” It “is always an unwanted, feared, dreaded, detested, avoided ‘thing,’ a state of being for which

\textsuperscript{99} The language of “mental hygiene” largely fell out of use by the end of the 1950s, but the impulse for church people to aid in prevention efforts continued. In 1959, Congregational minister and professor of sociology at Brooklyn College, Herbert H. Stroup, urged church people to root out “incipient cases” of illness in a quest to sustain “normal existence.” Stroup discussed ways Christian resources could be deployed in support of maintaining normality. Different in Stroup’s account, however, was the proposal of a more robust theological anthropology to balance church resources with secular tools. Herbert H. Stroup, “Keeping Sane in a Crazy World,” \textit{The Christian Century}, September 18, 1959, 1338-40.

\textsuperscript{100} Hall, \textit{Conceiving Parenthood}, 269.
palliation or removal is imperatively desired.”101 Whether bodily or emotional, sickness proved a matter of chance, disruptive for the one who suffered, and it demanded remedy.

Turning his attention to mental illness, Menninger refused to define it as a “‘thing’—like a specimen in a museum—for which a label must be found.” Rather, he saw mental illness as “a state of functioning” or a “way of behaving.” Using the analogy of a trout gyrating wildly after being caught on a hook, he saw strange behaviors as “efforts [on the part of the sufferer] to get rid of the affliction,” behaviors that sometimes succeeded and sometimes failed.102

Menninger named mental health as “the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment—or the grace of obeying the rules of the game cheerfully. It is all of these together.” He described mental wellbeing as “the ability to maintain an even temper, an alert intelligence, socially considerate behavior, and a happy disposition.”103 In addition, rather than seeing mental illness as a binary state where one was either well or sick, Menninger assumed that mental wellbeing occurred along a spectrum. That view included the sense that all humans suffered from mental maladies, at one time or another. “If one has a mind at all,” he argued, “his mental processes are subject to some of the faults and failing that characterize the human mind.”104 Using accessible, non-medical language, the doctor pronounced that mental health enabled humans to function productively in the world; mental illness inhibited that ability.

102 Karl A. Menninger, “Psychiatrists Use Dangerous Words,” The Saturday Evening Post, April 25, 1964, 12.
103 Menninger, The Human Mind, 1.
104 Ibid., viii. He also named mental illness a “universal human experience.” Menninger, The Vital Balance, 417.
Going deeper, Menninger described two basic categories of “mental sickness.” First, he outlined, “afflictions which cause anguish and pain primarily in the persons who suffer them. They suffer depression or fear, uncontrollable anger or bitterness, and sometimes this anguish drives them frantic or drives them to drink or drives them to the doctor and he drives them to the hospital.” 105 This most commonly recognized form of mental illness, he asserted, manifested itself in pain, queerness, isolation, discouragement, ineffectiveness, disagreeableness, idleness, isolation, despoliation, and defilement.106 Second, the doctor identified “a kind of mental illness from which individuals may suffer but the people around them suffer a great deal more.” With this type of emotional distress, he reflected, “whether one calls it vandalism or psychopathy or criminality,” the mental abnormality of others “results in our suffering.”107 In many ways, that two-fold typology reflected the prevailing twentieth-century lay and professional categorization of mental illnesses as either neuroses or psychoses.

While offering definitions, the nation’s leading psychiatrist also acknowledged uncertainties about mental distress. In a 1951 lecture delivered at the Chicago Theological Seminary, for example, he confessed, “mental illness has long been a mystery” and remains so, even with greater scientific insight. Paradoxically, however, Menninger knew mystery persisted despite the fact that mental illness was “enormously prevalent—more abundant than all other forms of illness put together.”108 Alongside the desire to attend to human suffering, the intellectual challenge of understanding and

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105 Hall, ed. A Psychiatrist's World: The Selected Papers of Karl Menninger, M.D., 796. In that 1953 reflection, Menninger noted that the first type of illness was currently “a more recognized field for psychiatry” and that the other “is coming to be.”
106 Ibid., 784.
107 Ibid., 796.
solving the longstanding problems of mental maladies captured the faithful physician’s interest.

5.4.2 Menninger on Origins and Causes

Menninger detailed causes of mental distress. To begin, he dismissed deeply held presumptions. Convictions about supernatural origins were the first target of his re-education efforts. In an interview with L. M. Birkhead, minister of All Souls’ Unitarian Church in Kansas City, Missouri, Menninger observed that in the past human misbehavior was often explained by demonic possession. He disagreed with supernatural causation, but he admitted, “sincere devout people still exist who regard the misbehavior of mankind as nothing but evidence of sinfulness and the cure as religious salvation.” Others, he noted, refrained from blaming God (or the lack of God, or the Devil, or witches), but instead pinned culpability on human behavior, linking mental illness with immorality.¹⁰⁹ Assumptions of moral causes, he argued, were no more valid or helpful than supernatural ones. Finally, Menninger pushed aside thoughts that sufferers inherited mental defects. Education about illness, treatments, and preventative measures, he asserted, trumped theories of familial disposition, or “hereditary damnation.”¹¹⁰ Whether supernatural, moral, or hereditarian, earlier theories, Menninger concluded, “all assume that something mysterious and malignant floating in the ether or transmitted in the germ plasm gets into the individual and makes him go wrong.” The result? The afflicted one “gets called names.” But, “calling people witches or devils or psychopathic personalities” he argued, “doesn’t help” bring healing.

¹¹⁰ Menninger, The Human Mind, viii.
In exploring the origins of mental maladies, Menninger also looked past purely biological views of causation. Instead, he insisted that ailing “must be looked at in terms of “psychodynamics, psychoeconomics, development, biology and adaptation.” Three thinkers influenced this understanding. First, from the nineteenth-century French physiologist Claude Bernard he understood that the interaction of one’s internal and external environments (milieus) influenced sufferers. From the Swiss psychiatrist Adolf Meyer, Menninger adopted the sense of “mental illness as an unskillful reaction to external stress.” Finally, from the Austrian neurologist and creator of psychoanalysis, Sigmund Freud, he embraced notions of “the struggle between creative and destructive forces, between life and death instincts, between love and aggression” that caused mental maladies. Menninger held that stress caused “aggressive, hostile and destructive feelings” and that mental illness resulted when those feelings were not “handled effectively.”

While adopting theoretical constructions, Menninger reserved a role for sin in causing *some* abnormal human behavior. He drew a distinct line, however, between sin and illness. Commenting, for example, on the 1978 mass suicide in Jonestown, Guyana where the Rev. Jim Jones led nearly one thousand people to their deaths, Menninger’s Protestant moral sensibilities appeared. “Some of my colleagues,” he observed, “persist in believing that coining Greek and Latin names and slapping them on accused individuals enables then to disguise depravity and to make the committing of evil (sins) something pardonable because it is something psychiatric.” The event in Guyana “is not a psychiatric problem: it is a moral problem” Menninger contended. “Jones was a

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111 Drane, 759.
wicked, corrupt, unscrupulous, and evil man. Why call him by euphemistic ‘scientific’ names? What do we gain by throwing around words like \textit{paranoia} and \textit{dementia}?\footnote{Menninger cited in ibid., 758-759.} Menninger’s Protestant faith attuned him to the realities of human suffering and the reality of sin. When appropriate, his medical training allowed him to frame mental distress in scientific terms. Because his assessments rang true with professionals and proved understandable by laity, Menninger’s view of illness held broad influence.

\textbf{5.4.3 Public Perceptions}

Alongside widely read descriptions of mental illness by Menninger, journalistic and cinematic exposés of institutional life played a role in shaping public perceptions about the causes of mental distress. Portrayals by those like Albert Deutsch and Albert Q. Maisel generated public outrage; they also demonstrated that presumed links between mental illness and sin continued to fade. In the preface to his 1948, \textit{The Shame of the States}, journalist Deutsch declared, that while “insanity was once considered a sin or the consequence of sin…we no longer regard our mentally sick patients as criminals, witches or paupers.” Instead, Deutsch named mental illness a sickness that rendered “a person socially inefficient” and necessitated treatment, treatment that provided “some form of social control.” In addition, the term “insane,” he argued, “is fast becoming obsolete in modern medical parlance,” instead replaced by notions of disease.\footnote{Deutsch, 9-10. Karl Menninger authored the introduction to Deutsch’s volume. In 1943, legislation in Illinois officially dropped the terms “lunacy” and “insanity” and substituted “mental illness.” Charles Leslie Venable, “Modernize Treatment of Mental Illness,” \textit{The Christian Century}, August 11, 1943, 926.}

Two decades later, a study in the \textit{Journal Health and Human Behavior} revealed “the virtual disappearance of ideas that mental illness is a result of sin or the devil.” No longer did Americans think of mental distress as “merely evil or willful misbehavior” or
that punishment was the only solution.”¹¹⁴ Not linked with the demonic, at least not explicitly, twentieth-century Americans tended to view mental maladies medically, as illnesses.

Public reactions to sufferers, however, remained mixed. Differing levels of comfort and knowledge about the afflicted were evident in the Methodist Minister John B. Oman’s 1952 observations. Oman, who served the First Methodist Church in Trenton, NJ and worked as a prison and asylum chaplain, assessed that “those who understand” mental illness “react toward it the same as toward physical illness.” But, those who do not understand, “usually react toward it with a feeling of awe (more or less natural when something is beyond one’s comprehension) or are morbidly curious.” The “most ignorant,” he observed, tend to ridicule, a response he named “a defense mechanism resorted to by many to cover up their own lack of knowledge, and therefore not a true expression of their real emotions.” Rarely were the sick at fault for their illnesses, but even so, they found themselves “banished from society” once they crossed the threshold of a mental hospital.¹¹⁵ For Americans, illness prompted public sympathy, but dependency did not. In the case of mental illness, the difference between the two was not always clear.¹¹⁶

¹¹⁶ Mental patients were not the only ones featured in media portrayals that shaped views of illness. For a period in the early 1960s, coverage indicated that the mental health system—and psychiatrists in particular—had regained prestige lost around the turn of the twentieth century. Between 1957 and 1963, for example, “Hollywood produced more than twenty films that presented psychiatrists—the purveyors of reason, knowledge, and well-being—in glowing and idealized terms.” That praise, however, was short lived. A later batch of films and novels, including *One Flew over the Cuckoo’s Nest* (1962) and *Shock Treatment* (1964), displayed psychiatrists as “either malevolent or comedy-like figures.” Among the films portraying physicians in a favorable light were *The Three Faces of Eve* (1957), *Splendor in the Grass* (1961), *Pressure Point* (1962), and *Freud* (1962). Despite their reclamation of professional
5.4.4 Social Science Weighs In

By mid-century, social scientists began to survey public perceptions about mental illness, and one of the earliest studies suggested that public and professional perceptions did not always match. “In the 1950s, the public defined mental illness in much narrower and more extreme terms than did psychiatry.” The results also showed that “fearful and rejecting attitudes toward people with mental illnesses were common.” Over the next four decades, views shifted, but stigma persisted. A later study indicated that between 1950 and 1996, “conceptions of mental illness…broadened somewhat…to include a great proportion of non-psychotic disorders.” By the end of the century, the public differentiated between severe mental illness and less severe disorders, showing deeper knowledge of medical diagnoses. During that time, though, “perceptions that mentally ill people are violent or frightening” increased substantially. Negative stereotypes drove that change, perceptions often generated by media coverage of the underlying mental conditions of individual committing heinous crimes. While suspicions of links between sin and mental maladies may have eased, patients, and the institutions where they sought care remained tainted by stigma.

5.4.5 Protestants Understandings

Evidence demonstrated that believers too understood what mental illness was and who suffered from it. Definitions of mental illness in Protestants publications, though, were brief, general, and without medical detail. As a result, they offered a limited portrayal of suffering.

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117 Jo C. Phelan and others, “Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?,” *Journal of Health and Social Behavior* 41, no. 2 (2000), 188.

118 Ibid.
5.4.5.1 Who Suffers?
Believers pointed frequently to the vast reach of mental maladies. They affirmed the United States Public Health service’s pronouncement that mental illness was “America’s number one health problem.”119 Rarely, though, did they admit knowing sufferers or admit to being those who ailed. And, not until the end of the century did some step forward and admit their own afflictions. In 1968, for example, when a Presbyterian elder shared his experiences in churches related to his wife’s mental illness, he did so pseudonymously.120 In almost every case, the afflicted were generalized, unnamed, institutionalized others, far from local church communities.121

Protestants did acknowledge categories of people that might be in need of care. Stressful working conditions turned “defense workers” and government clerks in Washington D.C. into “nervous wrecks and psychopathic cases.”122 Soldiers returning home from war should prompt churches to prepare to deal with “deep psychic wounds” inflicted on the battlefields.123 Protestants also suspected that mental illness played a role in juvenile delinquency. The identity of other burdened and sick souls, however, remained elusive. It seems likely that continued social stigma kept Christians hesitant to

119 Oman, 100.
121 An exception was a discussion in 1959 about the mental health of former Air Force Major Claude Eatherly, who flew the B-29 bomber that dropped the atomic bomb on Hiroshima, Japan during World War II. After repeated suicide attempts and a “life of delinquency,” church leaders wondered if Eatherly needed not just psychiatric care, but instead “the ministries of religion” to attend, theologically, to his spiritual distress. “Who Needs the Psychiatrist,” The Christian Century, May 6, 1959, 541.
name those that suffered or to share their illnesses, even while acknowledging that many did.

5.4.5.2 Physician, Heal Thyself: Clergy Perceptions
Ordained Protestants held opinions too. Though sufferers remained anonymous, given the prevalence of mental illness, attending to them was surely a central task for ministers. Less obvious, was whether leaders understood themselves susceptible to mental maladies. Some thought “the very fact that a man has chosen the ministry for a vocation may indicate some sort of inner disorder,” perhaps a “neurotic need for helping other people.” Clear that clergy “as a group probably have as good a physical health record as any other group in the community,” they wondered how to assess the emotional health of men of the cloth.124

Alternately, others asserted that clergy, at least well behaved clergy, lived beyond the grasp of mental illness. A reflection titled, “Are Ministers Cracking Up?” found it acceptable for some to suffer mental anguish, but not clergy. Taking an only thinly veiled defensive tone, the Presbyterian minister and church leader William Hudnut rebutted a Life magazine exposé of rampant “mental and emotional illness among the clergy” that asserted “the number one problem of American clergymen is mental health.”125 He argued that the few ministers that did “crack up” did so because they lacked the “discipline to crack down” on themselves, implying that clergy should be more

adept at controlling their mental health than laity. Hudnut provided practical stress-reducing techniques for religious leaders, but behind this tactical advice lay a fear of vocational failure and perhaps a denial of clergy humanity.

5.4.6 Closing Thoughts on Perceptions of Illness
While Americans no longer explicitly connected mental illness to demonic possession, original sin, or individual transgression, they still struggled to understand its appearance. That even medical literature speculated when talking about the causes of and cures for mental maladies gave the public good reason to question, and meant that a cloud of uncertainty and suspicion surrounded those that ailed. Proximity to sick friends and relatives may have eased discomfort about abnormalities, but even nearness provided no immunity from stigma. The public and professionals, however, continued to seek cures.

5.5 Sharing the Provision of Care
Insanity was once the sole domain of asylum physicians (and before then simply the purview of the parish priest), but by the 1930s, a gaggle of health professionals—psychiatrists, psychologists, psychoanalysts, mental hygienists, and social workers—declared their authority to help. Clergy too staked a claim, but they were forced to find

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126 Ibid.
127 Differences between specialties warrant explanation. Formal medical care for mental illness grew out of the work of nineteenth-century asylum physicians. The medical doctors that were direct descendents of those “alienists” were psychiatrists. MDs, psychiatrists attended medical school and then specialized in psychiatry. Neurology, another medical specialty, developed in the United States during the Civil War, with an interest “in wounds involving nerve tissue.” In the nineteenth-century, they treated many of the same ailments as psychiatrist, but “unlike the founders of institutional psychiatry—many of whom were identified with pietistic Protestantism and moral issues—neurologists tended to identify themselves with the world of science and especially European scientific medicine.” With a focus on the brain and the central nervous system, and with a different methodological background, neurologists remained organizationally separate from psychiatrists and frequently eschewed work in institutions. See, Grob, Mental Illness and American Society, 1875-1940, 50-62.

Psychology was a “discipline with its roots in philosophy rather than medicine. Doctors of psychology earned Ph.D.s, and not medical degrees. In the United States, at first, psychology was a research-oriented discipline that studied individuals and groups. Eventually, though “clinical” psychologists began to work outside of universities, in clinics and schools where they made prescriptive
ways to cooperate—as a result, they asserted pockets of expertise. Of central concern for ministers was assessing psychiatry, psychology, and psychoanalysis, and determining how those tools could and should interact with Christianity and the resources of Christian communities. Menninger addressed those questions enthusiastically.

