Boisen's pioneer studies with schizophrenia

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Dissertation

BOISEN'S PIONEER STUDIES WITH SCHIZOPHRENIA

by

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CHAPTER I

INTRODUCTION

The concept of schizophrenia has undergone a considerable change during the recent years. The Kraepelinian classification of the disease as "dementia praecox" has tended to encourage pessimism and paralyze therapeutic endeavour both in physician and nurse. With the introduction of dynamic concepts in psychiatry and the formulation of new psychotherapeutic techniques, a new psychiatric understanding of schizophrenia has developed and actual attempts at psychotherapy are being made. The etiology of schizophrenia has been studied from different points of view and thus a considerable body of highly significant data has come into being. These contributions have added much to the understanding and therapy of schizophrenia in particular and of mental illness in general. The religious aspects of the problem, however, have never received a systematic treatment except in a casual or incidental manner. To Anton T. Boisen goes the credit for initiating a scientific inquiry into the religious aspects of schizophrenia. His contribution, therefore, has significance both for psychiatry and religion.

1. The Problem

The problem of this study is (a) to determine Boisen's specific contribution to the problem of schizophrenia; (b) to
evaluate this contribution in terms of his religious and clinical experience and in the light of modern psychiatric formulations; (c) to analyze these findings to see their implications for religious therapy and prevention of schizophrenia; and, in general, (d) to indicate Boisen's contribution to pastoral psychology.

The focal point of this study will be a critical examination of Boisen's theory of schizophrenia in terms of his hypothesis, methodology, data and conclusions. Since the theory has a basis in his own personal experience an attempt will be made to relate, analyze and interpret this experience. The scientific basis of his assumptions will be examined in the light of his clinical experience and the estimate of his work by experts in the fields of psychiatry and psychology. The practical interest of this study will consist in finding out what specific contribution Boisen has to make for pastoral therapy with schizophrenia and for the task of prevention with which the Church is primarily concerned. Finally, the implications of Boisen's theory for religion will be considered and an attempt will be made to translate them into plans of action.

2. The Importance of the Problem

The problem of schizophrenia has been systematically investigated by various experts in the fields of psychiatry,
psychology and biological sciences; and the results of their inquiry have been discussed, evaluated and used in the therapy of schizophrenia. The religious aspects of the problem, especially from the standpoint of inner meanings and motivations, have been recognized but never seriously and systematically studied by any expert in the field of pastoral psychology. By his systematic investigation, stretching over a period of twenty-five years, Boisen has covered this neglected aspect of the problem, and the results of his inquiry need to be seriously considered and evaluated. The present study attempts to bring together the results of his investigations, to analyze and interpret them in the light of psychiatric research and to indicate their specific contribution to the problem of schizophrenia.

From the religious standpoint the present inquiry is of special interest and importance. It seeks to examine Boisen's view that there is a fundamental similarity between schizophrenia and certain types of religious experience, both being attempts at reorganization of personality in the face of overwhelming conflicts. This view needs to be seriously examined, for it has obvious implications for the study of religious experience and behaviour. If this view can be sustained, it will have considerable significance for our understanding of and approach to religious experience.
A further corollary that follows from Boisen's view of mental illness is that the study of personality disorders provides an important avenue of approach to the understanding of spiritual forces operative in human life. In other words, just as in psychiatry the study of abnormal behaviour is an important method of approach to problems of human behaviour, a study of the religious behaviour of the mentally ill can furnish important clues to our understanding of normal religious behaviour. This view merits a careful consideration.

Furthermore, if, as Boisen argues, religious concern is associated with acute schizophrenic disturbances, it follows that pastoral therapy has a place in the treatment of schizophrenia. Boisen has demonstrated the efficacy of pastoral therapy with schizophrenic patients. He has developed and successfully used special methods of pastoral ministry and counseling with the mentally ill. He has gathered a great deal of useful material from his contacts with mental patients. These are highly significant data for the student of religion and emphasize the importance of the present study.

Another factor that adds importance to the present study consists of the fact that it seeks to inquire into the problem of guilt in schizophrenia. Fosdick, in his book On Being a Real Person, states that "in dealing with personal maladjustment moral self-condemnation is often the most
misleading factor that can intrude itself.¹ This is a point of real issue and it will be of interest to examine this point of view in the light of Boisen's studies. From Boisen's standpoint schizophrenic patients, showing attitudes of blame and personal condemnation, stand a much better chance of recovery than those who resort to mechanisms of withdrawal and concealment.

This study is also interested in finding out the practical implications of Boisen's views for the task of prevention which is the Church's special responsibility. It is in this sphere that the Christian Church can make its major contribution in preventing mental ills and in building up positive mental health.

This study of Boisen's research with schizophrenia has several points of peculiar interest and significance. In view of his background, experience and equipment, this study becomes highly significant. In addition to his academic training and rich clinical experience, Boisen has carried on his research in close association with some of the leading psychiatrists and clinicians in the field. To this he has brought an extensive background of experience in conducting sociological surveys and research studies. His

¹ Fosdick, OBR, 152. (These abbreviations are explained in the Bibliography. The author's name should be consulted in each case.)
pastoral and teaching experience gives him a first-hand understanding of the problems of the pastor and parishioner, qualifies him to advance psychological interpretations of religious experience, and enables him to suggest concrete measures for the prevention of mental ills in our society.

Above all, Boisen's own religious experience and schizophrenic episode is an important aspect of the present study. This should be of special interest to students of religion and psychiatry alike. Boisen approaches the problem of schizophrenia, not only as a specialist in religious psychology and psychopathology, but as one who has himself been through a temporary though most acute form of schizophrenia. Herein lies the fascination and significance of his contribution to the problem of schizophrenia. He turns the problem inside out, that is to say, he studies it from the standpoint of inner experience and thus gives an authentic description of the mental state and ideation of the schizophrenic. The results of his inquiry have been embodied in several published and unpublished works and in numerous articles in leading psychiatric and sociological journals. The present study is an attempt to bring these together in a clear-cut, systematic and critical appraisal of Boisen's pioneer work with schizophrenia.
3. Methods of Research

The present study deals with Boisen's contribution to the problem of schizophrenia. The methods of inquiry, therefore, include the following: (a) survey of Boisen's published and unpublished works; (b) survey of psychiatric literature; (c) survey of pastoral literature; (d) interviews with Boisen and a study of his present methods of work; and (e) pastoral interview with and observation of schizophrenic patients.

Boisen's writings cover three broad areas: schizophrenia, religious experience and pastoral psychology. His published works include two books entitled Exploration of the Inner World and Problems in Religion and Life and numerous articles in the leading journals in psychiatry, sociology and religion. Another book that is soon to appear is entitled Religion in Crisis and Custom. Other unpublished works include his collected papers on religion and mental illness and types of mental illness. This study will further seek to supplement the written material with personal interviews and correspondence with Boisen, study of his present methods of work at Elgin State Hospital, and interviews with pastoral psychologists who are aware of his investigations or with whom he has been associated.