5.5.1 Oriented Toward Cooperation

Though Menninger harbored no reservations, opinions varied about the wisdom of cooperation between medical and religious professionals. Sometimes physicians eschewed blended approaches. In 1936, for example, a Methodist minister asked the Canadian psychiatrist C. M. Hincks “about training that would enable him to deal with the mental problems of his parishioners.” The doctor bluntly dismissed the clergyman’s question. Instead, he responded, “the practice of psychiatry is so rooted in medical science that it could not possibly be entrusted to the hands of a layman, no matter how wide his readings on the subject had been” and that “only the trained psychiatrist is qualified to examine,” diagnose, and treat mental disease. Unlike Hincks, Menninger heralded cooperation. He “recognized that suffering human beings transcend the perspective of any single vision [of diagnosis and treatment] or even of all visions taken together.”

Observations about human behavior. This led to conflict with psychiatrists, especially as they extended their practice outside of mental hospitals. See ibid., 260-4. See Grob’s ninth chapter, “The Emergence of the Mental Health Professions” for additional discussion including overviews of psychiatric social work and occupational therapy, both which played a role in twentieth-century mental health care.

Psychoanalytic thought and psychoanalysis stemmed from the theories about human behavior of the Austrian neurologist, Sigmund Freud, whose work “had relatively little influence on American psychiatry before 1920.” Ibid., 120.

Overlapping convictions—alongside many differences in thought—marked the relationships between these groups in the first five or six decades of the twentieth century. Sometimes they cooperated; often they competed for patients and authority.

Ibid., 306. In 1918, with Clifford Beers, Hincks founded the Canadian National Committee for Mental Hygiene.

Drane, 759. He thought that both religious workers and professional attending to mental maladies (psychiatrists, psychiatrist’ helpers, psychiatric social workers, psychiatric nurses and aides,
Specifically, Menninger, saw an affinity in the work of psychiatrists and clergy. Both professions, he asserted, were “aware of the vast extent of misery and suffering in the world.” In addition, each felt “impelled to do something to diminish this suffering,” through “advice to the individual” and “proclamation of principles of living.” The trained physician knew that religious leaders stood on the front line of response. “Every priest, pastor, and rabbi” he observed, “spends a considerable amount of his time, I am sure, listening to parishioners who are in distress because of recognized or unrecognized mental illness.” “Clergymen,” he observed, “more than most people are aware of the vast extent of misery and suffering in the world. They and the psychiatrists are together on this.”

Likely, Menninger’s willingness to cooperate stemmed from his religious upbringing and church involvement.

Though many of Menninger’s medical colleagues disagreed with him, the Protestant physician framed psychiatry and psychology as endeavors with connections to religion, if not direct links to Christianity. In 1951, he spoke to a group of Protestant ministers at the University Church of Disciples of Christ in Chicago. An observer at those Alden-Tuthill lectures noted that Menninger “stressed the similarities” between religion and psychology. Menninger “pictured the psychiatrist as one who is putting Christianity into practice” and translating “psychoanalytic theories and principles into theology.” He also found “the psychiatrist’s acceptance of his patients’ hostilities while

therapists and psychologists) were “dedicated to the kind of work in which the importance of the other person is greater than it is natural for that importance to be in a normal person.” Hall, ed. A Psychiatrist's World: The Selected Papers of Karl Menninger, M.D., 796. Perhaps the earliest joint healing effort was the Emmanuel Movement started in Boston in 1906 by the Episcopal priest, Elwood Worcester. Psychiatrists, other medical doctors, and clergy worked together to diagnose and care for patients. The practice of prayer and belief in the “primacy of the mind over the body” shaped the ministry. Ronald L. Numbers and Darrel W. Amundsen, Caring and Curing: Health and Medicine in the Western Religious Traditions (Baltimore: Johns Hopkins University Press, 1998), 256.

131 Hall, ed. A Psychiatrist's World: The Selected Papers of Karl Menninger, M.D., 778.
refusing to act against those hostilities…akin to Christian love” and reflected, “there is in
the theory and practice of psychiatry a basic attitude of faith.” \footnote{132} Downplaying conflicts
between faith and science, he argued, “the life work of the psychiatrist does not conflict
with either the usefulness or the content of religion.”\footnote{133} Even when others denounced
religious connections, Menninger presumed them. That he proved credible with clergy
was no surprise.

At times, it almost appeared that Menninger failed to differentiate between
ministerial and medical roles. Psychiatrists and clergy used many of the same tools—
both attended to emotional distress by “listening, comforting, correcting, and
reassuring.”\footnote{134} He even understood (and perhaps experienced) the work of physicians as
a form of ministry. He saw psychiatry as a “ministry of care to the most miserable, the
most unloved, the most pitiable, and at times the most offensive and even dangerous of
human beings.”\footnote{135} The doctor proclaimed that psychiatrists “ministered” to patients, just
as clergy ministered to congregants. Psychiatrists engaged in a “ministry of care” in the
form of being a “friend, the guide, the protector, the helper, the lover of” and to “the most
miserable, the most unloved, the most pitiable, and at times the most offensive and even
dangerous of human beings.”\footnote{136} He understood compassion, like that dispensed by

\footnote{132} Virgil E. Lowder, “Menninger Relates Religion and Psychiatry,” \textit{The Christian Century}, April
11, 1951, 475.
\footnote{133} Ibid. Menninger also identified a morality in psychiatry and assumed that “beliefs which must
in the last analysis be described as religious are implicit in the theory and practice of psychiatry.” Drane,
759.
\footnote{134} Menninger, “Religio Psychiatri,” 14.
\footnote{135} Hall, ed. \textit{A Psychiatrist’s World}, 783.
\footnote{136} Menninger, “Religio Psychiatri,” 17. In that explanation, as others, Menninger supported his
assertions with a verse from scripture, here “‘Passing through the valley of weeping, they make it a place of
springs.’ (Psalm 84).” His mother’s Bible study training had lasting impact.
Clergy and psychiatrists could be of one mind.

Yet, Menninger also drew distinctions. He defined, for example, a unique role for clergyman as moral prophets. Clergy, through preaching, had a venue to promote mental health: “No psychiatrists or psychotherapists, even those with many patients, have the quantitative opportunity to cure souls and mend minds which the preacher enjoys. And the preacher also has a superb opportunity to do what few psychiatrists can, to prevent the development of chronic anxiety, depression, and other mental ills.” Properly used, the pulpit encouraged mental health. “Like the psychiatrist,” Menninger argued, “the minister feels impelled to do something to diminish this suffering, not only by advice to the individual, but by proclamation of principles of living. In their sermons they endeavor—most of them—to hold out hope, comfort, encouragement, and reassurance to congregations in which there are many who need this help.”

Though clergy played a role, Menninger presumed that “the injunction of Isaiah to ‘Comfort my people,’ rest[ed] heavily upon psychiatrists.” Medical professionals undertook the critical part in bringing healing. Others noted professional differences too. In 1955, Mainline Protestants in St. Louis welcomed the assertion by the rabbi Joseph R. Rosenbloom at a meeting of the Institute on Religion and Psychiatry. The young rabbi professed it “fatuous to believe that [religion and psychiatry] seek the same things with the same methods. Religion is religion and psychiatry is brand of medicine. And while they frequently move along parallel lines, they are distinct. Psychiatry seeks to reconcile

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137 Deutsch, 15.
139 Hall, ed. A Psychiatrist's World, 778.
140 Menninger, The Vital Balance, 416.
the patient to circumstance and to himself. Religion seeks to reconcile him to spiritual values and disciplines.” Rosenbloom continued, forecasting that “the greatest failure that may come in these two fields is not that they will not come together—become one great movement—but that they will not be used to bolster one another.” Despite identifying separate roles, such hopes fostered continued conversation.¹⁴¹

Menninger recognized, and seems to have supported, the transfer of authority from clergy to psychiatrists in matters of mental health. The doctor reflected that, with the rise of science, “the clergyman’s morally burdened parishioners became the psychiatrist’s complex-laden patients; sin became symptom, and confession became psychotherapy.”¹⁴² Though clergy should participate in the provision of care, Menninger reserved the more important role for medical professionals. “It is not accident,” he reflected, “that the highest social esteem, once reserved for princes and royalty, for high priests and prophets, is now accorded to physicians.”¹⁴³ Some agreed. Pastors in Wisconsin, for example, were asked, not to provide care, but to “acquaint their congregations with the services being rendered by the state society for mental health” and to “work with other community agencies in hosting educational programs. Even church leaders affirmed that, sometimes, care and counseling were best if left to trained medical professionals.¹⁴⁴

¹⁴¹ “2,000 Attend Institute on Religion and Psychiatry,” The Christian Century, June 1, 1955, 660.
¹⁴³ Deutsch, 15.
¹⁴⁴ “Offer Wisconsin Pastors Aid in Counseling Mentally Ill,” The Christian Century, June 16, 1948, 614. Whether churches or the state made the request is unclear, but either way, the news item supported the request.
5.5.2 Clergy Seek New Tools

Many clergy, though, were eager to incorporate psychiatric and psychological insight to strengthen their care of souls. From 1940 through 1970, advertisements and book reviews of the *Christian Century* teemed with texts aimed to help them do so. Titles included: *The Church and Psychotherapy, Psychology for Pastor and People,* and *Pastoral Psychology: A Study in the Care of Souls.* Ministers also assessed purely medical volumes, frequently recommending secular books like *Steps in Psychotherapy,* *Culture and Mental Disorders,* and *Today’s Neurotic Family* as valuable resources. Often, clergy gathered to learn from medical professionals in person. In 1944, for example, “a large percentage of Denver ministers” appeared for the first in a series of four lectures on psychiatry. Topics included “The Relation between Mental Disease and Religion,” and “A Psychiatric Interpretation of the Golden Rule.”145 Similar sessions took place around the country in the 1940s and 50s. At work in those publications and gatherings was a suspicion that medical professionals possessed knowledge and authority that clergy craved. Perhaps, the sting of lost authority spurred the educational interests of pastors.

5.5.3. Engaging with Medical Professionals

Clerical adoption of psychiatric, psychological, and psychoanalytical techniques generated decades of debate, and little resolution. Many saw great opportunity and urged dialogue. In 1946, for example, the Rev. John Gessell argued that while psychiatry was a “highly specialized science,” it was not necessary that “we, as Christian laymen and ministers, let the church’s function of ministry to the ill in mind and spirit atrophy.”146

146 Gessell, 1247.
According to Gessel, the church had a role to play in the care of those suffering from mental illnesses, and from his vantage point, those newly emerging scientific and medical disciplines offered resources.

Protestant support was also apparent for organizations that enabled dialogue between the medical and religious communities. A *Christian Century* editorial from April 1956 noted, “an auspicious star brooded over the launching of the National Academy of Religion and Mental Health.” Beyond the “threat of atomic annihilation,” the editors of *Century* saw no greater need than addressing mental health.\(^{147}\) Willingness on the part of the medical-establishment to engage with religious leaders, however, developed more slowly. In a May 1956 editorial report on a joint meeting of the American Psychiatric Association and the American Psychoanalytic Association, the *Century* called for renewed cooperation between pastoral and psychiatric efforts.\(^{148}\) Both disciplines, the APA acknowledged, shared concern and responsibility for “human well-being” and thus greater understanding of each other’s approaches provided mutual benefit.” But, the editorial also noted that “in the persons of some of its wisest men, the church has been putting its best foot forward for some time, looking for just such cooperation, and finding a little.”\(^{149}\) Many welcomed the APA’s call for reciprocity.

Other church leaders were less enthusiastic. In 1940, John Wright Buckham, professor of Christian Theology at the Pacific School of Religion, for example, worried that adoption of secular insight might signal trouble. Psychology, he argued, had supplanted ethics, degraded reason, belittled religion, and attempted to displace

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148 The groups gathered in celebration of the 100\(^{th}\) anniversary of Sigmund Freud’s birth.

philosophy. While his concerns extended far beyond the impact of psychology on Christianity, in all things he urged “let psychology be servant, not master.” Though not calling for cooperation to stop, Buckham urged caution.

5.5.4 Creating Conversation

Notwithstanding skeptics, Menninger worked to bring physicians and clergy together. In 1954, “his interest in the relationship between religion and psychiatry led to the first Gallahue Conference on Religion and Psychiatry, a gathering of noted psychiatrists and theologians” that discussed common issues. The gatherings, which continued annually though the end of the decade, “led to the establishment of training programs at Menninger for scholars in theology and psychiatry and for clergy in pastoral care and counseling.” As part of those initiatives, Karl, along with William, worked with the Rev. Dr. Seward Hiltner and others leaders of the clinical pastoral education movement begun by Anton Boisen. Together, they hoped to alleviate suffering caused by mental illness.

5.5.5 Pastoral Counseling, A “New” Discipline

Clergy had counseled parishioners for centuries, but a “new” field of pastoral counseling emerged with clerical adoption of scientific techniques. Mainline Protestants were happy to seek answers to problems related to illness outside of the church,

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152 Hiltner, a Presbyterian, was a leader in the field of pastoral counseling and faculty member at Princeton Theological Seminary for nearly twenty years. He was one of the first students to train with Anton Boisen, and went on to publish 10 books and hundreds of articles, most dealing with the application of psychology to pastoral care. In the 1930s, he served as executive secretary of the Council for Clinical Training, and later as the executive secretary of the Commission on Religion and Health. “Rev. Seward Hiltner, 74, Dies; Taught at Princeton Seminary,” *The New York Times*, November 28, 1984, D.27.
understanding God as working in the church and the world. In 1955, the journal *Pastoral Psychology* published *The Minister’s Consultation Clinic: Pastoral Psychology in Action*, a text that exemplified the exploration of the new field. Geared toward clergy, the volume compiled questions from ministers and other professionals. Readers sought advice about a wide variety of topics: “The Limits of Counseling with Neurotics,” “The Pastor and Suicide,” “Unpardonable Sin and the Psychopath,” “The Interrelationship of Theology and Counseling,” and “The Relationship of Preaching to Pastoral Counseling.” Inquirers wondered about their work as caregivers, the relationship of theology to psychology and psychiatry, and how those scientific disciplines might inform ministry. Respondents weighed in with psychological, ministerial, and medical insight. Early the next year, subscribers shared their reactions to the book.

Menninger, who was also one of the volume’s respondents, endorsed pastoral counseling. In addition to training ministers at the Menninger Institution and served on the editorial boards of *Pastoral Psychology*, and the *Journal of Pastoral Care*. A half-century after his prophetic vision, Boisen’s hope of cooperation between religion and medicine in attending to mental maladies, was a reality for a number of clergy and medical professionals. Although not all of their colleagues agreed, Boisen and Menninger were among many that saw great possibilities for cooperation between religious leaders and mental health professionals. By 1964, the Menninger Clinic’s

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153 A review of the theologian Leslie D. Weatherhead’s *Psychology, Religion and Healing* captured that Mainline sentiment well. The reviewer noted Weatherhead’s reminder that “(1) religion has to do with the whole of man; (2) that the splendid work of doctors in the area of physical methods is in constant need of spiritual assistance in a cooperative fashion; (3) that God works just as thoroughly through the skills of men to bring health and happiness to the minds, bodies, and souls of his children as man will let him.” Clyde J. Verheyden, “Healing the Whole Man,” *The Christian Century*, August 6, 1952, 901.

154 The Minister’s Consultation Clinic, ed. Simon Doniger (Great Neck, NY: Channel Press, 1955). See the volume’s table of contents for each section for a list of topics.

Pastoral Care programs “had trained forty-four theology students and seventy-three clergy through three-month clinical programs.” Menninger felt that “his mother would have been pleased with its success as an exercise in ‘practicing Christianity.’”

Despite interest in pastoral counseling, clergy failed to reach a consensus about the practice. By 1950, though, pastoral counseling was embedded enough in mainstream Protestantism that those without training feared incompetence. Reflecting on his first nine years in ministry, the Rev. Robert E. Luccock, for example, confessed that he “came out of seminary poorly trained to handle a counseling ministry.” The Congregational minister encouraged men in seminary to seek the training he lacked so that they could “avoid regrettable fumbling of the cases that are sure to come to [them], and to equip [them] to be helpful.” With scientific techniques viewed as the most authoritative, clergy felt they needed non-theological training to serve well.

Although enthusiasm for training as psychologically and psychiatrically informed pastoral caregivers prevailed, some continued to recommended caution. The Rev. Dr. John Oliver Nelson, for example, urged balance in training ministerial candidates. “It has become a plain necessity that the minister be able to spot a neurosis or sense of insecurity,” he argued. The Presbyterian professor of Christian Vocation at Yale also acknowledged that pastoral caregivers should be competent deploying the latest secular

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156 Friedman, 263. Because training in pastoral counseling, beyond the knowledge to be gained by the many published books, required financial resources, it likely proved out of reach of all but middle and upper class clergy.


techniques. The minster should “make his pastoral counseling largely nondirective,” should “use group dynamics where they will work,” and should “keep aware of what goes on within his own mind and emotions.” But, Nelson counseled, “in the best balanced approach, seminarians are kept aware that clinical techniques merely provide therapy for a set of ills which Christianity, through the life of conviction and devotion, has long been concerned to prevent.” These were simply new tools for a task that had been undertaken by clergy for centuries.

Others voiced stronger concerns and worried that psychological method would obliterate theological reflection. In 1951, the professor of pastoral counseling and pastoral theology at Wartburg Theological Seminary, Dr. William E. Hulme, cautioned that pastoral counseling without a theological framework was like un-enriched, bleached flour—devoid of life sustaining nutrients. For Hulme, theology should not be used dogmatically or with an air of authoritarianism. However, for the professor, the centrality of the atonement—recognition of that “God was in Christ, himself suffering in man’s stead to redeem him”—was critical to any pastoral counseling endeavor. Even while adopting secular resources, staying grounded in the doctrines of the Christian church remained crucial in the eyes of those like Hulme.

5.5.5.1 Strained Relationships
Despite moments of cooperation, tension between religious and medical workers emerged and garnered public attention. A 1951 Time feature on “Psychiatry and Religion,” for example, began with the assertion that “psychiatrists and clergymen,

meeting over the ailing psyche of modern man, still eye one another suspiciously.”

Hopes of cooperation often failed to materialize. “Rare is the churchman,” the article continued, “who makes systematic use of psychiatric techniques in his ministry to souls; rare is the [psycho]analyst who lives and works upon specific premises of religious faith.” The magazine, though, declared Menninger an exception, a man who “practices Presbyterianism as well as Freud” and “sees no irreconcilable conflict between the two.”

The same could be said of both Menninger sons.

The younger Menninger brother acknowledged that some found “psychiatry, especially psychoanalysis…anti-religious and destructive of religious faith.” Aware of opposition, Karl and William both worked to refute those claims. The older Menninger rejected commonly voiced views that psychiatrists “persuade their patients to a Godless, immoral philosophy,” that they “repudiate the conscience,” “advocate irresponsible self-expression to the disregard of the moral law,” and that they “attempt to thwart the design of the Creator, whom they deny while they themselves play God.” William affirmed, “psychiatry is no more pro- or antireligious than is surgery.” While some suspected that psychiatrists might not be believers, Karl Menninger claimed otherwise, even when they outwardly eschewed faith. “Referring to the agnosticism of some modern psychiatrists, the older Menninger brother explained: ‘I suspect that this refers more to conceptual nonconformity than to deep reverential emotion.’” He even characterized Freud as “more

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religious than he [Freud] realized.”¹⁶⁴ Both brothers fought opposition to the type of religion and scientific integration that marked their own lives.

The most commonly voiced concern about secular professionals claimed that “psychoanalysts favor sexual promiscuity and that they encourage people not to have any sense of guilt about it.” Karl Menninger decried such assumptions as “false,” and stated that their “reiteration is a lie, a slander, and canard, and a misrepresentation of facts, and a piece of dishonest and dishonorable slander.” Medical professionals, the doctor argued, attempted to solve the abnormal personalities associated with sexual irregularities, not to promote them.¹⁶⁵ Menninger lamented those misunderstandings, arguing that they perpetuated the suffering of mentally ill persons that could otherwise receive treatment.

5.5.6 The Role of the Church

Though clergy competed with secular professionals through the 1950s, Americans continued to endorse the work of Protestants in healing. In 1946, for example, Harmon Wilkinson of the National Mental Health Foundation appealed to the religious community for help with “mentally defective” Americans. He imagined Protestants engaged in “full-time Christian service” with needy mentally ill patients.¹⁶⁶ More formally, in 1950, Minnesota Governor Luther W. Youngdahl appointed seven (of an eventual eighteen) full-time chaplains at the state’s mental hospitals.¹⁶⁷ Three years later,

¹⁶⁴ Lowder, 475.
¹⁶⁵ Other arguments by religious people against psychiatry, psychology, and psychoanalysis Menninger acknowledged included assertions that those approaches promoted a dangerous sort of self-knowledge and individual freedom, that “it fails to relieve the unresolved sense of the guilt of sin.” See Menninger, “Religio Psychiatri,” 14-16.
the state of California mandated chaplains on the staffs of state mental hospitals.\textsuperscript{168} Public organizations and institutions seemed to value the role of clergy with mentally ill Americans, but chaplaincy service lacked direct connections to practice in congregations.

Though Menninger was clear about the role of clergy in mental health care, he had little to say about wider congregational participation. Church members sensed some responsibility but rarely detailed plans of action. Most often, they did more thinking than acting and simply articulated something close to the Rev. Seward Hiltner’s 1943 assertion: “In the field of mental health,” he argued, the church “has a twofold task, curative and preventative.”\textsuperscript{169} Similarly, in 1952, the Rev. John B. Oman urged churches to educate members \textit{and} the public about the prevention, treatment and research necessary to combat mental illness. Providing “proper facilities” for prevention and treatment, for example, helped the church put “legs on its prayers.” “To do less,” he argued, “is to miss completely the spirit of Christ.” The “healing of the demoniac” by Christ was, for Oman, “sufficient proof of our Lord’s concern for the mentally sick. His church can have no less an interest and still be Christian.” He placed the “future of millions who are mentally sick” squarely on the shoulders of nation’s Protestants.\textsuperscript{170} Thirty-two years after his original statement about the church’s role, Hiltner worried that “excessive emphasis on positive mental health” on the part of Christians and others could “turn into a sneaky way of avoiding social responsibility for persons now suffering.”\textsuperscript{171}

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\textsuperscript{170} Oman, 103.
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The professor of theology and personality at Princeton Theological Seminary lamented the lack of progress—secular and religious—in attending to mental illness.

Perhaps, as clergy asserted their right to master scientific tools, laity felt incapable of stepping in. In a 1986 reflection, English professor Robert Drake recalled attending a worship service that included a young woman home for a visit from her life-long stay at the local mental hospital. Drake found himself in the middle of a summer Baptist revival haunted by the words of the spiritual “Where you There?” He wondered if he, “like Peter, had denied [his] Lord, maybe even gone to sleep on him when he needed me.”

Noting the “crazy” young woman was also moved by the song, Drake felt shock and wondered “would she have liked to talk about [her miserable lot as part and parcel of it all], would she have liked to ask other people, myself included, where they were when she had suffered her own affliction?” Convicted by his own lack of action, Drake felt his faith challenged. The call to action, however, proved less clear.

5.6 Stigma: Baseball, Hot Dogs, Apple Pie, and Mainline Protestants

Despite advances in treatment, and some attention from Protestants, social stigma continued to plague those living with mental illness. Menninger lamented that the attitudes of “uninformed” Americans led to “cruel stigma…present in the minds of too many good people.” While he denounced stigma, he also feared that psychiatrists helped propagate it. In a 1964 Saturday Evening Post article, the doctor asserted, “psychiatrists use dangerous words,” labels that might stigmatize patients. Diagnostic terms like schizophrenic, manic depressive, and psychotic, he claimed, “frighten patients and worry their anxious relatives and friends” and even affect psychiatrists. Such labels

173 Ibid.
174 Menninger, The Vital Balance, 408.
led medical professionals “back into the pessimism and helplessness of the days when mental illness was thought to be made up of many specific ‘diseases,’ and when each ‘disease’ bore a formidable label and a gloomy prognosis.” Menninger worried that labels could “blight the life of a person, even after his recovery from mental illness.” Although admitting that many of his American Psychiatric Association colleagues disagreed, he confessed that he avoided using terms schizophrenia “just as” he steered clear of “words like ‘wop’ or ‘nigger.’”

With that warning against diagnostic labels, Menninger hoped to prevent stigma’s lingering effects. Reflecting on the mental distress of a college student, for example, he wondered, “suppose she had been officially labeled?” Her parents and “the college authorities would have” more likely “reconciled themselves to probability that this girl would never return to college.” And, if she had returned, “it would have taken extraordinary courage for her to face her comrades as a ‘schizophrenic.’” Instead, concluding, not that the young woman was afflicted with a specific mentally illness, but rather that she experienced a “moderate to severe personality disorganization related to certain exaggerated stresses” that was “amenable to treatment,” allowed her to say to her friends, “I had a severe spell of illness; I was quite depressed but got it straightened out. I’m fine now and I think I learned a great deal from the whole experience.”

Even while dispensing them, Menninger understood the added burdens of diagnostic labels.

Menninger also recognized that the stigma associated with mental maladies minimized public funding of psychiatry and psychiatric research. “The enormous effect

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175 Menninger, “Psychiatrists Use Dangerous Words,” 12.
176 Ibid., 14.
177 Later research demonstrated that stigma prevented patients from seeing treatment. See, for example, sources cited in Nelson, “Bioethics and the Marginalization of Mental Illness,” 189.
of a substantial investment in research pertaining to mental disease” he argued, “is like a
dream of Aladdin’s lamp.” While citizens found themselves bothered by (and gladly
attended to) poverty, the suffering of children, racial and ethnic discrimination, they
considered interest in the plight of the mentally ill “abnormal” and put it “out of their
minds.” The doctor also framed what the sociologist Erving Goffman later named as
“courtesy stigma,” the fact that people who choose to attend to mental maladies would
themselves “be regarded by some as abnormal, a little crazy.”\footnote{178} Perhaps he spoke from
experience.

Rather than stigmatize those seeking psychiatric treatment—whether inpatient or
outpatient—Menninger named them courageous and more intelligent than others that
needed help but lacked the wisdom to obtain it.\footnote{179} Besides, Menninger asserted, no one
proved immune from mental maladies. In fact, he found “that curious emotional defense
which impels some people to believe themselves exempt from all failure, from all
weakness, from the taboo of ‘abnormality,’ is perhaps the greatest enemy of healthy
mindedness.”\footnote{180} He put little stock on the societal definitions of normality against which
stigma was generated:

The adjuration to be ‘normal’ seems shockingly repellent to me; I see neither
hope nor comfort in sinking to that low level. I think it is ignorance that makes
people think of abnormality only with horror and allows them to remain
undismayed at the proximity of ‘normal’ to average and mediocre. For surely
anyone who achieves anything is, a priori, abnormal; this includes not only the

\footnote{178} Hall, ed. \textit{A Psychiatrist's World}, 800-2. There, Menninger seemed to say that Christ called his
followers to accept that sort of courtesy stigma. “Jesus said,” Menninger reflected, “‘Whosoever shall seek
to save his life shall lose it; and whosoever shall lose his life shall preserve it.’ And, of course, [Jesus] too
has often been called crazy.” See my Chapter 6 for a discussion of Goffman’s stigma theory, including
“courtesy stigma.”

\footnote{179} Menninger, \textit{The Human Mind}, ix.

\footnote{180} Ibid., viii.
geniuses, but the presidents, the leaders, and the great entertainers. I presume most of the people in Who’s Who in America would resent being called normal.¹⁸¹

Menninger found emotional distress, even if occasional, more normative than health.

Undeterred by stigma, Menninger operated with a personal sense of responsibly to attend to mental maladies and he hoped to remove obstacles for others to do the same. Perhaps Christian hope in healing and redemption as ever-present possibilities drove his willingness to see things this way. From the days when he watched his mother’s service to those in need, Menninger understood the power Christian faith and physical proximity could have in slashing social stigma in order to enable the perishing to be rescued.

Nonetheless, stigma deepened, and perhaps because the nation took its cues from Protestants. If Christians failed to attend to suffering, who could be expected to do so? Unlike Menninger, with only sporadic Protestant involvement in caring for mental maladies (and waning attention by the 1960s) believers lacked the proximity to sufferers that would ease their own entrenched stigma. To be sure, because mental illness was prevalent in the population at large, chances are Christians did know those who suffered. They simply refrained from talking about mental distress—their own or that of family members—publically.

While Menninger found the “normality” defined by society overrated, the same cannot be said of twentieth-century mainstream Christians. Baseball, hot dogs, apple pie, and happy, well-adjusted, healthy Protestants proved normative in the 1950s, 60s, and 70s. Cultural normativity brought societal prestige and power. In the face of mental illness, the risk of being abnormal, or even the curse of “courtesy stigma” generated from

¹⁸¹ Ibid., x.
deep advocacy for mentally ill Americans proved obstacles too great for Protestants to climb. Or, at least most chose not to.

5.7 Conclusion

Menninger believed God called Christians to offer help in the face of suffering and evil. “By their fruits,” he reflected, “ye shall know them.” He found not reacting sinful: “Caring. Relinquishing the sin of indifference. This recognizes acedia as the Great Sin; the heart of all sin. Some call it selfishness. Some call it alienation. Some call it schizophrenia. Some call it egocentricity. Some call it separation.” For few twentieth-century Protestants did the divine call to attend to mental illness seem as clear as to Menninger. While sure that medicine could remedy suffering, and confident of the role of physicians, he left the ultimate role for healing to God. “By the grace of God,” he observed, and through help from caring physicians, “most psychiatric patients get well.” A realist, the doctor knew that sometimes healing would not arrive.

In 1965, Menninger was ousted as CEO of the Menninger Foundation after growing tensions with senior staff members. His brother William stepped into the lead role, but died of cancer the following year. William’s son, son, Dr. Roy Menninger then took the reins of the family practice. Karl Menninger, while no longer atop the organizational chart, continued to be involved and exert influence on the Foundation and in mental health care around the country. In 1975, Time described the then octogenarian

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182 For Mennonites, in contrast, whose pacifism already marked them as outsiders, little risk existed, because they already lived outside the cultural norm. They felt freer to hold on to their mission to help those afflicted with mental maladies.

183 A Chevrolet advertising campaign in the early 1970s portrayed “Baseball, hot dogs, apple pie, and Chevrolet” as quintessentially American.

184 Menninger, Whatever Became of Sin?, 189.

as driven by “encyclopedic knowledge, insatiable curiosity, moral strictures and unflagging energy.”

Years later, a medical colleague painted Menninger as “brilliant,” but also “quixotic, volatile, challenging, demanding, ruthless in the pursuit of truth. He was unaware of how hurtful he could be. And yet he was the mobilizer of great feelings of loyalty and admiration.”

Menninger left an indelible mark and helped many.

By the mid 1980s, *Family Circle* considered the Menninger Clinic the nation’s top psychiatric hospital; the American Psychiatric Association named Menninger “America’s greatest living psychiatrist.” He served as the face of the new, public psychiatry but also as a representative Protestant in his desire to serve, and his willingness to blend the secular with the sacred to achieve the desired ends.

Protestant responses to mental maladies had evolved as the century progressed. In the 1940s and 1950s, rooted in early twentieth century Social Gospel influences, believers called for church support for and cooperation with emerging organizations (often secular) that sought to care for those with mental illnesses. They understood God at work providing care through the church and the medical establishment. By the 1960s, though, they adopted a more reflective tone and lost their prescriptive call-to-action in the world. They continued to hope, though, that the afflicted would find comfort amidst suffering, if not in the church, then through secular providers. Mental illness, however, was simply one form of suffering among many, and despite the focus of those like Menninger, it failed to spark dedicated efforts at amelioration as it had in the past. Other pressing social concerns, including communism and the Cold War, the threat of nuclear war, and Civil Rights, occupied Protestant agendas.

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Centuries earlier, the colonial clergyman Cotton Mather assumed that sickness was part of life, and a reality that prompted believers to turn toward God. When they ailed, twentieth-century believers turned first to medical professionals. The Revolutionary era physician Benjamin Rush hoped that science would enable healing. In some ways, he was right, but, as more professionals grasped for authority, and as cures for mental maladies remained elusive, providers squabbled with each other as much as they attended to patients. The reformer Dorothea Dix hoped that establishing solid, caring institutions would ease suffering, but within decades of her death, mental hospitals looked more like the places she hoped to reform than her vision of salvific facilities. The early twentieth-century sufferer, Anton Boisen saw a way forward in affirming experiences of mental illness as useful and therapeutic, and while some adopted his approach, his hope for a leadership role for clergy and the church failed to materialize. Likely, Mather, Rush, Dix, and Boisen would have been dismayed by the suffering that persisted for those living with mental maladies, even if they would have commended Menninger’s life work.

On July 18, 1990, Menninger died of cancer in Topeka. With his death, hope disappeared for a unifying figure for Christian action in the face of mental illness. Perhaps no one individual could have effected large-scale change, or navigated the diverse theological landscape to do so. As early as 1948, the journalist Albert Deutsch had declared that “the day of the individual crusader [on behalf of mentally sick Americans] is over.” “Our time,” he stressed, “calls for organized, persistent effort in
behalf of desired social change.”¹⁸⁸ Many Protestants concurred, but few lasting efforts to do so prevailed.