1. See the Bibliography for information.
The subject of this study involves a survey of psychiatric literature, especially that in relation to the problem of schizophrenia. Although no studies can be found which deal directly with a problem such as undertaken in this study, many investigations that bear on the subject have been made by psychiatrists, psychologists and religious thinkers.¹

In the early years of the development of psychiatry as a science, scientific workers were biased against religion in their reaction to its association of mental illness with demoniacal possession. Bernard Hart recalls the radical attempt to treat insanity as a dysfunction of the brain rather than as resulting from demoniacal possession—an attempt which terminated with the advent of the science of psychopathology.² With the introduction of dynamic theories and formulations in psychiatry the concept of mental illness has undergone quite a transformation. Several persons have made important contributions in this direction. Among them may be included Freud, Bleuler, Jung, Meyer, and Sullivan. However, beginning with Freud and perhaps influenced by his thinking, psychiatric interest in religion has been confined to its pathological manifestations in abnormal behaviour, or to its role in the etiology of mental illness.

¹ See the Chapter IV for a comprehensive historical survey.
² Hart, PI, 24-25.
The earliest attempt to understand the religious aspects of mental illness was made by Hurd in 1887. He studied the religious thinking of his patients and classified their religious delusions under different categories.\(^1\) However, serious scientific interest in religious aspects of mental illness began with Jung. He recognized the ethically worthless religiosity of the unconscious transformation of an erotic conflict into religious activity; but at the same time he criticized the onesidedness of Freudian and Adlerian theories, in ignoring the religious needs of the patient. He emphasized the integrative function of religion in building up positive mental health.\(^2\) In 1906 he applied Freud's interpretation of dreams to schizophrenic thinking and demonstrated its closeness to dream activities. He also concluded that schizophrenia represents a failure in emotional adjustment.\(^3\) Another important contribution comes from Storch who made an attempt to explain schizophrenic behaviour in terms of regression to primitive ways of life.\(^4\) Schou studied the religious ideas of mental patients and concluded that each type of mental illness represents a distinct constellation of religious ideas.\(^5\) Campbell made a similar study.\(^6\)

1. Hurd, MD.
3. Jung, PDP, 89.
4. Storch, PAF.
5. Schou, RMM.
6. Campbell, DB.
In 1928 Boisen's first research paper appeared under the title "The Sense of Isolation in Mental Disorders."\(^1\)

Since 1930 a considerable amount of research has been done and the problem of schizophrenia has been tackled from different points of view. The theoretical formulations of earlier investigators have been supplemented with the therapeutic procedures of clinically-minded psychiatrists. Actual attempts at psychotherapy of schizophrenia have been made by Sullivan, Alexander, Fromm-Reichmann, Hill, Eissler, Chassell and others. Psychometric and projective techniques have been used to study the schizophrenic's thinking disturbances, irrational behaviour and verbal productions. Psychiatric social workers have made valuable studies of the pre-psychotic schizophrenic personality. To Boisen goes the credit for making a most comprehensive study of the subjective and religious aspects of schizophrenia. His main findings are embodied in his important psychological study, *The Exploration of the Inner World*, which appeared in 1936. With the introduction of the clinical movement in theological education and the development of pastoral counseling, a large body of knowledge and experience has accumulated and the Protestant ministry has won a place of prestige and recognition in the field of

\(^1\) Boisen, Art. (1928), 555-567.
psychiatry. Boisen has a unique place in effecting this rapproachment between psychiatry and religion.

4. Definition of Terms

Certain terms and concepts that will frequently appear in this study need some defining and delineation. At present many of these terms are given varying meanings and connotations. In defining them an effort will be made to emphasize the elements consistent with the viewpoint followed in this dissertation.

RELIGION. Etymologically, religion may mean taboo or binding together.\(^1\) Whatever derivation is accepted, the latter does bring out the integrative aspect of religion—a concept which seems to be lacking in most of the non-psychological definitions of religion. From the standpoint of this study integration is an important aspect of religion. Religious concern is involved whenever one strives to achieve an integration of personality on the basis of what one conceives "to be supremely worthwhile not only for himself but for all human beings."\(^2\) While the highest expression of religion is thus seen in a conscious striving for values (both personal and social) in cooperation with God, or "Sustainer of Values," in its inferior though none the less religious forms,

2. Wieman & Wieman, NPR, 29.
religious concern may be said to be present whenever one seeks to realize what he considers to be the highest values in life, involving himself and other human individuals. Boisen views religion as

an attempt to raise one's values to the level of cosmic or universal and to establish and maintain right relationship with those to whom one looks for response and approval, those whose composite impress is represented in the idea of God.¹

Religion is however not only a striving after personal or social values; it is also a search for "a value underlying all things, and as such is the most comprehensive of all philosophies of life."²

PERSONALITY. This is another difficult concept which is hard to define. It is generally agreed that both innate and acquired characteristics enter into its making, but there is a wide difference of opinion as to its structural and functional aspects.³ Allport defines personality as

the dynamic organization within the individual of those psychophysical systems that determine his unique adjustment to his environment.⁴

While this definition does stress the unique and dynamic qualities of personality, it does not seem to take into account the social determinants involved.⁵ Sullivan and Johnson stress

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1. Boisen, EIW, 53.  
2. Allport, PER, 226.  
4. Allport, PER, 48.  
5. See Kluckhohn & Murray, PNS, 3-48.
the interpersonal components of personality and conceive of it as something growing like any other living organism.\(^1\)

Thus any adequate conception of human personality must include its unique and dynamic features as well as its social and interpersonal components.

**RELIGIOUS EXPERIENCE.** Religious experience involves a consciousness of objective values, but these values are bound up with other human values.\(^2\) A genuine religious experience integrates all values and gives them their fullest expression. This integration can be achieved either through a progressive development of personality, or through CONVERSION; it may be gradual or eruptive. Starbuck describes the former type of religious experience as "the blossoming out into new life," and the latter as the "eruptive breaking up of evil habits and abnormal tastes by a turning of the life forces along new channels."\(^3\) In the present study interest will be centered around the **second type of religious experience** and an attempt will be made to study it from the standpoint of the pathological.

**CONSCIENCE.** There is much confusion of ideas in connection with the term conscience. Some regard it as the root cause of all human troubles, while others view it as integrative

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2. See William James, VRE, 58; and Johnson, PR, 37.
3. Starbuck, PR, 158.
principle of moral development.\textsuperscript{1} Thus Boisen describes it as a guide in determining the direction of growth and conceives it as the internalization of organized systems of meanings and moral judgments one takes over from the group, especially the early guides.\textsuperscript{2} Alexander suggests a distinction between the "mature conscience" and the "taboo conscience" of early childhood.\textsuperscript{3} This distinction is very helpful and avoids the confusion when conscience is identified with the Freudian super-ego. It is, however, difficult to say how far this distinction can be maintained in practice. In our view, conscience is an integrative force in life. It is a growing and dynamic thing; it may become an ego-alien when it loses its dynamic qualities and is not comprehended into a growing system of values and loyalties.