The closing sentences of Menninger’s *The Human Mind* included his hope that, “surely there is a balm in Gilead.” Taken from the lines of an American spiritual, it reflected the doctor’s confidence that healing would come, whether through science, or from God. Looking into the nation’s twentieth-century Protestant congregations, those living with mental maladies may have been more comfortable with the Old Testament formulation: “Is there no balm in Gilead? Is there no physician there? Why then has the health of my poor people not been restored?” (Jer 18:22) Despite Menninger’s efforts, many remained ill, with comfort provided only infrequently by Protestants churches. Many continued to hope, however, that healing would come.

¹⁸⁸ Deutsch, 13.
6. Suffering, Stigma, and Hospitality: A Practical Theology of Mental Illness

Only a community that is pledged not to fear the stranger—and illness always makes us a stranger to ourselves and others—can welcome the continued presence of the ill in our midst.

-- Stanley Hauerwas

Because of God’s faithfulness, [Christians] are supposed to be a people who have learned how to be faithful to one another by our willingness to be present, with all our vulnerabilities, to one another…in and out of pain.

-- Stanley Hauerwas

6.1 Introduction

6.1.1 Connecting Past, Present, and Future

Why study the past?  It is a worthy endeavor on its own, but a window into the faithful practice of Christian forbearers—whether we judge their responses well guided or misguided—helps inform current thought and action as Christians wrestle with similar situations.  The preceding chapters profiled five people of faith—a clergyman, a physician, a reformer, a minister and patient, and a psychiatrist—that hoped to alleviate suffering.  As they peered at the distress caused by mental illness, their Christian beliefs, occupations, and convictions meant that each defined the problem differently, and reacted accordingly.

This chapter undertakes different, but related, work.  I first recap the historical range of American Protestant responses in the face of mental maladies.  I then turn to modern congregations and reflect theologically about the challenges believers face in

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2 Ibid., 81.
light of similar suffering. I offer that assessment in hope of enabling Christians—present and future—to respond more fully and faithfully to the suffering stemming from mental maladies.

6.1.2 Argument and Approach
We have seen that three centuries of American Christian practice displayed varied reactions to mental distress. The stories of the paradigmatic figures profiled in the earlier chapters illustrate, rather than exhaust, the subject. They show, however, a number of paths Christians took. Early American Protestants like the Puritan preacher Cotton Mather reasoned that sin caused suffering and responded with theological counsel about God, faith, and illness. With the rise of formalized medicine, Christians like the physician Benjamin Rush increasingly shared scientific assessments that suffering stemmed from disease and sought medical innovations to alleviate distress. When adequate treatments remained unavailable to many, the lay advocate Dorothea Dix worked for more far-reaching care through the establishment of asylums. By the turn of the twentieth century, Protestants shared lessons learned from their afflictions. For those like the patient and pastor Anton Boisen, mental maladies called the church to step up and train clergy to claim a role in providing care alongside medical professionals. Later in the century, the psychiatrist Karl Menninger brought modern medical expertise to bear and proved willing to collaborate with clergy to do so. Together those figures demonstrate both the range and the progression of Protestant responses amidst a rapidly shifting medical, social, and religious landscape.

Chapters one through five narrated the work of public figures, conversations, and activities largely beyond the walls of local congregations. Each of the individuals
profiled experienced a call to provide assistance, an impulse rooted in their interaction with the long tradition of Christian care giving and sustained by their Christian communities. In this chapter, I turn my attention toward local congregations. I also center my account there because the forces of stigma that stymie the provision of much-desired care prove powerful in church life.

I have argued both that over time Protestants abdicated the care of mental maladies to secular medical professionals and that social stigma—particularly after the turn on the twentieth-century— inhibited Christian responses. Yet, stigma need not impede Christian response to the distress mental maladies bring. I suggest the practice of hospitality as a remedy to limited Protestant reaction. I argue that the practice of hospitality, “a way of life fundamental to Christian identity,” counters stigma and clears the way for more faithful and attentive care.\(^3\)

Framing reaction in light of Christian practice reasserts a role Christians are called to fill amidst suffering, one that is neither completely dependent on—nor fully independent of—secular medical care. Intentional, attentive, and theologically reflective hospitality witnesses to the love of God in Christ and incorporates both care providers and care receivers into God’s ongoing, redemptive work in the world. Offering such hospitality, however, requires an ethic that is, in many ways, counter cultural, and rightly so. Stigma stems from societal norms that often differ from the divine intention for God’s creation to be in relationship with God and fellow believers.

Rather than providing a single answer to a complex set of questions and realities, I explore suffering, stigma, and hospitality to encourage thought and action amidst unique

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\(^3\) Christine D. Pohl, *Making Room: Recovering Hospitality as a Christian Tradition* (Grand Rapids: W.B. Eerdmans, 1999), x.
experiences of distress. I first offer a historical survey of hospitality, and then explore the practical and theological problems that suffering presents. Third, I return to stigma theory to study how stigma shapes human relationships. I move beyond stigma theory, however, and by assessing stigma theologically, suggest that God calls Christians to claim both solidarity with and for the suffering and the stigmatized. Finally, I look more deeply at the practice of hospitality, framing it as a combination of acts of welcome, incorporation, patience, and compassion.

A brief discussion of what this chapter does not do seems apt. First, others have argued that medicine and psychiatry need the witness of the church and Christian ethics.\(^4\) I agree, but my focus differs. I attend to congregational-based practices of Christian hospitality, sensing that until the church can attend faithfully to suffering, it has limited wisdom to offer the world.\(^5\) Second, I neither recommend nor discourage use of medical technologies such as psychotherapy or psychotropic pharmaceuticals.\(^6\) Finally, because individual encounters with mental distress, medical diagnoses, religious beliefs, and social interactions all shape the experience of mental illness, and each of these elements can generate suffering, I do not define a solely medically based view of illness. Instead of a focus on disease, I consider the broader category of suffering and turn to Christian understandings of health that extend beyond (and sometimes counter) medical assessments of illness.


\(^5\) While the world at large is not the focus of my theological reflection, what the world might gain from the church’s faithful practice of hospitality is insight into dismantling social stigma, stigma that prevents care and deepens suffering for many.

\(^6\) For a “Thomistic account of the Christian use of psychiatric technology” that proposes the benefit of virtue ethics to psychiatric theory and practice, see, Kinghorn.
To be sure, my reflections fall short of a comprehensive, systematic theology of mental illness. Instead, the practical, theoretical, and theological work of this chapter involves what the theologian David Kelsey names as primary, or pastoral theology. I ground my reflection in concrete human situations and seek “to throw light on the theological content, rational, and criteria of truly faithful Christian ministry” and practice. This effort involves “critical reflection on the entire range of practices that make up both the common life of communities of Christian faith and the lives of individual persons of faith.” I consider my work an undertaking in practical theology, theology that attends to human response to suffering, given God’s mission in creation. This chapter offers theological resources for ongoing conversation that I hope invite and encourage the

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7 David H. Kelsey, *Imagining Redemption* (Louisville: Westminster John Knox Press, 2005), 87. Primary and secondary theologies necessarily relate to one another. Kelsey asserts that secondary, or systematic, theology “seeks to throw light on the meaning and truth of beliefs that are inseparable from the practices that make up the life of communities and persons of Christian faith,” but is systematic in one way or another. It may be systematic by “starting with what are taken to be the simplest and most easily understood beliefs and moving step by step to explain more and more complex and difficult ideas about God and all other realities as God relates to them and they relate to God.” It may also “be systematic in its effort to show how Christian beliefs about these matters are systematically interconnected,” or “in that it proposes a coherent scheme of more or less rigorously defined technical concepts by which Christian beliefs can be reformulated to provide an internally coherent network of explanation that are adequate to all aspects of human experience.” Ibid., 87-8.

A secondary, systematic, theology of mental maladies is an important, and much needed addition to the theological literature, but beyond the scope of this dissertation. The work of a number of theologians—often theologians of disability—heads in that direction. See, for example, theologies of disability by Nancy Eiesland (Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994), Hans Reinders (Hans S. Reinders, *Receiving the Gift of Friendship: Profound Disability, Theological Anthropology, and Ethics* (Grand Rapids: William B. Eerdmans, 2008), and Thomas Reynolds (Thomas E. Reynolds, *Vulnerable Communion: a Theology of Disability and Hospitality* (Grand Rapids: Brazos Press, 2008), and the theological work of John Swinton (particularly, John Swinton, *From Bedlam to Shalom: Towards a Practical Theology of Human Nature, Interpersonal Relationships, and Mental Health Care* (New York: P. Lang, 2000)).

8 With this suggestion, I draw on the theologian Andrew Purves’ sense that “practical theology is theology that is concerned with action: first with God’s action, the mission Dei; and second, with the action or praxis of the church in its life and ministry in faithful communion with the God who acts, the mission of the church.” God’s acts are first, ours our second, and “even then,” Purves argues, they are “but a participation in the Holy Spirit…to the prior act of God.” Andrew Purves, *Reconstructing Pastoral Theology: a Christological Foundation* (Louisville, KY: Westminster John Knox Press, 2004), xxv.
reconsideration and reshaping of Christian speech and practice. In total, I seek a practical theology that enables response in the face of mental maladies that has been disabled by social stigma and the abdication of care to scientific medicine.

6.2 A Historical Recap and Sorting

Mental illness prompts questions. Why do some suffer? What did I do to deserve this affliction? What does it mean to be sick? Does God still love me? What is health? Do mental and physical health differ? What does faith mean in the light of chronic illness? How are Christians called to “be the church” in the face of distress? Why does the church seem to ignore mental illness?

Aware of such questions, my historical work demonstrates that Protestant reactions to mental illness were rooted in responses to three broad lines of inquiry. They asked, 1) Why did mental illnesses exist?, 2) How should Christians react?, and 3) Who bore responsibility for responding? As the stories of the figures in the previous chapters show, both theological and practical considerations shaped the emphasis on—and their answers to—these questions. The same holds true for modern believers.

Alongside this hope for reshaping Christian practice, I acknowledge that behaviors often fail to cohere with religious beliefs. As the sociologist Mark Chaves notes, religious incongruity is “ubiquitous.” Religious congruence, while rare, is not impossible, and the purpose of reflective, practical theology, I argue, is to highlight instances of, and reasons for, incongruence and to seek greater congruity. Chaves uses “religious congruence” “in three related senses: (1) individuals’ religious ideas constitute a tight, logically connected, integrated network of internally consistent beliefs and values; (2) religious and other practices and actions follow directly from those beliefs and values; and (3) the religious beliefs and values that individuals express in certain, mainly religious, contexts are consistently held and chronically accessible across contexts, situations, and life domains. In short, it can mean that religious ideas hang together, that religious beliefs and actions hang together, or that religious beliefs and values indicate stable and chronically accessible dispositions in people.” Mark Chaves, “SSSR Presidential Address Rain Dances in the Dry Season: Overcoming the Religious Congruence Fallacy,” Journal for the Scientific Study of Religion 49, no. 1 (2010), 2. Chaves’s purpose in this article is not to encourage or discourage congruity in belief and practice. Rather, he seeks to improve the scientific study of religion by disabusing researchers of the presumption of religious congruence. Later in the chapter, I return to Chaves’s proposal of requirements for congruity of belief and practice.
6.2.1 Why did mental maladies exist?

Over three centuries, Christians offered an array of reasons for the presence of mental illness, often drawing on multiple explanations simultaneously. Most posited sin—original or personal, corporate or individual—at the root of all illness, including mental disorders. A few insisted on direct links between individual behavior and the infliction of illness. Suspicions of demonic possession and illness as divine punishment appeared, but in America such explanations always took a background role and continued to fade as the centuries progressed. Under continual debate was whether mental illness was a physical, spiritual, social, or moral problem, or some combination thereof.

Why did mental illness persist? Some saw those who suffered to be at fault. Women and men, they argued, refused to abandon non-normative behaviors (willful sin, moral laxity, “deviant” behavior such as masturbation or homosexuality) that contributed to illness. Others suffered because they resisted or refused treatment.

Instead of placing blame solely with individuals, some faulted secular and ecclesial institutions for failing to provide adequate care. Others thought that an increasingly complex society made mental distress inevitable, especially for populations deemed vulnerable (minorities, immigrants, the poor, and women). Protestants diagnosed individuals, society, and sometimes both, as sick and in need of treatment. Many simply

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10 Social context often determined perceived normativity. Ian S. Evison noted how broader social ethics and a sense of normative behavior, shaped psychiatric diagnoses. “Before the Civil War, psychiatrists discussed whether drapetomania, slaves running away from their masters, was a mental disease…During the suffragette campaigns of the late nineteenth century psychiatrists discussed whether the discontent of women was a form of ‘nervousness’ that might be remedied by a ‘rest cure.’….During the Vietnam war, psychiatrists discussed how to cure the ‘inappropriate’ reluctance of soldiers to go into battle….And during recent revisions in the standard diagnostic manual, the DSM-III psychiatrists have classified smoking as an illness and no longer refer to homosexuality as an illness.” On Moral Medicine, 828.
accepted illness as part of what it meant to be human and finite, without struggling to identify specific causes.

6.2.2 How should Christians respond?

Christians considered a range of responses, and the proper locale of treatment formed an initial line of inquiry. Protestants sometimes initiated healing efforts in congregations and church-sponsored facilities, but they also affirmed a role for state-run and private institutions, particularly for more acute mental illnesses. Some advocated for believers to minister inside of secular hospitals as chaplains, mental health professionals, and volunteer caregivers.

Modes of response also varied—some urged individual confession of sinful behavior, others offered intercessory prayer on behalf of those who ailed. In the early twentieth century, preventative measures, including mental hygiene programs, captured Protestants’ attention. Usually, Christian responses reflected the desired outcome of religious intervention—both enabling cures and providing help in coping appeared as goals of Protestant involvement.

6.2.3 Who should respond?

When Christians acknowledged the need to care, they held different inclinations about who should take the lead. Some saw this task as the purview of clergy; others saw roles for laity. Further, perceptions varied about who could rightly claim “expert” status in the diagnosis and care of illness—clergy or physicians. In this vein, some viewed cooperation between religious and medical professionals as a logical harnessing of God-given resources, for others religion and medicine formed independent spheres. Also

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11 Twentieth-century debates about the permissible use of psychiatry and psychology stemmed from these lines of inquiry.
part of the inquiry about who should respond were questions about divine versus human agency. Some asserted that matters of sickness and health were exclusively under God’s control. Others assumed humans, through faith in Christ, could work cooperatively to ensure both health and healing.

6.2.4 Discussion
Both Christian beliefs and social realities (the state of medicine, the availability of institutional care, media portrayals of insanity) determined how individual Protestants responded. Dix, Mather, Rush, Boisen, and Menninger had unique answers to those questions, ones rooted in their theological beliefs, professional opinions, and social locations. While each approached the pursuit of healing differently, mitigating suffering remained their central concern. Only Mather and Boisen were formally trained theologians, but each of the five deployed formal or practical theological insight in their responses. In many ways, the same holds true for modern believers, as a similar set of considerations continue to animate responses.

6.3 Concealed Insanity: The Modern Context
6.3.1 Recent History
Believers like Mather, Rush, Dix, Boisen, and Menninger sought to discern God’s leading, and such promptings always formed a core Christian impulse. Following the witness and example of Christ, in the face of illness and suffering, believers felt confident that Christianity could bring healing. They also envisioned the roles they could take to diminish suffering caused by mental distress. Nonetheless, despite centuries of thought and practice no normative Christian responses emerged. Perhaps the chronic nature of
mental illness, the elusiveness of cures, and the power of social stigma thwarted the standardization of reactions.

By the late twentieth century, little evidence appeared that Mainline Protestants spent much time figuring out how to offer care or seek cures for mental illness. While some initiatives appeared, efforts to attend to mental maladies failed to top congregational agendas, if they appeared at all. Beyond attendance at weekly worship services, activities like Sunday schools, vacation bible schools, youth groups, work with local social service agencies for the homeless, and short-term mission trips were more likely to occupy parishioner attention. In contrast to attempts to ameliorate the suffering of mentally ill parishioners and community members, other endeavors proved easier to plan and recruit volunteers for; they were also less fraught with complexity and stigma.  

Nonetheless, pockets of productive activity did appear. The psychiatrist Harold Koenig outlined a range of mental health services provided by churches and other faith-based organizations in the late twentieth and early twenty-first centuries. On the congregational level, initiatives included spiritual and pastoral care, companionship, and the provision of food, shelter and support for the afflicted. Networking and advocacy organizations like Pathways to Promise and FaithNet (an initiative of the National Alliance on Mental Illness) offered educational and referral resources. Religiously affiliated organizations, such as the Pine Rest Mental Health Services, the American Association of Pastoral Counselors, and the professionals of the American Association of

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12 To be sure, many Christians attended to mental distress as family members and health care professionals. In those endeavors however, faith and healing often existed in separate realms, at least overtly.
Christian Counselors, provided a range of medical treatments, social services, and counseling.\textsuperscript{13}

6.3.2 The Face of Mental Maladies

Whether or not early twenty-first century believers responded to mental maladies, mental distress remained prevalent and affected many inside and outside of sanctuary walls. Because illness and suffering are always experienced in unique, human contexts, what follow are six vignettes that highlight complexities of mental illness in the early twentieth-century Protestant life. These profiles ground the theoretical and theological reflections that follow.\textsuperscript{14}

\textit{Elena}

Exhausted, Elena sat in a pew one Sunday morning. Two days earlier, she awoke, worried about her husband who had been severely depressed for weeks. He had been working from home, but not accomplishing much—depression meant that concentrating proved difficult. For the past several days, as Elena drove home from work, she called her husband, praying that he would answer the phone. The fear that she barely wanted to admit to herself was the she would arrive home and find that he had committed suicide, perhaps hung himself in the garage. That Friday morning she had asked him again if he was thinking about hurting himself. When he couldn’t say “no,” she realized she needed to take action. After calling the counselors at their health care company’s


\textsuperscript{14} I draw these vignettes from circumstances I encountered as a chaplain at a state mental hospital, as a member of a local congregation, and as a participant in local clergy networks. Names and details have been changed, added, or altered in each scenario. Some scenarios are composites of separate cases.
mental health provider, she prepared to have him admitted to the hospital. She couldn’t bear the burden alone anymore of making sure he was OK twenty-four hours a day. He needed help. They needed help.

After getting their young son to school, she drove her husband to the local private mental hospital. He checked in willingly, but called that night angry that she had abandoned him there. Two days later, as she sat in church, emotionally and physically spent, she was aware that only a few people knew about her husband’s illness and hospitalization. When their son had major surgery years ago, they’d received several meals and lots of attention. She knew no casserole would be delivered tonight. The ministers in the congregation knew what was going on, but nothing was said during the service’s prayer concerns. Elena wasn’t sure she would have wanted it any other way. She worried about the lasting effect of people knowing of her husband’s mental illness. While surrounded by fellow worshippers, Elena felt very alone.

Charlene
Charlene, a seventy-eight year old woman, received sympathy in church one week when the minister announced the death of her brother. She welcomed those condolences, but knew that no one fathomed how complicated her brother’s death felt. Yes, her brother died, but he had been institutionalized for thirty years in the state mental hospital—after killing their younger sister. Having suffered with schizophrenia for most of his adult life, he was not well when the murder took place, but that fact brought little consolation. Charlene suffered alone, only the minister knew of her family secrets. Her brother’s death meant Charlene grieved many things simultaneously—his death, her sister’s murder, her brother’s illness, the loss of many things in her life as a result.
Helen and Aaron

Helen, the director of Christian education at a local church, adopted a son eleven years ago—Aaron was just two at the time. The boy’s birth parents led troubled lives, and he was removed from their care repeatedly in his first years of life. During the adoption, Helen was excited about the ability to offer care and a new life for the young boy—he was cherubic, and the future seemed bright. The picture didn’t remain rosy for long. By age five Aaron’s behavior often was erratic, and increasingly violent. Sometimes he scared her, and by age thirteen, he was strong enough to inflict physical pain.

Over the years, Aaron had been in and out of psychiatric wards. He’d received multiple diagnoses—attention deficit disorder, bipolar disorder, and others. Doctors tried many combinations of medicine. Most treatments helped for a while, but then Aaron’s confusion and violent tendencies returned. For the past year, Aaron had lived in a small group home. Helen was able to talk to him daily and see him frequently, which offered both of them some comfort. Sometimes friends from her church inquired about her son, but after so much chaos and distress, many had grown weary of—or uncomfortable about—asking. Helen dreaded encountering their discomfort.

Last week Helen received a call from the group home administrator. Aaron was being kicked out because his behavior had grown too violent. He’d even recently tried to escape from his second floor bedroom window. While just a young teenager, his behavior was too dangerous for him to come home. The only choice Helen had was to pick him up and take him to the emergency room of their town’s large general hospital. They spent days waiting to see if room would open for him—either there or anywhere else in the state. After three days, and with no bed available, the hospital asked them to
leave. Thankfully, the group home said they would take Aaron back for a few weeks, if his behavior had calmed down. Helen prayed it would.

In the mean time, Helen tried to keep everything together at her job and search for a place that would take her son. She no longer even cared about finding a place close to home, she just wanted to make sure Aaron was safe and taken care of. Helen worried that she’d failed as a mother. She grieved the loss of her son’s “normal” future and the peacefulness of her past life, but felt guilty doing so.

Susan and John
Susan, the chaplain at a state mental hospital was called to visit with a patient. In his early 30s, John, had been hospitalized many times, and she recognized him from a short stay a few months earlier. She remembered John lamenting that the medicines prescribed to treat his schizophrenia made him feel horrible, and not like himself—he gained weight, lacked energy, and had no interest in his hobbies. During that earlier visit, he said that as soon as the doctor discharged him, he planned to throw his pills in the trash. Susan wondered if he had, and if lack of treatment precipitated the return of his symptoms and his readmission to the hospital.

As they sat down to talk, John expressed anger at his church. Members of the congregation had called the police to take him away in the middle of a worship service. John professed to being fine and didn’t understand the police involvement. He clearly wasn’t well, and while the young man couldn’t understand why his church had betrayed him, the chaplain could imagine that his delusions and odd behavior frightened fellow church members enough to call the authorities.
After years of illness and periodic drug abuse, John had long since lost contact with his family. Now he was mad at his friends, mad at his church family, mad at God. John was convinced that everyone hated him and that God was punishing him. As they sat together in the day room of the hospital ward, Susan offered a prayer, but knew that it would be tough, at least right now, to find words that would comfort the distraught young man.

**Deborah**
Deborah, a pillar of a local congregation, struggled to get ready for church one Sunday morning. She finally crumbled into a chair at home. She poured herself a glass of scotch, even though it was only 9:00 a.m. For decades, she and her husband rarely missed church. Three months ago, though, he shot and killed himself in his study. She still could not quite think about the moment she found him. She was sad, exhausted, and angry.

Over the years, dealing with her husband’s depression had been hard enough, but now she faced new, unimaginable pain. Deborah was receiving good care from her minister and attention from the congregation, but she was embarrassed to go to church—embarrassed and distraught. She also knew that being in church would require lots of energy. Energy to receive the well wishes, energy not to break down in tears, energy not to scream the real reason behind her husband’s death to those who had not figured it out. Where had her church family been during the decades of struggle through her husband’s depression? Were they really present now? A drink every now and then seemed to help ease the pain, but she missed the chance to worship. Deborah decided to figure out how to go to church next week, but not today.

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Frank
Frank, a Lutheran church leader, hung up the phone after receiving word that one of the most promising young pastors under his care had just been found dead in his church office. Over just a few years, the father of three young boys had launched a congregation and grown it from a handful of families to several thousand members. He seemed a model pastor of a vibrant church and was well known and respected in the surrounding community.

The staff member who called Frank confessed that she suspected the minister had taken his own life. Hours later, police confirmed her suspicion. After locking himself in the building, the pastor intentionally overdosed. He left suicide notes for his wife and coworkers. It seemed no one knew the minister was struggling; he’d always presented a cheery front.

In disbelief, Frank could not seem to make himself move out of his chair, but he knew that he should do something. This was his close friend and a beloved member of the local community. Frank knew that he had an obligation to help the congregation, the staff, and the family. He suspected he’d be asked to lead the funeral. Frank had presided over hundreds of memorial services, but now, he struggled to claim the hope of the Resurrection. How would he be able to find the words? What would he say to everyone seeking answers? “Dear God,” he prayed, “please help.”

6.3.3 Discussion
Scenarios like these trouble sufferers and bewilder family members, congregations, and clergy. While each experience of mental distress is unique, these vignettes surface common themes: the pain and discomfort of illness, isolation, sadness, exhaustion, reluctance fully to voice the nature of ailments, and a desire for care. They
also hint at deeply ambiguous relationships with faith communities for those who suffer and their families. Men and women affected by mental maladies often long for God’s presence and the comfort of fellow church members, but their distress rarely prompts the provision of casseroles, intercessory prayers, or spiritual care as quickly as other ailments, if at all. Fear, stigma, and even aversion shape responses.

Given the scripturally based understanding of a call to love God and neighbor and to continue the healing and caring work of Christ, the inability to attend to the suffering caused by mental maladies might seem curious. It might also be labeled unfaithful or sinful—whether a sin of omission or commission. For individual believers and congregations seeking to repair this breach, how might they proceed? What forces shape congregational responses? What theological considerations offer guidance? What might faithful responses look like?

6.4 Reflections on Suffering

6.4.1 Suffering and Mental Illness

As the vignettes above display, mental maladies bring suffering in many ways. Those who ail experience unwanted symptoms including stifling depression, crippling anxiety, or frightening delusions. With medical attention, symptoms sometimes bring formal diagnoses like chronic depression, obsessive-compulsive disorder, or schizoaffective disorder. Receiving a diagnosis often focuses treatment efforts. Pharmaceuticals relieve symptoms, but they can also bring unpleasant side effects. Diagnoses, though, may feel reductive instead of helpful. For some sufferers, receiving a diagnostic label brings further distress, as they come to terms with being, not themselves, but labeled “a schizophrenic,” “a manic depressive,” or “crazy.” In addition, medical
diagnosis can make those who ail feel as if they handed over the ability to define their own experience of suffering.¹⁵

Even productive medical care proves complex. The psychiatrist and theologian Warren Kinghorn, for example, observed that instead of an “idealized modern science” that names and solves all problems,

contemporary mental health care involves a complicated socio-politico-scientific culture in which the cries of the distressed, the methods of modern scientific inquiry, the economic powerhouse of modern medical and pharmaceutical interests, the self-interests and professional commitments of clinicians, and the wide range of sociocultural attitudes toward madness are inextricably mixed.¹⁶

Diagnosis and treatment remain far from an exact science and inherent flexibility and ambiguity can exacerbate suffering.

Suffering, though, proves deeper than frightening symptoms and diagnostic complexity. Because treatments are not always available or utilized, and because in many cases cures prove elusive, many who suffer face chronic distress. Not only do sufferers despair, family members and friends find themselves weary and at a loss for ways to help. Sometimes, loved ones burn out and walk away, forced to sever ties with those in need of care for their own health or safety. Disease causes discomfort and disorientation, but estrangement and isolation deepen that distress. And, for sufferers, the prospect of chronic affliction can disable hope and disrupt a sense of connection to family, friends, and God. Mental illness can cast doubts on a meaningful existence.

¹⁵ For a discussion of the “usurpation” and “loss of voice” experienced by patients, see M. Therese Lysaught, “Patient Suffering and the Anointing of the Sick,” in On Moral Medicine, 359.
¹⁶ Kinghorn, 129-130.
6.4.2 Suffering and Theology

Suffering presents existential difficulties; it also prompts theological reflection. Four Christian claims stir theological inquiry and offer insight in the face of suffering. First, Christians believe in a loving God who created the world and named it good (Gen. 1:31). As the theologian Susan L. Nelson reflects, “the earth, our bodies, and our passions, our dependency upon one another, our strengths and our vulnerabilities, the complexities of life lived in community with all sorts of creation—all of this is good.”

Yet, second, while God named creation good, as Nelson’s assertion names, creation is not perfect. Borrowing a phrase from the theologian Karl Barth, theologian Daniel Migliore argues that this “shadow side” of creation includes the “finite, limited, and vulnerable” realities of human life and assumes that “challenge, risk, and growth are part of creaturely existence as intended by God.” Inherently, even if paradoxically, creation is simultaneously good yet imperfect and finite.

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18 Daniel L. Migliore, Faith Seeking Understanding: An Introduction to Christian Theology (Grand Rapids: W.B. Eerdmans, 1991), 89. Susan L. Nelson, and others distinguish between suffering and evil. “Evil is an awareness of,” she argues, the “disjuncture between the pronouncement that life is God’s good creation and the knowledge that suffering and violence are real and threaten not only life and health but also any sense of meaning, order, and blessing. Evil is the experience of suffering, misery and death, and the accompanying fear that such suffering undermines any hope of meaning and order in the world of a God who exercises providential care.” Nelson, 399.

Nelson’s work focuses more on evil than suffering, but the categories she proposes for considering God’s relationship to evil are useful in thinking about suffering not “severe” enough to be named evil (a moral view, radical suffering, ambiguous suffering, eschatological imagination, and redemptive suffering). To be sure, by differentiating between suffering and evil for the purposes of my theological reflections here, I do not intend to imply that suffering associated with mental maladies can never be named evil. The despair of chronic affliction can seem evil. In addition, mental illnesses that prompt violence perpetrated by—or against—the one who ails, for example, can readily be called evil. Despite, however, frequently overlapping coverage of mental illness and violence in the media, in the vast majority of cases, experiences of mental illness can be categorized as misery more so than evil.

19 Similar to Nelson’s work, the theologian John Swinton reflects that “if the claim is true that in Christ God has overcome evil and suffering and that even now, the world is not the way it has to be or indeed the way it will be, then the problem of…suffering becomes both a mystery and a paradox.” Here, and throughout his text, Swinton discusses “suffering and evil.” Although suffering and evil bear commonalities, and often exist simultaneously, my work focuses on instances of human suffering, but not necessarily evil. John Swinton, Raging with Compassion: Pastoral Responses to the Problem of Evil (Grand Rapids: William B. Eerdmans, 2007), 1.
Christians also hold, third, that though human sin brought (and continues to bring) brokenness—and thus suffering—into the world, God through Christ entered the world to bring healing, redemption, and salvation. Suffering may be part of human reality, but Christians refuse to concede that it has the final word. Through the incarnation, Christ entered into, and overcame, human suffering, for us and with us. The healing brought by God in Christ takes place both here and now, and in the world to come. Fourth, the doctrine of creation assumes the “coexistence and interdependence of all created beings.” With or without brokenness and suffering, God created humans to stand in relationship with God as Father, Son, and Spirit, and with one another. That interdependence grounds Christian identity and calls Christians to work for the good of each other.

6.4.3 Stigma Prompts Theological Disorientation

As individuals and communities, Christians live and wrestle with suffering and brokenness. Suffering disrupts a sense of the rightness of the created order and thus believers often deem suffering problematic. Much suffering seems inexplicable. Theologian Stanley Hauerwas observes that suffering carries a sense of “surdness” or inability to be fully voiced. It denotes “frustrations for which we can give no satisfying explanation and that we cannot make serve some wider end.” To suffer, he argues “is to have our identity threatened physically, psychologically, and morally. Thus our suffering even makes us unsure of who we are.” Mental illness can cast adrift those who suffer, in visible and invisible ways.

20 Migliore, 89.
It seems, then, that distress, like that stemming from mental maladies, would spark a response. It often fails to do so, or at least it fails to prompt action in line with theological assertions. Though Christian doctrine and belief affirm the four theological claims above, in the face of suffering associated with mental illness, believers often fail to act as if those assertions are true.²² I argue this is the case, at least in large part, because, the logic of stigma vies for attention with—and often overpowers—theological claims. Social norms trump Christian professions and, as a result, bring theological disorientation.

What do responses to mental maladies look like when shaped by social stigma instead of core theological convictions? Using the theological assertions above as a guide, we see that theological disorientation takes different forms. First, instead of a theocentric or Christocentric logic, Christians (even if mostly unconsciously) deploy a culturally shaped anthropocentric logic. While Christian doctrine asserts that God created the world and named it good, Protestants ingest and adopt modern American social norms that indicate that only some of creation is good. Other parts of creation, including those living with mental illnesses, are deemed “diseased,” “defective,” and “unproductive.”²³

Second, the logic of stigma also refuses to accept the paradox of the finite and limited nature of creation. Instead, it names conditions, events, and even some people as things that “should not be.” Mental illness becomes an unwanted anomaly, something to be hidden, shunned, or avoided. Third, while theology draws attention to God’s saving

²² Belief and practice, of course, fail to cohere for other reasons. Here, my focus is on the ways stigma contributes to religious incongruence. See note above for a discussion of religious congruence and incongruence based on the work of Chaves.

²³ The American framework that includes a sense of entitlement for what is “better” or “perfect” and a presumption that problems are always solvable exacerbates this phenomena.
work in the world in and through Christ, the logic of stigma asserts that humans are responsible for bringing change and ensuring salvation. The healing of human distress is presumed to rest on human effort alone. God and faith communities, it seems, have little help to offer. Finally, while Christian belief affirms the interconnection of all of creation, the logic of stigma dictates that men and women, as independent actors, hold ultimate responsibility for bearing suffering.

In total, the logic of stigma declares those living with mental maladies as “other, frightening,” “dangerous,” “unwelcome,” and even “contagious,” rather than as fellow children of God. As the result of stigma, what Christians profess, and how they react differs. Stigma clouds theological wisdom and misshapes Christian reaction to mental illness.