GUILT. This is another important term that will frequently appear in our study. It is a legal term and has the same meaning in psychiatric literature as that of sin in religion. There is a difference, as Boisen points out, between the sense of guilt and the actual faultiness which "is at variance with the requirements of the highest fellowship" of which one may be aware.\textsuperscript{4} Guilt feeling is a normal

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\textsuperscript{1} Cf. Brill (ed.), BWF, 859-861; Chisholm makes conscience the root cause of war, see Art. (1948), 1-35.
\textsuperscript{2} Boisen, EIW, 305.
\textsuperscript{3} Alexander, FP, 82f.
\textsuperscript{4} Boisen, EIW, 307.
\end{flushleft}
human experience and is conducive to ethical and social progress. A sense of guilt or sin that is the outcome of a negative and gloomy childhood conscience or super-ego is, however, definitely harmful. Religion provides resources through which excessive guilt feelings may be assuaged—repentance, confession, forgiveness, and reparation. The social aspect of guilt must not be overlooked. The sense of guilt arises from a sense of isolation from those whom one loves and whose ideals and standards one has accepted for himself; it can only be dealt with by restoring the individual to the fellowship of that which is supreme in his system of loyalties.

PSYCHIATRY. Psychiatry sprang up as a borderline field between religion and medicine. The term itself came into use only towards the end of the nineteenth century, although it can be traced in German literature as far back as 1837. Formerly the word medical psychology was commonly used, which included in its sphere the custody, care and treatment of the mentally ill. In general, psychiatry represents that branch of science which deals with the mental disorders of human personality. It is, however, being increasingly recognized that psychiatry has a broader scope.

2. Johnson, PR, 214-221.
3. Hall (ed.), AP, 484.
than mental illness. The recent trends in psychosomatic medicine and psychotherapy are giving psychiatry a central place in all branches of medical specialties. Sullivan defines psychiatry as "the study of interpersonal relations," and has, along with White and Meyer, done much to develop and clarify the modern concepts of psychiatry.

The concept of MENTAL ILLNESS has also undergone considerable modification and extension. The clinical approach in medicine has done much to shift the focus of interest from the study of mental disease as such, to the person involved in the disease process. From the time when mental illness used to be regarded as demoniacal possession or as dysfunction of the brain we have now come to the time when it is looked upon as a complex of constitutional, psychogenic and environmental components. Consequently, a new understanding of the nature of mental illness has begun, and new therapeutic techniques are being devised in the light of this new understanding.

The term PSYCHOSIS is now used for different types of mental illness, while the term NEUROSIS is restricted to the milder forms of mental disturbance. In psychosis there is more or less "an almost complete loss of contact with the surrounding world." But the neurotic individual, in spite

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1. White, AP, 54; see also Alexander, FP, 19.
of his psychic conflicts and anxieties, is able to maintain some contact with reality. In borderline cases between neurosis and psychosis it is difficult to strike a dividing line; but, in general, this distinction seems to be valid. Acute psychotic reactions must be distinguished from their end results. Certain types of acute psychotic reactions represent a continuing battle of severe intensity. These benign reactions may be constructive, as Boisen suggests, and show better prognostic indices than their malignant end results.

Psychoses are divided into two groups: ORGANIC psychoses may have diverse causal factors, but they represent one common feature, i.e., injury to the cerebral cortex.¹ They may be associated with trauma, syphilis, senility, infectious diseases, toxins, and circulatory, glandular, or nutritional deficiencies. FUNCTIONAL psychoses do not preclude organic factors, but they are primarily psychogenic. Among them are included schizophrenias, manic-depressive psychoses, paranoia and paranoid conditions. It must be borne in mind that these classifications are merely descriptive; they are not disease entities as such, nor do they represent exclusive groups of symptoms. In many cases mixed symptoms are manifested which defy classification.

¹. Pennington & Berg, ICP, 272.
A brief word may here be said about SCHIZOPHRENIA. Kraepelin first introduced the term dementia praecox in 1896 to describe this group of psychoses. The term means "early decay of mental ability" and revealed the prevalence of the belief that the disorder, starting early in life and progressing through successive stages of deterioration, was characteristic of all cases. But today we know that this is not true in all cases; it can afflict people of all ages and does not necessarily represent deterioration of mental ability or intelligence. Bleuler introduced the term schizophrenia in psychiatric literature in 1911. It means "split personality" and is an improvement on Kraepelinian term. Acute schizophrenic reactions must be distinguished from their pre-psychotic or schizoid features or from their malignant involvements. A schizoid personality is characterized by introversion and social withdrawal. These seclusive tendencies, encouraged by situations of stress and strain, are some of the predisposing causes of schizophrenic breakdown. The SIMPLE type of schizophrenia represents a progressive withdrawal from the outside world, and is associated with mild delusions and hallucinations. The PARANOID type resorts to the mechanisms of projection, and thus finds a

1. White, AP, 522.
2. Lichtenstein & Small, HBP, 200f.
spurious solution of unsolved problems in a world of make-believe and delusions. The HEBEPHRENIC type represents the end result of the "drifting reaction or the demoralization which may follow upon an unsuccessful attempt at reorganization."¹ The hebephrenic misinterprets reality, while the paranoid acts in terms of his misinterpretations. The CATATONIC type is marked by phases of stupor and excitement. Repressive, negativistic and impulsive tendencies are characteristic of this type.² Prognostically, it shows a better outlook than the other three types. According to Boisen, catatonia "represents a desperate attempt at reorganization, following upon an awareness of danger, which tends either to make or break."³ These acute schizophrenic reactions may result in malignant involvements when the attempt at reorganization fails.

5. Synopsis of Dissertation

Following this introductory chapter, a review of psychiatric studies in schizophrenia is included in the second chapter. It summarizes the latest studies in schizophrenia from different points of view—histopathology, endocrinology and somatogenesis. Psychoanalytic, psychobiologic and sociodynamic approaches are briefly discussed. The syndrome of

¹. Boisen, EIW, 315.  
². Strecker, FP, 116-117, 130.  
³. Boisen, EIW, 315.
schizophrenia is treated in terms of its relationship to other forms of mental illness, its varieties, symptomatology and developmental aspects. The chapter concludes with a discussion of the various therapeutic formulations and therapies in relation to schizophrenia.

Chapter three presents a biographical sketch of Boisen. His early life and background and his educational and vocational interests are briefly discussed with special emphasis on their significance for his later growth and religious experience. An attempt is made to relate and interpret his mental illness in terms of its causation and end results. Boisen's work as pastor, chaplain and research worker is briefly described and the importance of his contribution to psychiatry and religion is indicated.

The next two chapters contain a detailed analysis of Boisen's studies with schizophrenia. His fundamental hypotheses concerning schizophrenia are discussed in the light of his clinical research and the views of psychiatric investigators. His theory of schizophrenia is considered in terms of its etiology, developmental aspects and dynamics. The implications of his therapeutic formulations are then considered. The discussion closes with a critical appraisal of his investigations.