6.4.4 Reclaiming Theological Congruity

Incongruence of religious belief and practice, though, should not be surprising; it proves as common as suffering. Nonetheless, a closer coherence between belief and practice is possible, even if rare and difficult to achieve. How might such coherence be achieved? The sociologist Mark Chaves names three conditions that are required (together or separately) for congruence of belief and practice. First, “congruence can be achieved through conscious cognitive effort.” By analyzing ideas or beliefs in relationship to actions, “we can try to reduce recognized inconsistencies.” Second, “congruence also can be achieved through social rather than cognitive effort.” In discerning the proper fit between beliefs and a practice, individuals might follow the advice given by religious leaders or learn to make those assessments themselves “through

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24 Mark Chaves notes that we should expect incongruence of belief and practice.
immersion in a homogeneous religious culture or through intense involvement with an all-encompassing group.” Finally, congruence can occur without “cognitive or social control” through “experience that forges internalized, automatic responses to situations so that religious schemas spring automatically to mind in certain situations.” Such “implicit, unverbalized, rapid, and automatic” response, though, proves “difficult to achieve” and takes time.25

Notwithstanding the power of social stigma, Christian hospitality, when well-practiced, fulfills—at least in part—each of the conditions Chaves names as required for congruence. The final portion of this chapter outlines the contours of that practice. Beginning to dismantle, or work around, the power of stigma, however, calls for two preliminary tasks. First, we need a deeper understanding of the workings of stigma in social relationships. Second, we must name an alternate telos to the normative societal claim that humanity is good only when useful or productive. We need a telos that does not exclude those who suffer from God’s good creation. Together, that theoretical work paves the way for (and sustains the practice of) Christian hospitality in the face of mental maladies that has the best chance of helping belief and practice align, dismantling the effects of stigma, and allowing for more faithful attention to suffering.

6.5 Stigma Theory: Revisiting and Redeploying

6.5.1 How does stigma operate?

Social stigma proves powerful, even within the walls of congregations that profess God’s love and the promise of the redemption of all of creation. How and why

25 Chaves, 7. Chaves argues that the third option promotes the most powerful route to congruence, but it is the most difficult to achieve. The first option might be used to describe the intended work of practical theology, which includes a continuous cycle of practice and reflection.
does stigma overpower theological convictions, the experience of God’s love, and our call to care?

Stigma theory helps explain those dynamics. The sociologist Erving Goffman developed stigma theory to describe the construction of social identities. “While the stranger is present before us,” he observes, “evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind….He is thus reduced in our minds from a whole and usual person to a tainted, discounted one” (emphasis added).26 Stigma creates distance between one’s “virtual social identity” (based on characteristics that a person is assumed to possess) and “actual social identity” (based on characteristics that a person actually possesses.) Perceptions and reality often differ. As an example, consider the account John from the vignette above, the young man hospitalized after a call from his congregation. If the hospital released John and he complied with his treatment plan, he might live a life free of symptoms of illness. Yet, fellow congregants might continue to view him as erratic, unreliable, and potentially dangerous. The stigma of mental illness proves difficult to shake. Similarly, a veteran diagnosed with Post Traumatic Stress Disorder might encounter resistance leading a church youth group, long after symptoms abate.

Reviewing constructs introduced earlier in the dissertation, Goffman identifies three origins of stigma. The first, rooted in “abominations of the body,” includes attributes like missing limbs, facial deformities and other very visible characteristics. Second are “blemishes of the individual character” including a “weak will” or

“dishonesty” that might be inferred from “a known record of, for example, mental disorder, imprisonment, [or] addiction.” The final source includes “race, nation and religion.”

Regardless of its origin and strength, Goffman defines stigma in contrast to “normal,” thus stigma marks both normalcy and its alternative, “deviancy.” For the stigmatized, including those living with mental health problems, this division between “normal” and “deviant” creates distance in social relationships, as those who suffer are defined as “other” and “not like us.” A mental illness visible through strange behavior, an unkempt appearance, or an unreliable presence, for example, might mark the one who suffers as an undesirable person, not to be welcomed into a church community, rather than a child of God to be embraced.

6.5.2 Visibility

For many stigmatizing attributes, the visibility of the trait determines the impact. Goffman designates stigmatizing realities as either visible and “discrediting,” or hidden and “discreditable.” Unlike a broken leg or physical deformity, mental illness often proves invisible in human relationships. In this sense, Goffman likens ex-mental patients (or those masking current illness) and “expectant unmarried fathers…in that their failing [to meet normative social expectations] is not readily visible.”

The afflicted, or those who have recovered from severe past mental distress, are often able to hide symptoms and treatments and limit knowledge of their past and present illness. Fear of the effects of stigmatization prompts them to do so.

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27 Ibid., 4.
28 Ibid., 48.
29 William F. May discusses how the fear of normals—of their own limitations—deepens stigma and encourages invisibility on the part of those who suffer. “Not all expedience in our treatment of the distressed springs from gross callousness; rather, we are busily engaged in obscuring from view our own poverty: by hiding from ourselves and hiding our selves. We consign to oblivion the maimed, the
Visible mental illness can lead to exclusion. Returning again to John, who was hospitalized after strange behavior at church, we see a case of visible illness. Although the congregation’s call to the authorities to remove John may have been appropriate for John’s protection and their own, church members likely foster a view of John’s ongoing danger to the group. Whether or not his health warrants it, in the future, John may find himself unwelcome (or received coldly) in his community of faith.

Both visible and invisible realities that prompt stigma cause suffering. Invisible, or hideable, mental illnesses bring suffering because they force sufferers to be in the world as less than fully themselves. The case of Charlene, who grieved alone following the death of her hospitalized brother because of her reluctance to share the details of his hospitalization, demonstrates suffering generated from stigma-induced invisibility. In social situations, those who ail invisibly manage “undisclosed discrediting information” about themselves. Hiding a potentially stigmatizing attribute takes work (and sometimes careful planning), but it is an effort that those who ail and their families might deem worthwhile.

Often, mental maladies remain hidden. “Passing” for normal seems a path of least resistance, but stigma also holds power to maintain invisibility. Goffman argues that “because of the great rewards in being considered normal, almost all persons who are disfigured, and the decrepit, because we have already condemned to oblivion a portion of ourselves. To address them in their needs would require us to permit ourselves to be addressed in our needs….The hidden away threaten us with what we have already hidden away from ourselves.” William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991), 150.

30 I focus here on the negative consequences of stigma, and that emphasis is central in Goffman’s account. He does name, however, positive effects (“secondary gains”) that are possible for the stigmatized. For example, sufferers might see trials “as a blessing in disguise” bringing valuable lessons about “life and people.” Stigma might also allow sufferers to “re-assess the limitations of normals,” and realize that normals lack coping skills gained by the afflicted. Goffman, 11.

31 Ibid., 42.
in a position to pass will do so on some occasion by intent.”³² Passing, though, poses tradeoffs. In the context of churches and mental illness this means, for example, that sufferers may present a public front that fails to match the reality of their experience. They choose to be known as less than fully themselves. The sociologist Arthur Frank, reflecting about cancer, makes a point germane to mental illness. “Every attempt to hide cancer,” he argues, “every euphemism, every concealment, reconfirms that stigma is real and deserved.”³³ The forces of stigma may convince those who suffer—or who are at risk of suffering—that the virtual social identities imposed by stigma are true. Society seems to tell those living with mental illness that they are “other,” “useless,” “dangerous,” and “unwelcome,” and sufferers may begin to believe those messages. If churches, the people of God, seem to confirm those beliefs, sufferers may wonder if God feels the same way.

### 6.5.3 Navigating the World amidst Stigma

Given those dynamics, how do the stigmatized (or potentially stigmatized) navigate the world? Goffman identifies three kinds of places where those with stigmatizing attributes (visible or invisible) may find themselves. First are *out-of-bounds places* where stigmatized people are forbidden, and thus where “exposure means expulsion.” An African American woman who “passed” for white might be able to eat a meal at a southern restaurant in the early twentieth century, but only by concealing her ancestry. Second are *civil places* where stigmatized individuals are “carefully, and sometimes painfully, treated as if they were not disqualified for routine acceptance, when in fact they somewhat are.” A homeless man recently released from a state mental

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³² Ibid., 74.
institution who shows up for worship at a prosperous suburban church might find a civil reception, but not a warm one. Finally, Goffman describes back places, locations where individuals need not conceal their stigmatizing attributes. These back places can be experienced involuntarily (institutionalized mental patients gathering for group therapy) or created voluntarily (recovering addicts gathering for a Narcotics Anonymous meeting.) Stigma shapes reception in each type of setting.

6.5.4 The Church as a Civil Place
In the face of mental illnesses, what type of place do congregations profess to be? What type of places are they really? My research and experience shows that the majority of modern Protestant congregations operate as civil places, places where those who suffer are not completely excluded, but where stigma causes suffers and families to navigate carefully. Many conceal illnesses, pain, and the needs for spiritual, emotional, and physical care. This does not have to be the case, however. Stigma theory offers additional insight about reshaping Christian practices.

6.5.5 A New Perspective on Stigma Theory: A Proposal
When those living with mental maladies hide their illness in order to belong in congregations, or when Christians deem—consciously or unconsciously—that mental illness is too difficult, complex, or dangerous for church help, stigma negatively forms Christian practice. Alternatives exist. What if the church views stigmatization as a positive and productive force, rather than a limiting and discriminatory one? What if it redeployes stigma theory and views religious stigmatization as evidence of faithful practice? This section considers those alternatives.

34Goffman, 81.
Stigma theory helps name aspects of human interaction in congregations. It offers more, however, when considered with the theological propositions above in mind: 1) a loving God created the world as good, 2) while good, creation is finite, 3) God through Christ brings healing, and 4) all of creation is interconnected.

Goffman’s third category of stigma’s origins identifies religious beliefs and practices as potential sources of stigma. Because religious people sometimes respond to situations in culturally non-normative ways, religious affiliation and practice do generate stigma. During World Wars I and II, for example, thousands of pacifist Quakers and Mennonites refused military service. Some Americans stigmatized those conscientious objectors as unpatriotic, untrustworthy, and subversive. A natural impulse for many in the face of such stigma is to reduce potential social tensions by adopting more normative behavior. Making such adjustments, though, reduces the coherence between belief and practice.

In the face of the suffering stemming from mental maladies, I suggest that Christians embrace a position of social difference, even if such as stance warrants stigma. Following the example of Christ, Christians are called to be a stigmatized people. We are called to resist social norms contrary to Christian belief and practice. We are called to eat with outcasts and tax collectors, with sinners, and with those who ail. We are called to remember that our identities are defined by our baptisms into the body of Christ, not by our adherence (or lack of adherence) to social norms. We are called to be a people who willingly enter into the suffering of one another. We are called to remember that suffering is a universal experience. While the world may tell us

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35 Here, we might consider Paul’s plea in Romans 12:12: “Do not be conformed to this world, but be transformed by the renewing of your minds, so that you may discern what is the will of God—what is good and acceptable and perfect.” NRSV.
differently, we are called to remember—on our own or with the help of others—that when we suffer, especially when we suffer, Christ remains in relationship with us. When the world deems those with mental illness as frightening, unproductive, unwelcome, and “other,” Christians can embrace them as suffering, frustrated, welcome, and “just like us.”

The adoption of a faithful, counter-cultural position as a community serves as a reminder that Christians possess the resources and the power to alter our view of those around us (and ourselves) and to reshape our practices. Doing so, however, takes conscious effort and prompts consequences.

6.5.6 Damned by Association: Sympathetic Normals and Courtesy Stigma

On the most basic level, Goffman distinguishes stigmatized individuals from “normals”; he also defines other social positions. In particular, he notes the role of “sympathetic others” who in the presence of a stigmatized individual “are ready to adopt his standpoint in the world and to share with him the feeling that he is human and ‘essentially’ normal in spite of appearances.”

Sometimes, sympathetic others share the stigmatizing attribute (fellow patients in a mental hospital), but they can also be outsiders (close friends and family members of sufferers.) Sympathetic normals, Goffman observes, understand the plight of the afflicted.

Goffman deems some sympathetic normals “wise.” With “wise” contacts “the individual with a fault need feel no shame nor exert self-control, knowing that in spite of his failing will be seen as an ordinary other.”

Goffman suggests two ways individuals become wise. The first results from “working in an establishment which caters either to

36 Goffman, 19.
37 Ibid., 28.
the wants of those with a particular stigma or to actions that society takes in regard to those persons” (a nurse or chaplain at a state mental hospital). “A second type of wise person,” Goffman observes, is “the individual who is related through the social structure to a stigmatized individual—a relationship that leads the wider society to treat both individuals in some respects as one.” Goffman continues, “the loyal spouse of the mental patient, the daughter of the ex-con, the parent of the cripple, the friend of the blind, the family of the hangman, are all obliged to share some of the discredit of the stigmatize person to whom they are related.” 38 Goffman declares this phenomenon—a sharing of discredit—“courtesy stigma.” It seems to me that Christians, in the face of mental maladies and other forms of suffering and injustice, are called to be wise, sympathetic normals, aware of, but unconcerned about the infliction of “courtesy stigma.”

Goffman notes that sympathetic normals become wise by first passing “through a heart-changing personal experience” and are often “marginal” individuals. Goffman here does not refer to religious conversion or the choice to affiliate with a community of faith, but a Christian confession of Jesus as Lord seems to fit well as such a “heart-changing” experience that encourages one to become a sympathetic normal. Christian hospitality calls for a willingness to engage with those in need, even those labeled by society as “other.” Being damned by association should be an expected part of Christian witness, but is a reality difficult to embrace in a society, like modern American, where Christian belief and practice are deemed normative.

38 Ibid., 30.
6.6 Identifying a Telos: Thinking Theologically about Health and Healing

Having explored the dynamics of stigma more thoroughly and identified a role for Christians among the stigmatized, I now turn to consideration of a telos—a hope or end point—that reflects Christian beliefs and orients Christian practice.

Mental illness causes suffering. Stigma exacerbates suffering. Suffering is problematic, but not always addressed. While faithful Christian practice in the face of mental maladies benefits from an understanding of suffering, it does not require a precise definition of—nor church-wide agreement about—mental illness. More central is a consideration of health. Christian attention to suffering hopes to alleviate distress and enable health. Christians declare health and healing as goals worth pursuit, despite the universality of illness.

Like illness, health can be described from a number of perspectives. Health might be defined, simply, as the absence of disease. The World Health Organization offers a slightly wider description and defines health functionally, as “a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.” Part of the trouble with such a definition, of course, is that conceptions of

39 Mental illnesses cause suffering whether they stem from physical, emotional, environmental, or moral causes. Here, I refrain from debating the causes of mental illness, and instead focus on the suffering it brings.

As highlighted in the vignettes above, we might think about illness or disease as inflicting two sorts of suffering, primary and secondary. Not only the symptoms of disease (primary), but also the experience of illness (secondary) generate distress. This is the case, as sociologists Freund, et. al. argue, because the “capacity to reflect means that humans typically suffer not merely from disease but also from their experience of illness and the meaning that they and others attach to it.” A physical disability such as cerebral palsy might mean, for example, that one is, in actuality, incapable of “normal” bodily activities, but one might also simply be perceived to be physically and emotionally limited. Such perceptions alter human relationships and inflict a separate sort of secondary suffering. In the case, above, of John, the young man hospitalized after his congregation called the authorities, his schizophrenia caused hallucinations and odd behavior. Then, as a result, his congregation’s fear of behavior they perceived a danger to John and perhaps, themselves, precipitated estrangement. Peter E. S. Freund, Meredith B. McGuire, and Linda S. Podhurst, *Health, Illness, and the Social Body: A Critical Sociology* (Upper Saddle River, NJ: Prentice Hall, 2003), 126.

“physical, mental and social well-being” prove subjective. Health, as the sociologist Freund argues, is “a social ideal that varies widely from culture to culture or from one historical period to another.”\textsuperscript{41} Given this subjectivity, if the concept of health is to be helpful in shaping the responses of Christian communities to suffering, we need to anchor that understanding beyond, or at least in addition to, medical and social conceptions.