In chapter six an attempt is made to study the implications of Boisen's studies for religion and for religious
therapy with schizophrenia. The discussion centers around five questions: schizophrenia and religious conversion, psychiatric approach to religion, religious therapy for schizophrenia, the task of prevention, and the clinical pastoral movement. In the concluding chapter a summary of this dissertation is included and the main conclusions are outlined.
CHAPTER II

SCHIZOPHRENIA

In the previous chapter we have briefly discussed the nature of our problem and its importance and relevance as a subject for research. Our main interest in this inquiry centers around Boisen's studies in schizophrenia. We shall also be concerned with his life and mental illness, for they have important bearing on his point of view. However, such an inquiry must begin with a discussion of the nature and syndromy of schizophrenia itself. What is the fundamental nature of schizophrenia? Is it a disease process or a functional disorder? How is it related to other forms of mental illness? How does it manifest itself in terms of reaction patterns and psychological constructs? What type of personality is particularly vulnerable to it? Is it a unity? If so, what is its characteristic symptomatology? Can it be prevented, cured or arrested? To such questions we shall now turn our attention.

1. Schizophrenia in Relation to Other Forms of Mental Illness

To appreciate the nature and magnitude of the problem that schizophrenia represents, it is necessary to study it in relation to other forms of mental illness. We propose
to do this under four heads, viz., the concept of mental illness, organic psychoses, functional psychoses, and the dimensions of the problem.

1. The Concept of Mental Illness

The concept of mental illness, as we have said before, has undergone a considerable change and extension during recent years. From the time when mental illness used to be regarded as evidence of demoniacal possession or as dysfunction of the brain, we have now come to the place where it is looked upon as a complex phenomenon in which various constitutional, environmental and psychogenic factors are involved. Abnormal human phenomena have been a subject of interest from earliest times. No early records of mental disease in primitive society are available; it is a valid assumption, however, that abnormal mental phenomena have always existed in human society. Recent studies in comparative psychiatry and anthropology justify this assumption.1

Ethnological literature, also, supports the view that in demonism the primitive man found a satisfying causal explanation for the things he could not understand.2 This of course included all abnormal mental phenomena, and thus man first began with a demonological concept of mental illness.3

1. Deutsch, MIA, 1-19.
2. Sumner, FOL, 7, 510.
It is interesting to note the wide prevalence of this conception in ancient and medieval times. Since this conception was inextricably mixed up with religion the cure and treatment of the mentally ill came to be regarded as exclusively a priestly function, and the temples and shrines became centers of "religious therapy." During the Middle Ages numerous healing shrines sprang up all over Europe and patients flocked to them to receive healing at the hands of the priest. The therapeutic influence of these shrines must have been very salutary. However, the demonological conception of mental illness had some very unfortunate results. It led to dark periods of witchcraft hysteria and most inhuman treatment of mental sufferers.

But the times were changing and with better understanding of mental illness better methods of treatment began. The initiative came, as before, from religious leaders and their holy shrines. With the Renaissance there came a revival of the ancient Greek theories which regarded insanity as due to a generalized pathology of humors and tensions. But pathological research soon led to an abandonment of this view in favor of a localized pathology, and attempts were

1. Sadler, TPP, 1-10.
made to find cerebral lesions for particular mental symptoms.  

Humanitarianism went hand in hand with scientific inquiry, and during the closing years of the eighteenth century we find Pinel in France advocating humanitarian treatment of the mentally ill. Similar developments took place in England and America. Thus the nineteenth century can be looked upon as an era of great reforms in the care and treatment of mental sufferers. The founding of the Mental Hygiene Movement in 1909 marked the culmination of these humanitarian activities.

On the medical side, the ancient Hippocratic conception of mental illness as a disease of the brain persisted and interest was centered around disease identifications and classifications. This gave rise to numerous confusing nosologies, until Pinel and Esquirol brought order out of this chaos by recognizing four large groups of insanity: mania, melancholia, dementia, and idiocy. Kraepelin's study of general paresis was a milestone in the history of descriptive psychiatry. Although a staunch supporter of the physiological theory of mental illness, he did succeed in classifying mental illnesses in terms of their onset, course and end results. His classificatory scheme is still the basis of modern psychiatry.

2. Zilborg and Henry, HMP, 323f.
The psychological point of view gradually won its way into modern psychiatry through the study of hysteria. The investigations of Mesmer, Charcot and Janet led to the conclusion that certain hysterical phenomena had an apparent physical pathology. The full implications of their efforts, however, came to light in the dynamic psychologies of Freud and his associates. Freud stressed the importance of unconscious motivation not only in hysterical phenomena but in all mental aberrations.¹ His concepts of repression, transference and sexuality have shifted psychiatric interest from the study of brain and glands to the study of dynamic processes within personality. In Meyerian psychobiology we again see a shift of interest from the intra-psychic to the interpersonal aspects of mental illness.² A synoptic approach to mental illness is developing in the light of recent therapeutic formulations.³ There is a much better understanding today of psychoses that have clear organic etiology and those that are reactions to life situations and are mainly functional disorders. While the importance of somatic factors is recognized, the psychogenic view of mental illness has important prophylactic and meliorative implications.⁴

¹. Freud, GIP.
It gives meaning and support to all preventive measures with respect to mental illness; a "constitutional" view of it, on the other hand, frustrates all therapeutic endeavors.

Boisen's studies of the subjective aspects of mental illness have considerably increased our understanding of the ideational content of psychotic patients. He has shown us that the "wilderness of the lost" is not a world of mere fantasy or nirvana, but a world of meanings and motivations, a world characterized by intense mental activity and alertness. His sociodynamic approach to schizophrenia, as representing a failure in the realm of interpersonal relationships, is full of implications for society in general and for the Christian Church in particular.

11. Organic Psychoses

While there is still some lack of clarity in the use of "psychosis" and "neurosis," and in borderline cases no dividing line can be drawn, in clinical practice the two broad divisions can be easily recognized. The term psychosis represents more or less a complete break from reality, while the neurosis is restricted to milder forms of mental disturbance. The same situation obtains in the use of the terms organic and functional with respect to psychosis, for in many cases elements of both enter into the picture. However, this classification is in common practice today.
The distinguishing feature of all organic psychoses is some kind of injury to the cerebral cortex.

Damage to subcortical areas and other structures of the nervous system may produce specific psychological and physical symptoms but in general will not produce psychosis...the bulk of the experimental evidence on animals and the clinical evidence from patients tends to support the contention that gross lesions only will produce psychosis.

While this is a somewhat controversial point, it is clear that some kind of brain injury or damage is always associated with organic psychoses. This injury may be caused in various ways: mechanical means, toxic agents, infectious diseases, circulatory or neoplastic conditions. The choice of psychosis will probably depend upon organic etiology and other non-organic factors. Barring several mixed or undefined conditions, the following are the main categories of organic psychoses.

**General Paresis** is a disease of syphilitic origin, caused by a minute infectious organism that attacks the nerve-cell layers of the paretic cortex. Unless early intensive treatment is undertaken, there occurs rapid physical and mental deterioration. There is controversy regarding the organic basis of *senile psychosis*; it is essentially a disease

1. Pennington and Berg, ICP, 272.
of old age, although, in certain cases, it may begin quite early. It is characterized by egocentricity, extreme conservatism, inefficiency, forgetfulness and suspiciousness. In many ways, it represents a regression to childhood. Korsakoff's Psychosis is characterized by retention difficulty, confabulation and disorientation for time.\(^1\) It usually develops as a result of chronic alcoholism, pellagra, typhoid, lead poisoning or other toxic conditions. Sadler describes other psychoses that have definite organic etiology: exhaustion psychoses, cerebral syphilis, cerebral arteriosclerosis, brain tumors, encephalitis and sequelae, choreas, post-traumatic states and epilepsies.\(^2\) The organic psychoses involve, in many cases, psychogenic components either as etiological or resulting factors, and they have important bearing on the course and end result of a particular psychosis. In certain cases, physical incapacitation or mental deterioration have definite bearing to one's life situation and one's emotional attitudes.

### iii. Functional Psychoses

Functional psychoses represent severe mental disorders for which no clear organic basis has been established. This, of course, does not imply that organic factors may

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1. Lichtenstein and Small, HP, 263ff.
2. Sadler, TPR, 900-915.
not be present or may not develop during the course of the disease. But such disorders are primarily psychogenic in origin. They develop as a result of intrapsychic conflicts which are determined by the external and internal factors related to the individual—the original endowment and special traits of personality, the moulding influence of the home, the stresses of the actual situation.1 Among the major functional psychoses may be included schizophrenia, manic-depressive psychosis, involutional psychosis, paranoia and paranoid conditions. There are other undetermined conditions which cannot be easily categorized. On the whole, these major groups represent certain distinguishing features which justify their classification into separate categories.

The psychosis of schizophrenia will be considered in detail hereafter. We have already included a brief definition of it in the previous chapter. It has certain characteristics which distinguish it from other functional psychoses. It is a very serious mental disorder which has, in most cases, a long developmental history. Certain forms of it—for instance, excited and stuporous catatonic and paranoid conditions—are often difficult to distinguish from other functional disorders. But, on the basis of careful

clinical observation, its identity can easily be established. In advanced stages of psychotic deterioration nearly all functional psychoses lose their distinctive character and represent a very confused and conglomerate behaviour phenomenon.

The manic-depressive psychosis was first recognized by Kraepelin who, however, thought of it as constituting two distinct entities. It is generally recognized today that it represents a single entity. Mania and depression, in most cases, succeed each other in the same person and thus the basic dynamism seems to be the same. In its milder forms manic-depressive psychosis can hardly be differentiated from neurosis; the latter represents merely a milder episode of the former. In the manic states the patient becomes highly euphoric, hyperactive, and loses all sense of perspective. The depressive states are followed by exactly the opposite reactions: the patient becomes melancholic, negativistic and full of self-pity and guilt complex. These manic and depressive phases may succeed each other rapidly or may take weeks or months before they alternate; in some cases they often slightly overlap. Freud described a manic-depressive patient as an id force without interference from the super-ego, an oral personality in contrast to the schizophrenic whom he represented as a phallic personality.
Despite these alternating cycles there are some common characteristics or personality traits reflected by the patient: lack of insight and decisiveness; defective memory and temperamental fluctuations. Kretschmer has pointed out a marked correlation between the pyknic component of physique and the manic depressive psychosis. Sadler further points out that this psychosis is basically an emotional disturbance.

Manic-depressive psychosis has many points of contrast with schizophrenia. In point of numbers it comes next to schizophrenia, though it may probably represent a higher rate of readmissions. Its common features may be summarized as follows: weak superego, oral traits, extroversion, endomorphic physique, sociability, low sense of values, self-deceiving type, history of repeated attacks, better contact with reality, and favorable prognosis. In schizophrenia, on the other hand, we find strong superego, phallic traits, introversion, ectomorphic physique, seclusiveness, high sense of values, acceptance of responsibility, developmental disorder, complete indifference to reality and poor prognosis. In excited catatonic state and manic states, differential diagnosis is often difficult, but close clinical observation combined with some of the distinguishing symptoms given above leaves little doubt.

1. Sadler, TPP, 784-786.
2. Kretschmer, PC, 145f.
Involutional psychosis is often included under manic-depressive group, although in certain respects it seems to be a class by itself. It usually occurs in women during their menopausal period and somewhat later in men. Its characteristic symptoms include diffused anxiety, sleeplessness, suspiciousness, mutism, impulsiveness, destructive tendency and hypochondriacal ideas. Mihilistic and cosmic delusions often occur. This psychosis is somewhat similar to the depressive phase of manic-depressive psychosis. Certain traits characterize the person who succumbs to it: sensitiveness, seclusiveness, rigid upbringing and sexual maladjustment. In this respect it resembles the pre-psychotic personality of the schizophrenic.

Paranoia includes a large number of psychotic reactions and is often found in association with other forms of functional disorder. Pure paranoid states involve a highly systematized delusional system, but they rarely occur in such unmixed forms. The paranoiac correctly perceives reality but misinterprets it to suit his own purposes; he is usually free from hallucinations, for he has succeeded in projecting his own failures and inadequacies on to the outer world and believes himself an object of hostility and persecution. In contrast to him, the schizophrenic, as we shall see, accepts responsibility and blame for his condition and

thus exposes himself to severe intra-psychic conflicts from which the paranoiac usually escapes. The paranoiac's reasoning processes are also more or less intact. If one accepts his premises, one cannot but be impressed with his logic. Boisen calls the paranoiac a self-deceiver who accepts defeat by denying it, and in terms of his delusional misinterpretation is able to achieve a measure of integration. He becomes easily institutionalized in the mental hospital.

Freud believed that paranoia represented a fixation at homosexual level of development, while Meyer, Kretschmer and others posit a constitutional factor as determinant of paranoia. The psychogenic view regards it as a faulty reaction to life situations. With regard to etiology, Sadler states that paranoid trends seem to develop in persons who are sensitive, suspicious, and jealous and inordinately ambitious. Prognostically, strong paranoid trends represent a poor outlook for recovery.

iv. Dimensions of the Problem

The seriousness of the problem of mental illness cannot be overemphasized. More than half a million people in this country are in mental hospitals at any one time. In 1935 it was estimated that there were approximately 590,000 pa-

1. Sadler, TPP, 847.
2. Deutsch, SS, 30-32. Thorman, TMH.
tients resident in mental institutions. These figures did not include those mentally ill patients who were in general hospitals, homes for the aged and so on.¹ In 1948 this number rose to 600,000, in addition to 9,000,000 who should have received psychiatric help.² That schizophrenia is a tremendous health problem is shown by the fact that in 1938 there were nearly 21,279 schizophrenic admissions to all mental hospitals.³ In 1946 Lowry wrote, "there are apparently 250,000 such cases registered on the books of our mental hospitals, and more than 21,000 new cases are being received each year."⁴ At present perhaps more than fifty per cent of all state hospital inmates are schizophrenic patients. In giving this estimate Robert White writes, "the disorder must be considered highly costly, whether we reckon the cost in dollars spent or in the more important coin of human lives."⁵ These figures would give us some idea of the magnitude of the problem that schizophrenia represents. The seriousness and baffling nature of the problem is recognized by the mental hygienists and investigators in this field. More psychiatric literature is appearing on this problem alone than any other. From 1927 to 1946 there appeared in the American

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¹ Landis and Page, MSM, 19.
² Rennie and Woodward, MHM, 154.
⁴ Lowry, P8W, 176.
⁵ White, AP, 521.
Journal of Psychiatry more articles on epilepsy and schizophrenia than on any other single subject. A mere glance at the psychiatric journals today will show the seriousness with which this problem is being tackled from almost every angle. Religious interest in schizophrenia is indicated by the extensive researches which Boisen has carried on. The present study proposes to make available a critical survey of his work. What is more, it attempts to study his life and schizophrenic experience, without which the full significance of his studies cannot be realized.