How might we think theologically about health? Christians hold that physical and emotional health, defined medically, is “a good,” but not the ultimate good. The ethicist Courtney Campbell declares that medicine—in its concern for health—summons “theological critique” when health is viewed as an “an absolute, the end of the human journey, rather than a value whose meaning is intelligible only within some broader account of human nature and destiny.”\textsuperscript{42} If only medical notions of illness and health animate Christian responses, then the only solutions deemed appropriate may be medical ones. And, beyond working as medical professionals, Christians may see no role for themselves amidst the suffering that results from illness. The witness of Jesus and Christian tradition offer—and require—more. As an alternative, if believers view health not as the absence of disease, but as oriented toward human flourishing (as defined through relationship with the Triune God), then health may be present (and worked toward) even in the presence of illness.\textsuperscript{43}

A central theological problem with suffering stemming from mental maladies is that it disconnects the believer from others and from confidence of God’s presence. As a

\textsuperscript{41} Freund, McGuire, and Podhurst, 126. See Kinghorn, 91-104 for a discussion of theories of psychiatric disease, illness, and health.
\textsuperscript{42} Courtney S. Campbell, "Religion and Moral Meaning in Bioethics," in On Moral Medicine, 27.
\textsuperscript{43} To be sure, the opposite holds true, that unhealthyness could be declared, even in the absence of disease. A fuller discussion of the differences among disease, illness, and health is beyond the scope of this chapter.
result, I argue that a more theologically adequate *telos* of health and healing is the ability of humans to live in relationship—in communion—with the Triune God and with one other, to live as they are created to live. Along these lines, consider John Swinton’s definition of mental health as

> the strength to live as a human being, the strength to maintain holistic relationships with God, self and creation, the strength to continue moving towards the restoration of the *imago Dei* irrespective of one’s circumstances.\(^{44}\)

Mental health understood theologically, Swinton argues, has little to with the absence of disease diagnosis. Instead, health is the restoration of the image of God in those who suffer—both by those who ail and by those around them.

Central to the *imago Dei* that animates Swinton’s proposal is an understanding of the perichoretic relationality of the Trinity. Father, Son, and Holy Spirit exist in ongoing relationship and unity, just as all of creation exists in ongoing relationship with the Triune God. As a result of that focus on the relationality of the image of God, mental health, Swinton declares, “is a communal process” that “is the work of the whole people of God as they struggle to participate faithfully in God’s continuing redemptive mission in and to the world.” Suffering calls for action on behalf of all. Working toward mental health “has as much to do with the building of a community which can absorb pain and difference and grow in spite of (or because) of it, as it has with the eradication of individual ailments.”\(^{45}\) Christian hospitality enables that work of healing.

### 6.7 Moving from Theory to Practice

Healing, as the historian Amanda Porterfield demonstrates, has formed “a persistent theme in the history of Christianity, treading its way over time through ritual

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\(^{44}\) Swinton, *From Bedlam to Shalom*, 72.

\(^{45}\) Ibid., 155. Here, Swinton draws on the work of Stanley Hauerwas.
practice and theological belief, and across space through the sprawling, heterogeneous terrains of Christian community life and missionary activity.”

Porterfield names three aspects of healing in Christian tradition. Christian healing involved, first, “cures accomplished in the name of Christ and through the agency of” the “Spirit and saints.” Often deemed miraculous, cures involved the disappearance of distress and disease. Porterfield argues, however, that Christian healing more commonly involved, second, the “relief of suffering,” and third, an “enhanced ability to cope with chronic ailments.”

Christian communities play a role in reframing health and in offering healing, regardless of the infirmity. The theologian Joel Shuman argues that “the central issue for Christians is not that illness is fundamentally bad or that God heals the sick (although both of these things are certainly true), but that God cares for and intervenes on behalf of

47 Ibid., 4. The historian Martin Marty offers a framework for thinking about how theological convictions shape the relationship of faith and healing. Marty names four categories of responses to the question, “What precisely do people have in mind when they express the hope or make the claim that their faith has something to do with the understandings of illness and health and the process of healing?” Two of his categories—the two theistic options—are relevant to the discussion here.

Marty first presents a category he labels “God Experiences with Me: Empathy.” Assuming a divine agent who experiences illness alongside humans, believers in this group “tend to have accommodated their religious outlooks to modern scientific viewpoints” and they “readily commend themselves to the care of those who advocate and practice the most advance scientific medical techniques.” While reluctant to affirm miraculous cures, they refrain from outright denials, and “commend themselves and their fellow to the God whose love they believe to be stronger than death.” Their faith provides “courage to cope with tribulation and often triumph.” In addition, they “believe that answers to intercessory prayers will help sufferers to deal better with their setbacks and to interpret what is going on in their bodies, whether in times of sickness or health.” In many ways, this categorization describes the approach and reactions of Mainline Protestants in the twentieth century, as outlined in Chapter 5.

Second, Marty characterizes a group he labels “God Worked a Miracle in Me,” or “Monergism.” These individuals ascribe “all agency to a God who may withhold physical healing or may impart it to those who follow prescriptions such as praying for cures.” God is the “sovereign agent,” and humans have no “integral role” in affecting healing. This viewpoint, though, does not necessarily “limit humane sympathy or empathy.” Instead, they “relegate to the realm of mystery any final accounting of why God withholds healing and comfort….or they may at times blame their own apparent lack of sufficient faith.”

Martin E. Marty, “Religion and Healing: The Four Expectations,” in Religion and Healing in America, ed. Linda L. Barnes and Susan Starr Sered (New York: Oxford University Press, 2005), 490-499. Marty proposes these categories to help researchers (medical, anthropological, ethnographic) identify how faith and healing may be presumed to interact for individuals being studied and/or treated.
the sick in a variety of ways.” Going further, Shuman asserts, “because God cares for and intervenes on behalf of the sick, Christians must care and intervene as well.”

As noted, suffering demands a response. And so, instead of seeking intellectual explanations for suffering, the theological exploration that follows focuses on the impulse for a practical, theologically informed response. Rather than getting mired by the task of ferreting out, for example, whether individual, corporate, or original sin is to blame for human distress, or being waylaid by explorations of theodicy (How can a good God have created a world that includes suffering and evil?), an exploration of the practice of hospitality proves productive. Thinking through suffering in light of Christian practice, I follow the lead of theologians like Stanley Hauerwas, David Kelsey, and John Swinton and attend to questions of God’s presence amidst suffering and the faithful responses of believers. Instead of exploring “why?,” the church can ask “what?” and “what now?” Considering faith in the light of concrete instances of suffering, Kelsey frames this question as “What earthly difference can Jesus make here?”

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49 Hauerwas, for example, explores the “problem with the problem of evil,” and names theodicy a “parasitic endeavor.” Reflecting on suffering and the problem of evil, he that “Christians have not had a ‘solution’ to the problem of evil. Rather, they have had a community of care that has made it possible for them to absorb the destructive terror of evil that constantly threatens to destroy all human relations.” Stanley Hauerwas, Naming the Silences: God, Medicine, and the Problem of Suffering (Grand Rapids: W. B. Eerdmans, 1990), 41-2, 39, 53

Swinton asserts that “we can and always will speculate about why there is evil and suffering in the world and what God’s relationship is to it. However, in reality, we can never know the answers to the questions that so deeply trouble us. Indeed, attempting to know the unknowable can actually create fresh suffering and evil.” Swinton, Raging with Compassion, 13.

The following texts offer resources for thinking about suffering and the problem with the “problem of evil,” or theodicy. In addition to Swinton and Hauerwas, see, for example: Nelson, Edward Farley, Good and Evil: Interpreting a Human Condition (Minneapolis: Fortress Press, 1990), and Kenneth Surin, Theology and the Problem of Evil (Oxford: Blackwell, 1986).
6.8 Practicing Hospitality: A Calling and Challenge

Contribute to the needs of the saints; extend hospitality to strangers.  
(Romans 12:13)

6.8.1 An Introduction

Suffering prompts theological reflection. Theological reflection, as Mary McClintock Fulkerson argues, triggers not just intellectual, but embodied response. Hospitality constitutes a fitting embodied action in the face of the suffering and stigma generated by mental maladies.

Others have suggested different ecclesial practices in response to mental maladies (or, similarly, in reaction to disabilities)—pastoral care, friendship, and reoriented worship practices. Affirming the value of such explorations and practices, I assert that the practice of hospitality subsumes those activities and offers a fuller response. Hospitality offers both solidarity for and with the one who suffers. In order to combat the forces of stigma, it draws together the work of the whole community, not just clergy or individual members of the church body. Hospitality orients the total life of the

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50 Mary McClintock Fulkerson, Places of Redemption: Theology for a Worldly Church (New York: Oxford University Press, 2007), 13-14. Similarly, talking about early (pre Enlightenment) church, Hauerwas notes that “suffering was not a metaphysical problem needing a solution, but a practical challenge requiring a response.” Hauerwas, Naming the Silences, 51.

51 See note in Introduction for a list of sample pastoral care texts.

The theologian John Swinton (in Resurrecting the Person) calls congregations to consider how they might offer friendship to those afflicted with mental illness. He outlines practices that congregations might deploy and education they might undertake to receive warmly such individuals into Christian fellowship. In a companion text (From Bedlam to Shalom), Swinton presents friendship as a key to “healing” the church’s response to cognitive illnesses of all sorts. His focus falls on restoring the humanity of those who suffer from mental health issues by offering them friendship within a community.

Hans Reinders’ Receiving the Gift of Friendship also focuses on the practice of friendship, but does so in an effort to broaden theological anthropology in light of profound intellectual disabilities. Reinders rejects any account of what it means to be human that is rooted in an account of agency or rationality, “skills” that the most severely disabled do not, and will not, possess.

Writing primarily about physical disability, Nancy Eiesland proposes a reconsideration of the “body practices of the church,” including the laying on of hands and the Eucharist. Noting, “for many people with disabilities, the Eucharist is a ritual of exclusion and degradation” (because of “architectural barriers...demeaning body aesthetics, unreflective speech, and bodily reactions), she seeks a “resymbolization” of the sacrament, one shaped by an understanding of God as disabled. She seeks practices that liberate disabled persons from exclusion and a broadened understanding of God for both the bodily disabled, and able. Eiesland, 113, 90-3.
community, not simply liturgical or care giving practices. In addition, as theologian Christine Pohl asserts, hospitality “as a framework, provides a bridge which connects our theology with daily life and concern.” It is such a bridge that can help remedy religious incongruence and shrink the distance between belief and practice that persists in the face of mental maladies.

What is Christian hospitality? At the most basic level, it is the welcoming of strangers. It is more, however, as Henri Nouwen argues, than “sweet soft kindness, tea parties, bland conversation and a general atmosphere of coziness.” Nouwen deems that hospitality is both the receiving of a stranger and “a fundamental attitude toward our fellow human being.” Much more than a well-planned social hour with coffee and sweets following a Sunday worship service, Christian hospitality draws together guests and hosts into relationships of mutuality with one other and with God in Christ.

Here, as a central working definition, I adopt the description of hospitality offered by the theologian Letty Russell. She declares Christian hospitality “the practice of God’s welcome embodied in our actions as we reach across difference to participate with God in bringing justice and healing to our world in crisis.” Russell makes clear that

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52 Pohl, 8.
53 The Greek word translated as hospitality, philoxenia, means love of strangers. Pohl names strangers as “those who are disconnected from basic relationships that give persons a secure place in the world” and who “experience detachment and exclusion.” Ibid.13.
55 Nouwen, 67.
56 Letty M. Russell, Just Hospitality: God’s Welcome in a World of Difference, ed. Kate M. Ott and J. Shannon-Clarkson (Louisville, KY: Westminster John Knox Press, 2009), 2. Russell’s text was published posthumously. The phrase “calling and challenge” in the title to this section of my chapter comes from Russell’s text. While I adopt Russell’s definition of hospitality, my goal in discussing hospitality differs from hers in one important way. Russell challenges Christians to welcome strangers—individuals made strange by race, class, gender, nationality, and sexuality. She affirms such differences amidst Christian unity and she hopes individuals are welcomed while maintaining their distinctness. Not discounting her aims, mine differ slightly. The difference generated by mental illness is another sort of
hospitality is the work of God, carried out by God’s people. That work of God, by the people, takes place through the people by the power of the Holy Spirit. Hospitality is the “witness to God’s intention to mend” creation. To those made “different” or “strange” by crises like suffering, hospitality brings healing and restores justice. In addition, hospitality, as a theologically informed practice, is more than a one-way action aimed at someone in need; those who offer hospitality also receive it, often in unanticipated ways.

Both the impetus and goal of hospitality are rooted in the temporal, in the here and now. A vision of future healing, of eschatological wholeness, however, frames the practice. As the theologian Amos Yong argues, it is through “hospitable interactions that the church in turn experiences the redemptive work of God in anticipation of the coming Kingdom.” While powerful, the forces of stigma can be averted and reshaped; Christians are called to participate in that transformation. Goffman, even while articulating stigma’s pervasive power in forming social identities and shaping social relationships, notes that that “purposeful social action” can change how stigma operates. To be sure, Goffman wrote without Christian practices in mind, but the practice of Christian hospitality seems like the type of “purposeful social action” that he imagined had the power to diffuse stigma and alleviating suffering.

6.8.2 Hospitality in Christian History

In this final section of the chapter I first offer brief historical insight about the practice of hospitality, I then define Christian practice, and finally explore hospitality as a strangeness. Rather than a reality to be named “good” mental illness causes suffering. In addition, the resulting stigma is what the practice of hospitality seeks to overcome. I hope that those living with mental illness will be welcomed and cared for and that illness and especially stigma need not be defining features of their created nature.

57 Ibid., 18.
59 Goffman, 138.
combination of the activities of welcome, incorporation, compassion, and patience. In
discussion of each of the four elements of hospitality, I note 1) what hospitality requires,
2) what it counters, and 3) I offer examples of the shape it might take in congregations
attentive to suffering caused by mental illness.

Hospitality has long animated Christian life. Scripture witnesses to the
importance of both the divine and human provision of hospitality. “Images of God as
gracious and generous host”—providing manna, shelter, and protection—“pervade the
biblical” record.60 God appears as host, but also, as the Genesis 18 account of the Lord’s
appearance to Abraham by the Oaks of Mamre shows, as a worthy guest. Scripture
portrays hospitality as gracious, life saving, live giving, and abundant, and with both
physical and spiritual dimensions.61

Scholars anchor the witness of Christian hospitality in Christ’s life and ministry.
Yong asserts, for example, “Jesus characterizes the hospitality of God in part as the
exemplary recipient of hospitality” throughout his life and ministry.62 Jesus Christ,
though, both offered and received hospitality, and thus established the practice as one of
giving and receiving. Following the witness of Jesus, the apostle Paul “urged fellow
Christians to welcome one another as Christ had welcomed them” and “early Christian
writers claimed that transcending social and ethnic differences by sharing meals, homes,
and worship with persons of different backgrounds was a proof of the truth of the
Christian faith.” Hospitality encompassed “physical, social, and spiritual dimensions of

60 Pohl, 16.
61 For a more thorough discussion of the biblical insight about hospitality the history of Christian
practices of hospitality, see chapters 2-3 in ibid. For a discussion of “Luke-Acts and the Trinitarian Shape
of Hospitality,” see Yong, chapter 9.
62 See, for example, Jesus as a guest of Simon Peter (Lk 4:38-39), Levi (Lk 5:29), Martha (Lk
10:38), and Zacchaeus (Lk 19:5). Yong, 100.
human existence and relationships.” It both met physical needs, but also “recognized their worth and common humanity.” The early church, “partly in continuity with Hebrew understandings of hospitality that associated it with God, covenant, and blessing, and party in contrast to Hellenistic practices which associated it with benefit and reciprocity...pressed hospitality outward toward the weakest, those least likely to reciprocate.”

Early Christian provisions of hospitality were personal and direct, but eventually care for strangers became more distant and anonymous and, Christine Pohl argues, lost much of their earlier moral dimension. Today, hospitality is extended, although largely detached, from Christian moral underpinnings. As a result, Pohl calls for reclaiming earlier moral urgency.

Twentieth-century Protestants think of hospitality as a secular activity as much as a Christian practice. We think welcoming friends and not strangers. We think of hospitality that is paid for (at distant resorts, hotels, and restaurants) and not the gracious gift of care to those in our immediate midst and in need. We live in a world that tells us that we need the hospitality of strangers if we are “weak” or “needy” and not merely journeying through difficulty. And, while illness proves universal, we prefer thinking of it (particularly mental illness) as a condition that affects “others.” In addition, we often forget that hospitality is “potentially subversive and countercultural.” The historical witness of Christian hospitality, though, demonstrates its frequently counter cultural nature. A reclaiming of that sort of traditional hospitality, though, can thwart the force of social stigma that clings to mental illness.

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63 Pohl, 5, 6.
64 Ibid., 17.
65 Ibid., 15.
6.8.3 Reflective, Theological Practice

Hospitality is a human endeavor that happens, necessarily, in relationship with God and others. It is an ongoing practice, not an isolated event. In imaging the contours of hospitality, a more general definition of practice offers a helpful framework. Here, I use the moral philosopher Alasdair MacIntyre’s definition of a practice as

any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human power to achieve excellence, and human conceptions of the ends and good involved, are systematically extended.66

In this sense, practice is more than simple task or activity—it is complex. But it is also coherent—practice, in the MacIntyrian sense contains a certain internal logic. A practice is integrated with belief and imbedded in a community—it relies on the truth proclamation of the community and is a social endeavor. That sociality proves critical for the practice of Christian hospitality to combat stigma generated by social norms.