2. Psychiatric Classification

A great deal of psychiatric literature is available on the subject of schizophrenia. Perhaps no single group of psychoses has been so thoroughly investigated from almost every conceivable angle of etiology, pathology and prognosis. In recent years, the number of contributions on the subject has greatly increased, and there are some who seem to believe that in schizophrenia they can find a key to the understanding of the whole problem of mental illness. Prognostically, psychiatric opinion on the problem swings between two poles of an absolute pessimism shown by some followers of Kraepelin and the extreme optimism of certain schools of research.¹

¹. Sullivan, MCP, 71.
For the purposes of orientation, we propose to discuss the syndromy of schizophrenia, particularly as it bears on the subject of the present study.

1. Kraepelinian Classification

In 1860 Morel introduced the term "dementia precoce" to describe people who were "wrecked on the rock of puberty." In 1896 Kraepelin first discovered important symptomatological differences between manic-depressive psychosis and a group of acute forms of mental disorders which he described as "Dementia Praecox"—a term which means "early decay of mental ability." He believed that this disorder which started early in life and progressed through successive stages of deterioration was characteristic of all cases. But subsequent clinical experience revealed that Kraepelin was wrong on two counts: this distressing disease can afflict persons of all ages, and it does not necessarily represent deterioration of mental abilities or intelligence in all cases. Kraepelin's term implies hopeless prognosis and in too many instances has led to an attitude of absolute pessimism.¹

In 1911 Bleuler introduced the term schizophrenia and applied it to all psychoses except the manic-depressive group. The term itself means "split personality" and is a decided improvement on the term used by Kraepelin. It is

¹ Henderson and Gillespie, TBP, 200.
now generally used in psychiatric literature. There is a question, however, whether the inner world of many a schizophrenic does not really represent an integrated system of ideas and values, at least in terms of his own frame of reference. Boisen's studies may throw some light on this question. Bleuler's term also suggests the phenomenon of hysterical dissociations and multiple selves and is therefore somewhat confusing.¹

11. "Process" Schizophrenia

The two terms "schizophrenia" and "dementia praecox" are often used synonymously, as we find to be the case in Boisen's writings. But modern psychiatric opinion seems to distinguish true "process," or constitutional schizophrenia, from its schizophreniform reactions.² The term "dementia praecox" is used by some in a more restricted sense, that is, as representing "the congeries of signs and symptoms pertaining to an organic, degenerative disease usually of insidious development."³ The other term is said to represent primarily a disorder of living. It is reserved for the more reactive type of patients in whom mental disturbance has been precipitated by some psychogenic conflict or stress

1. White, AP, 522.
2. Hoskins, BS, 71f.
3. Sullivan, MCP, 73.
and where psychological factors are more prominent. In the present study this distinction will be observed.

There is even a tendency to regard the various schizophreniform reactions as "types" rather than disease entities. A study carried on at the Elgin State Hospital shows that schizophrenia is not a clinical entity with homogeneous types, but that it is made up of types that can be distinguished "on the basis of malignancy with 'process' schizophrenia at one extreme and recoverable schizophreniform types at the other."¹ Langfeldt has shown that the majority of schizophrenic cases given shock therapy are "schizophreniform" types, that is, cases with relatively good prognosis, while "process" schizophrenics do not improve whether they receive shock therapy or not.² Boisen, in a study of different types of dementia praecox, has shown that the present system of classification is somewhat unsatisfactory. "What it represents is types not disease entities. The types thus distinguished must be regarded as dynamic action systems and interpreted in terms of meanings."³ Boisen here makes a point of real significance which the psychiatrist often forgets. There is a danger that in the interest of nosologies and typologies we may overlook the "unique" individual with which we are dealing.

2. Langfeldt, Art., (1937), 221.
iii. Schizophrenic Types

Sadler discusses two general types of schizophrenic reactions. (a) The acute emotional disturbance which represents an acute conflict reaction and may often have very constructive results. It may be something of a problem-solving experience which, as Sadler states, Boisen likens to certain types of religious experience. (b) The psychic involvement which represents accumulative results of long-continued daydreaming, chronic concealment, and malignant pleasure seeking. Boisen compares these two types to panic and concealment reactions.

3. Symptomatology

The nature of mental illness cannot be understood on the basis of symptomatology alone; other factors must always be taken into account. This is especially true of schizophrenia in which submerged complexes always condition and color the symptoms. However, the different varieties of schizophrenia share in common certain features which differentiate them from other psychoses.

1. Indifference to Reality

In all psychoses there is a loss of contact with reality, but in schizophrenia there is a complete indifference to it.

1. Sadler, TPP, 820.
This, according to Robert White, is the most distinguishing feature of this disorder—"a lack of interest in adjustment to reality."¹ The patient may be quite oriented as to time, place and personal identity, but he loses all active interest in his surroundings. But passive interest is never lost, except in advanced stages. This extreme indifference to reality probably accounts for the apathy, dreaminess and inattention in most cases of schizophrenia.

1. Affective Rigidity

Sadler describes it as "emotional blunting" or loss of "spontaneous reactions." There is a marked disturbance of emotional or affective life, showing itself in complete indifference to those who were formerly close and in appropriate reactions to disconcerting news or disturbing situations. The patient is indifferent to everything. He can even face the threat of electrocution without moving an eyelash.² He can be made to do simple tasks provided they do not interfere unduly with his ruminations. Some patients, especially in the initial stages, exhibit irritableness and sensitivity to mental pain of any sort; but these affective expressions tend to disappear as the disease progresses. It is however important to remember, as Sullivan has pointed out, that in

¹. White, AP, 527-528.
². Sadler, TPR, 823.
many cases some evidences of affective activity can be detected by close observation. Boisen goes even so far as to say that it is a serious error to characterize schizophrenia as lacking in affect. "In my own case and in the case of most of the patients I have studied it was just the reverse." He admits, however, that in hebephrenia lack of affect is clearly noticeable.

111. Impulsiveness

Certain patients—usually catatonics and hebephrenics—are apt to display sudden bursts of violent activity without any apparent reason. They may be purposeful or merely outbursts in response to destructive impulses. This impulsiveness may arise from the extreme ambivalence to which the schizophrenic is often subject. This is clearly shown in his behaviour and ideation. He is torn between conflicting impulses and ideas. He wants to eat and he does not want to eat; he wants to do what he does not want to do. He believes he is God and Devil at the same time; ideas of grandeur and utter self-abasement may alternate with surprising rapidity. "In the delusions too, expansive and depressive ideas frequently mingle in multicoloured confusion."  