MacIntyre attests that the performance of practice can be measured against a standard of excellence at any point in time. In the case of the Christian practice of hospitality, scripture and tradition form the basis of that standard of excellence. Simultaneously, a practice continues to evolve and change as it strives to achieve and then extend the good that results from doing so. Practice, for MacIntyre, moves toward a goal or telos.

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What makes a practice uniquely Christian? We might say that a practice is Christian when it is cooperative activity undertaken by Christians, but this is not sufficient. In addition to Christian participants, the standards of excellence that define both the activity and goal against which excellence is measured must be rooted in Christian scripture and tradition.\(^67\) Christianity provides a specific understanding of \textit{telos}—a \textit{telos} of humanity’s communion with God made possible through the birth, life, death, and resurrection of Christ.\(^68\) Because of sin, humans and human activity exists at a distance from this \textit{telos}. But, through participation in practice that distance may be bridged.\(^69\) To be sure, “communities engage in…practices forever imperfectly—faltering, forgetting, even falling into gross distortions.” Even though human efforts may never lead to perfect execution, practices prove viable and useful in the life of communities. As theologian Dorothy Bass recommends, inherent imperfection calls for “theological discernment, repentance, and renewal” as “necessary dimensions” of practices and of “Christian life as a whole.”\(^70\)

Practice—Christian practice—calls for ongoing participation and consideration of activity and aims. The Christian practice of hospitality seeks to enfold both guest and host into the life of the Triune God, and does so through acts of welcome, compassion, incorporation, and patience.


\(^68\) This is a broader assertion of the \textit{telos} noted in my earlier discussion of healing.

\(^69\) Of course, a social group might define other \textit{teloi}. In the face of mental illness, a sociological view might seek to eliminate conditions that diminish “life chances” such as educational attainment and professional advancement. Those alternate “ends” are not inherently bad, but they fail to cohere with a Christian notion of \textit{telos}.

\(^70\) Bass, 9.
6.8.3.1 Welcome

For I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me.

-- Matthew 25:35

Welcome forms the first element of the practice of hospitality. Welcome, of course, assumes that there are hosts and guests, both outsiders and insiders. It requires that those who host, those on the inside, to signal to outsiders that they are free to join, and not only free, but desired and wanted guests. The host exerts the primary effort of welcome, but hospitality also requires the willingness of the outsider to embrace the invitation to enter. Goffman observes that “the stigmatized individual may find that he feels unsure of how we normals will identify him and receive him,” and so the willingness to respond to an invitation of welcome may require a leap of faith, or a bit of risk taking on the part of the one who has been invited.71

The practice of welcome, as part of Christian hospitality, is rooted in recognition of God’s welcome and a sense that “God values all creatures whether or not we consider them useful” or “like us.”72 The act of welcome involves hope that outsiders will receive the invitation, but welcome does not require reciprocity. “Hospitality is a gift offered without preconditions and expectations, [it is] an emblem of openness to the other.”73 Nor does welcome require assimilation or a requirement for guests to take on the characteristics of their hosts; outsiders are welcomed to be present, to be included, just as they are.

71 Goffman, 13.
72 Migliore, 88.
73 Reynolds, 20.
For outsiders and insiders to come together through welcome requires openness to what is strange and different on the part of both host and guest. Often, this means the host must initiate contact across boundaries, whether physical or social. Hauerwas claims that “only a community that is pledged not to fear the stranger—and illness always makes us a stranger to ourselves and others—can welcome the continued presence of the ill in our midst.” Welcoming involves risks on the part of the host too, but caution, and not inaction, should prevail.

The act of welcome counters experiences of exclusion and debunks notions that, using Goffman’s terminology, the church is an “out of bounds place” where the stigmatized may not enter. Welcome also counters past experiences of rejection and limitation. Finally, welcome counters isolation, signaling to the “other” that they are worthy of inclusion.

In the face of mental maladies, acts of welcome might take the form of extending invitations to those who suffer outside of the church. Congregations might host meetings of mental illness related advocacy organizations and support groups like NAMI (the National Alliance on Mental Illness). Welcome might also take the form of opening spaces for those already part of the church community to be present more visibly with their joys and their concerns, including suffering stemming from mental illness, perhaps in the form of spiritual care provided in group settings or in one-on-one conversations. Knowing that stigma causes reluctance to share experiences of suffering broadly, welcome need not require those who suffer to make their ailments know throughout the full congregation.

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74Hauerwas, “Salvation and Health,” 82.
6.8.3.2 Compassion

You shall also love the stranger, for you were strangers in the land of Egypt.

-- Deuteronomy 10:19

Welcome brings together insiders and outsiders, hosts and guests, but a more complete practice of hospitality also includes compassion. As God in Christ entered the world to suffer (and rejoice) with and for us, we suffer (and rejoice) with one another. Compassion “is a visceral response to the suffering of another” that “moves us to want to do something in response.” Christian compassion, though, need not (and perhaps should not) have the cessation of suffering as its lone goal. Rather compassion calls for the creation of safe space—physical and emotional—for the brave and honest telling of stories of pain, suffering, and joy. When we enter into the suffering of another, “by suffering-with (mit-leiden) the alienated other, the healer establishes a community that transcends the form of community from which the sufferer became alienated in the illness experience.” In doing so, compassion dissolves the classifications of “us” and “them.” In place is the formation of a “we” who encounter life side by side.

That willingness to listen, to try to understand the experience of pain and suffering with another, requires a sense that other is worth listening to. Goffman argued that “normals” (those not stigmatized) sometimes “believe the person with a stigma is not quite human.” Similarly, Swinton observes that, “in the minds of the media and the general public, people with mental health problems frequently ‘cease being persons.’

75 On Moral Medicine, 325.
77 Goffman, 5.
Instead they become identified by their pathologies—‘schizophrenics,’ or ‘manic depressives,’… terms that substitute their primary identity as human beings made in God’s image and passionately loved by God, for a socially constructed way of being” that then shapes their self understanding and relationships.78 Such views are acknowledged, but set aside, when empathetic listening takes place.

Compassion also requires a theological anthropology that accommodates finiteness. Through the work of thinkers like Descartes (cogito, ergo sum), Locke, Hume, and Kant, “to be human came to be identified with the ability to doubt, to think, and then to will.”79 Such views left those living with mental disease or disability suspected to be less than fully human. An alternate anthropology rooted in a sense of shared and interdependent createdness proves more faithful. It resists cultural proclamations of the value of humanity rooted only in productive achievement. Compassion calls for recognition that all are beloved children of God. Compassion requires that primary human identities are centered in God’s baptismal covenant through Christ, not in terms of medically driven definitions of health, economic productivity, or cultural normativity.

In the face of mental maladies and stigma, the work of compassion combats silence, shame, and the temptation to remain hidden. Compassion helps move aside a sense of defective humanity and restores the voices of those who suffer. By providing a

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safe environment for sufferers to voice their pain, compassion also combats the fear of exposure.

Attentive to the realities of suffering, compassion may look like the provision of casseroles—of the tending to physical needs in times of hardship. Compassion may also take the shape of friendship or formal care giving ministries such as Stephen Ministry. (Similarly, outside of the congregation, compassion might involve offering spiritual care in hospitals that care for those with mental illnesses.) Compassion may look like the incorporation of practices of communal lament, perhaps using psalms of disorientation, lament psalms where “suffering is simply acknowledged for what it is with no explanation” given. Finally, compassion may take the form of healing services or other liturgical practices that recognize sickness and provide assurance of healing in public settings.

6.8.3.3 Incorporation

So then you are no longer strangers and aliens, but you are citizens with the saints and also members of the household of God.

-- Ephesians 2:19

Welcoming the stranger and offering compassion are first steps in the practice of hospitality. Strangers, however, must not simply be brought into the fellowship of believers, they must be incorporated as full members. To the extent that welcome and compassion offer “solidarity for” the one who suffers, incorporation involves “solidarity

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80 Hauerwas, Naming the Silences, 80. “The psalms of lament do not simply reflect our experience; they are meant to form our experience of despair. They are meant to name the silences that our suffering has created. They bring us into communion with God and one other, communion that makes it possible to acknowledge our pain and suffering, to rage that we see no point to it, and yet our very acknowledgement of that fact makes us a people capable of living life faithfully.” Ibid., 82.

81 For a discussion suffering and liturgical practices (specifically, the Roman Catholic tradition’s Sacrament of Anointing the Sick), see Lysaught, 360-362.
with” and full mutuality between guest and host. In that sense, incorporation moves beyond mere “inclusion” or “tolerance,” each of which signal joint physical presence, but not necessarily mutual participation. The incorporation of Christian hospitality is also mindful that guest and host are incorporated not just into human fellowship, but also in the ongoing narrative and life of the people of God.

Incorporation demands dissolution of divisions between “us” and “them,” replacing these categories with “we.” Incorporation also requires awareness that both guest and host may be changed by their encounter. “Our resistance to human vulnerability,” the theologian Thomas Reynolds observes, “calls for transformation if we are to experience the power of the biblical witness and participate more fully in God’s inclusive love.” At the same time that the afflicted may find relief from their suffering and stigmatization, “normals” may find freedom in being able to more fully acknowledge their own limitations and finiteness.

By grounding identity in membership among the people of God, incorporation counters the loss of identity and longing for belonging that can accompany mental illness. Incorporation counters the church’s propensity to exist as a “civil place” where some only seem welcome. At the same time, incorporation requires confidence that difference will not dissolve the community. To be sure, incorporation as part of hospitality requires risk taking. Both hosts and guest must be willing to subordinate their differences as they live and work side by side as members of the body of Christ. Christian unity is grounded in the Triune God, and that perichoretic mutuality offers a model for human community.

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82 Reynolds, 21.
Congregationally, incorporation takes many forms. Participating in one of the oldest traditions of Christian hospitality, shared meals literally bring all to the table to share in sustenance and fellowship. Drawing on the work of John Dominic Crossan, the theologian M. Therese Lysaught observes that “Jesus’ Jewish culture,” decisions about “what we eat, where we eat, when we eat, and above all, with whom we eat…form a miniature map of our social distinctions and hierarchies.”

Shared meals reach across the social boundaries established by stigma, and with ongoing practice, begin to dissolve those forces that both deepen suffering and inhibit care giving.

Liturgically, baptism and Eucharist signal the enfolding of believers into God’s creation. Worship services can name all who gather—not just those whose suffering is known—as new creations in Christ. Finally, even when mental illness makes those who suffer sporadically unavailable, incorporation includes making room for those who suffer in the broader life and ministry of the congregation as teachers, caregivers, and leaders.

6.8.4.4 Patience

Do not neglect to show hospitality to strangers, for by doing that some have entertained angels without knowing it.

-- Hebrews 13:2

Finally, in addition to welcome, compassion, and incorporation, Christian hospitality requires patience. “To care for another when we cannot cure,” theologians Hauerwas and Pinchas claim, “is surely one of the many ways we serve one another

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83 Lysaught, 361. Christine Pohl makes a similar point: “Early Christian writers claimed that transcending social and ethnic differences by sharing meals, homes, and worship with persons of different backgrounds was a proof of the truth of the faith.” Pohl, 5.
84 For a discussion of liturgical practices of incorporation, see Eiesland, 107-118.

Patience, however, demands the courage to live in a tragic world, patience that can only be sustained in a community that understands that temporal suffering and tragedy do not have the final world. Patience amidst suffering proves possible with an eschatological viewpoint and a sense that while the life, death, and resurrection of Christ ushered in the Kingdom of God, it has yet to fully arrive. Amidst pain, patience allows communities to absorb suffering, proving meaning in the face of meaninglessness.

Patience requires tolerance for unpredictability. It also calls for a sense of God’s abundance amidst the world’s sense of alarm about scarce resources. Yong argues that “for Christians, the practices of hospitality…embody the Trinitarian character of God’s economy of redemption” where there is “never any lack of hospitality to be offered and received.” While complete healing may be only fully realized eschatologically, healing is experienced and witnessed to in the Body of Christ. While prompted to pray for cures to be brought by God, Christians are also called to play a more active role in reliving distress and helping those who suffer to help.

Patience requires imagination. In the face of suffering, together, Christians learn to imagine the shape of redemption. “The process of acquiring the capacities,” the theologian David Kelsey proposes, “including mastering the concepts, that are needed to perceive the world as created, be-graced, ambiguous, and redeemed is a major part of what is fostered by involvement in the practices that make up persons’ lives of faith and the common life of the Christian community.” As Kelsey demonstrates, the ability to imagine redemption both enables and sustains patient Christian practice of hospitality.

86 Yong, 126.
87 Kelsey, 106.
Patience counters despair and an absence of hope and meaning amidst suffering. Patience also counters the idolatrous view of medical technologies as the only solutions to suffering. While medicine and the forces of stigma seem to be in a hurry to categorize and classify conditions, diseases, and humans, Christian hospitality allows the gracious gift of time for guests and hosts to live into their roles of beloved followers of Christ.

Patience might look like determining, as a full community, how to let someone like John, the young man admitted to the hospital after a call from his congregation, return to worship, again and again, despite his illness and frightening behavior. Patience might look like the provision of casseroles for individual and families, even after a fifth, or tenth hospitalization. Despite the persistence of mental illness and notwithstanding the ongoing power of social stigma, Christians have all the time in the world (to borrow a phrase from Stanley Hauerwas) to continue to work to align practices and beliefs and to witness to the healing power of God in Christ.

6.8.5 Discussion
Practices, including the practice of hospitality are ongoing, transformative activities. The theologian Michael Warren calls on congregations to be both “communities of interpretation” and “zones of cultural contestation.” Communities, as they search for faithfulness in practice, are reminded of their distance from their telos through reflection on sacred texts and the text that is the congregation itself. Warren argues that “those in a Spirit-resonant community are meant to develop a perceptive system attuned to the gospel the way a parent of an infant can be so physically tuned” to
their child in times of need.  Communities of interpretation sense—consciously or unconsciously—suffering in need of redress. The challenge for communities is to bring suffering to consciousness and then to explore means of healing. By doing so, congregations more fully become places of redemption and healing for all involved.

Hospitality transforms both individual lives and Christian communities. Drawing insight from Jean Vanier and Ken Weinkauf, Christine Pohl asserts that a community that embodies hospitality to strangers ‘is a sign of contradiction, a place where joy and pain, crises and peace are closely interwoven.’ Friendships forged in hospitality contradict contemporary messages about who is valuable and ‘good to be with,’ who can ‘give life to others.’

Such communities are “signs of hope” that “nourishes, challenges, and transforms guests, hosts, and, sometimes, the larger community.” Those communities, I argue, in the face of mental maladies, are ones that can counter the forces of stigma and enfold those who suffer into the life of the community and into the life of God in Christ. “Because of God’s faithfulness,” Stanley Hauerwas asserts, “[Christians] are supposed to be a people who have learned how to be faithful to one another by our willingness to be present, with all our vulnerabilities, to one another…in and out of pain.” Even small attempts at the practice of hospitality witness to an ethic that claims all of humanity as good and worthy of the love of God and the love of the Christian community. This is not the way of the world, but it is the way of the cross.

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89 Pohl, 10.
90 Ibid., 10-11.
91 Hauerwas, “Salvation and Health,” 81.
6.9 Conclusion

Suffering stemming from mental illness calls Christian congregations into discussion of the shape of their life together in light of a loving and redeeming God. Through the sustained, face-to-face provision of hospitality, believers challenge their participation in social interactions shaped by stigma. Hospitality makes companionship, comfort, and healing possible.

Mental illnesses present challenges, but they are not the only sort of suffering worth attending to. My hope is that through an on-going investigation of the problems of mental illness and the transformations possible through the practice of hospitality, that Christian communities may be more aware of both the invisibility of, and their responses to, distress of many types. Suffering not only demands redress it also enables the possibility of new thinking, thinking that sparks believers to respond in creative ways to overcome stigma and fear and become more faithful participants in the Kingdom of God.
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Biography

Heather Hartung Vacek was born on July 29, 1969 in St. Louis, Missouri. In 1991, she earned a bachelor of science in industrial engineering and a bachelor of arts in economics from Northwestern University in Evanston, IL. She spent the next three years working as an engineer at International Business Machines in Research Triangle Park, NC. In 1996, she earned a masters in business administration and masters in engineering management from Northwestern University and returned to work in marketing and product management at IBM. In 2006, she earned a masters in divinity (summa cum laude) from the Duke Divinity School at Duke University in Durham, NC. In 2007, she matriculated in the Doctorate of Theology program at Duke Divinity School.

Heather was awarded a dissertation fellowship from the Louisville Institute (2011-2012). She is ordained a deacon in the Southern Province of the Moravian Church and serves as a Trustee at Moravian Theological Seminary in Bethlehem, PA. As of June 2012, she teaches at Pittsburgh Theological Seminary in Pittsburgh, PA as Assistant Professor of Church History.