2. Bleuler, TBP, 382.
iv. Automatism and Negativism

Like his ambivalence the patient may represent automatic and negativistic trends at the same time. When asked to do something, certain patients will comply almost automatically; at other times they may resist or do exactly the opposite. However in most schizophrenic reactions negativistic tendencies are on the ascendance. "This negativism is often associated or alternated with a type of autistic thinking, and this disorder tends to gravitate from the dreamlike ideation to feelings of being forced or coerced from the outside..."¹ This negativism may show itself in various ways: refusal to eat and dress; retention of saliva, urine or feces; rigidity of manner and behaviour; uncooperativeness. Mutism is another negative trait in catatonic reaction. The patient must not speak, for "voices" command silence; something terrible would happen if he broke his self-imposed silence. Catalepsy may accompany negativistic reaction; the musculature of the patient assumes a waxy rigidity, and the limbs assume any position where they remain until fatigue overtakes them. This is especially characteristic of catatonics; other schizophrenic patients may show the opposite reaction of extreme mobility.²

¹. Safler, TPP, 326.
². Bleuler, TP, 406-408.
v. Mannerisms

The patient gradually develops certain stereotyped mannerisms, gestures, habit spasms and ataxias. Sullivan cites several instances of such stereotypy: a patient would not eat food that his fingers had touched; another patient, when approached by anyone, closes his mouth; a catatonic may keep his fingers clenched until surgical operation becomes necessary to bring them back to their position. He calls them "quasi-communicative mannerisms, because "not only do they represent the autonomous activity of impulses dissociated from awareness, but they represent the activity of impulses that were once a part of the self dynamism, the dissociating system."¹ These mannerisms may also be reflected in speech as well as in writing.

vi. Speech Confusion

The schizophrenic speech is characterized by incoherence, negativism, mutism, neologism, and echolalia.² Sullivan and Gillespie explain these speech distortions as a method of escape from interpersonal relationships. Language becomes not a tool of social intercourse but a powerful means to avoid it and thereby strengthen one's delusional interpretations. The schizophrenic does not seek to commune with his fellowmen; he finds the reality of this communion in the

¹ Sullivan MCP, 80-81.
² Sadler, TPP, 826.
inner recesses of his fantasy world. Boisen, however, interprets the schizophrenic speech confusion as due to the fact that his mental and emotional life is so stirred and quickened that meanings outstrip symbols, and conventional language is inadequate to express the profuseness of his ideas.

vii. Schizophrenic Thinking

The schizophrenic's thinking is characterized by inconsistency, emptiness, dissociation and regression. Boisen describes it in terms of inner meanings and motivations. In acute schizophrenic reactions he finds concern with cosmic affairs—ideas of cosmic catastrophe, cosmic identification, rebirth and nihilistic delusions. Ideas of reference and of influence frequently occur, although Boisen finds persecutory coloring only in what he calls the "self-deceiving" type of patients, who achieve a certain measure of integration by their delusional misinterpretations. Semantically, the schizophrenic's thinking has been compared to the paleo-logician type of thinking. For the schizophrenic, identity consists of identical predicates, and he is more interested in the mere verbalization of words than in their connotation or denotation.¹

This concludes our discussion of some of the most common symptoms that characterize schizophrenias. We have not mentioned hallucinations, delusions and somatic sensations, for they are more or less common to all mental disorders. The symptomatology of the various subvarieties varies according to the type and the individual trend of the patient. In our next section we will discuss the four major varieties of schizophrenia.

4. Clinical Types

Kraepelinian psychiatry recognized four principal types of schizophrenia: schizophrenia simplex, catatonia, hebephrenia and paranoid schizophrenia. Later on he added numerous other subvarieties. There is a great deal of controversy over whether these varieties represent fundamental types of mental illness or are merely typical courses of events observable in schizophrenic states. In our view, Boisen's characterization of them as "dynamic action systems" rather than fixed disease entities is the best way of looking at them. It is, however, necessary to differentiate dementia praecox as an organic disease process from its schizophreniform reactions—a distinction which Boisen fails to make. In clinical practice, Kraepelin's classification is still used as a point of departure. Despite some unclarity and overlapping, the four main varieties have each a distinctive character which justifies their differentiation.
1. Heboidphrenia

Simple schizophrenia or heboidphrenia is characterized by the absence of any definite trend. It is regarded by some as the basic form of "primary constitutive deterioration," from which subsequent schizophrenic groupings result. Sullivan also regards it as probably representing organic deterioration.

These patients undergo a progressive shrinkage of initiative, a disintegration of social habits, including communication, and a seeming evaporation of any interest in events impinging on them.1

The onset of heboidphrenia is gradual, usually first evidenced by a general withdrawal from social situations. The patient is inclined to remain at home and avoid all social contacts. According to the conflict theory, which Boisen advocates, intra-psychic conflicts precede this general retreat. Daydreaming, introspection and generalized fears and anxieties gradually become his main preoccupation. Whatever drive or ambition he may have soon fizzes out, and he gets into difficulties with his family and friends for his apparent laziness and complete disregard for their interests or comforts. Apathy, insomnia and frequent somatic and hysteroform ailments make their appearance. He begins to see grotesque dreams and visions and hears "voices" that

1. Sullivan, MCP, 82.
seem insulting and disagreeable. Behavioral changes and peculiarities become noticeable: bizarre mannerisms, negativism, speech confusion, moodiness and emotional dulling. There is generally an absence of any definite hallucinations or delusions; they may be transitory or flitting, if they appear at all. The patient is easily institutionalized and often remains in the hospital for a long time without any apparent change in his condition. In some cases there is progressive deterioration. Boisen calls the hebephrenic an ambitionless "drifter" who accepts defeat by demoralization. He is easily adjusted to any situation that does not demand too much in terms of work or of attention to personal habits.

11. Hebephreria

In the prodromal stages this syndrome is not easily differentiated from catatonia or paranoid conditions. However, in most cases, it begins rather abruptly and represents "a definite history of fantasy tendencies and alternating moods." The most distinguishing features seem to be mental confusion and emotional depression, often accompanied by auditory and visual hallucinations. The patient abruptly withdraws from normal social contacts, shows much incoherence.

1. Sadler, TPP, 830.
in the train of thought, and frequently exhibits marked emotional disturbance. He is apt to be untidy and his behaviour seems silly, impulsive and senseless. Delusions and hallucinations are fleeting, changeable and fantastic. In advanced stages it is not easy to obtain any connected responses to questions. In the hospital he is likely to be found especially on the "habit training halls." There are rapid shifts between excitement and depression, or between different emotional expressions; his behaviour is childish, mischievous and playful, characterized with grimacing, posturing and stereotyped activities. Boisen describes the hebephrenic type as characterized by disjointed sentences, word salads, distortions and condensations, stereotypes, mannerisms and inappropriate affects.\(^1\) He represents this reaction as "the terminal stage of the drifting reaction or the demoralization which may follow upon an unsuccessful attempt at reorganization."\(^2\) In some cases it represents the termination of a prolonged catatonic state, and the prognosis is generally poor. However, Sullivan and Kempf have demonstrated that hebephrenia can be treated, and that in some cases there is spontaneous recovery.\(^3\)

\(^{1}\) Boisen, Art., (1942), 23-33
\(^{2}\) Boisen, EIW, 315.
\(^{3}\) Sullivan MCP, 79.
iii. Paranoid Schizophrenia

Paranoid states are often associated with other forms of psychosis, but in a great majority of cases they occur in conjunction with schizophrenia. Along with other varieties of schizophrenia, the paranoid type represents a conflict between instinctual tendencies and accepted social and moral codes. But whereas the other two types, just mentioned, accept defeat by demoralization or drifting, the paranoid accepts defeat by denying it and maintains his security in a delusional misinterpretation of reality. He refuses to accept his own unacceptable desires as being his own and attributes them to those about him. Many patients develop ideas of reference, ideas of grandeur, active auditory hallucinations, and feelings of being influenced from outside by hypnotism, and delusions of persecutions and food poisoning. In accordance with their delusions of grandeur, some patients decorate themselves with all sorts of ornaments, usually made by themselves. Their persecution complex is often so strong that even a twitch of the eyelid or a crawling sensation is interpreted as evidence of external influences or devices exerted on them by their tormentors. They believe themselves victims of hostility and aggressive sexuality. Thus we see that the paranoid makes use of the mechanism of projection for his unadjusted sexual and aggressive tendencies.

1. Sadler, TPP, 829.
The paranoid conditions develop later in life than other types, and deterioration is slower. There is a relatively closer approximation between the thought content and the emotional expression. The paranoid in many cases is able to achieve some measure of integration on the basis of his arrested deterioration and becomes a useful member of the hospital community.

iv. Catatonia

Catatonic reactions usually make their appearance in a comparatively abrupt manner. In the initial stages the symptomatology is somewhat vague; there may be mild depression and in some cases epileptic or hysterical convulsions. The onset in most cases begins with a profound stupor; definite clinical picture of alternating excitement and stupor appears sometime after the initial disturbance. The clinical picture of stuporous conditions includes the following features: mutism, extreme motility and negativism, insensitivity to pain, absolute apathy and indifference to one's surroundings. The patient requires complete nursing care and in some cases catheterization or enemas. Excited states are often associated with a sudden onset of frenzied excitement, discordant

1. Strecker, FP, 130.
2. Sadler, TPP, 827f.
activity, marked impulsiveness, speech confusion, homicidal or suicidal tendencies, and active auditory hallucinations.¹

One of the best descriptions of the subjective aspects of catatonia comes from Boisen who, in describing this condition is, as Klein puts it, "on home ground." He interprets catatonic reactions in terms of inner meanings and motivations. In our discussion of his theory we will deal with this reaction in greater detail. It is important to note that catatonic reactions often begin with some emotional shock or some violent setback. Inner tensions, already present, may be intensified by new challenges to major decisions or responsibilities, by new problems of adjustment, or by the sudden breaking forth of instinctual cravings which are neither controlled nor acknowledged.

v. Mixed Clinical Types

In clinical practice psychiatrists do not always find it easy to differentiate the four major varieties of schizophrenia that we have briefly discussed. In the initial stages the problem of differential diagnosis is particularly difficult; mixed forms and variations often occur. This is probably the reason that some investigators are inclined to cast serious doubt on this whole Kraepelinian scheme of classification. But, as Boisen has well reminded us, no

¹. May, Art., (1941), 440. Bleuler has an excellent descriptive account of catatonia. TP, 417-434.
science is possible without a basis of classification which permits significant relationships to become apparent. He has shown the inadequacy of the present classification, but he argues that it is based on correct observation. On the other hand, the tendency to create a vast and bewildering grouping should also be discouraged. Polatin suggests that at least the most important subvarieties should be recognized: pseudoneurotic type represents patients who remain ill with non-deteriorating symptomatology, and who are characterized by feelings of unreality and fear and other hysterical manifestations; acute confusional states manifest themselves in sudden onset with deterioration and confusion; hysterical reactions include amnesias, fugue states and hysterical fits; cyclic forms represent a periodic form of catatonia; schizoaffective group constitutes mixed symptoms of schizophrenia and manic-depressive psychosis; depressive forms represent prolonged depressive schizophrenia; symptomatic schizophrenic symptoms occur in course of organic psychoses as general paresis, brain tumor, and alcoholism.

5. Etiology

Various theoretical formulations have been made as to the etiology of schizophrenia, but it must be admitted that

2. Sadler, TPP, 831.
considerable obscurity still surrounds the subject. We propose to discuss only a few important theories of causation.

1. Histopathology

Postmortem studies of schizophrenic brains have been made, and certain cerebral changes in the cortical region, thalamus, or the basal ganglia have been reported. For instance, in 1911, E. E. Southard reported focal atrophies and scleroses in some eighty-six per cent of his series of dementia praecox; and in cases of late catatonia he found focal lesions of the cortex.1 Alzheimer also reported loss of nerve cells in the outer layers of the frontal lobes in dementia praecox.2 However, a survey of pathological research in 1920, showed negative results and concluded with the remark that the general pathologist is familiar with the tissue changes in the various kinds of neoplasm, but he can only surmise about the actual operative forces at work in their production.3 And in 1928 Dunlap stated that no consistent nerve-cell changes in schizophrenia have been found.4 Conn has also come to the same conclusion.5 We can only conclude by saying that while pathological research

2. As quoted by Bleuler, Art., (1915), 450.
may yet offer some important leads in this field it has definitely failed to establish any organic basis for schizophrenia.

ii. Physiologic Changes

In 1922, Cotton investigated the physical concomitants of schizophrenia and was convinced that it was a manifestation of focal infection—a conviction not shared by Kirby and others.\(^1\) Raphael's studies led him to conclude that schizophrenia represented somatic vulnerability as regards the endocrine-autonomic field, which under stress operative on the psychic level became clinically manifested.\(^2\) Gibbs found secondary sexual characteristics more frequent in schizophrenic women than the manic-depressive.\(^3\) These studies are full of interest, but, while they do throw light on the altered vegetative imbalance in schizophrenia, they do not explain its etiology.

iii. Neuro-endocrine Research

Kraepelin initiated research in endocrinology and suggested the hypothesis that schizophrenia represents a disordered metabolism or secretion of sex glands, and that it results from autointoxication. Lewin examined histologically the various endocrine glands but found no such anatomic-psychiatric correlation.\(^4\) Mott assigns an important role

\(^1\) Kirby, Art., (1912), 1035.  \(^3\) Gibbs, Art., (1924), 179.
to endocrine disorders, but similar disorders have been noticed in undernourished people. ¹ Carmichael, Goldstein and others have shown that schizophrenia or other mental disorders cannot be established on the basis of either biochemical changes or endocrine disorders.² Hoskins and his associates present an "immaturity concept" of schizophrenia and state that, while certain endocrine deficiencies do exist in schizophrenics, the disease itself represents a generalized failure of bodily adaptation that manifests itself in various somatic and psychic ways.³

iv. Genetic Aspects

Kallmann supports the genogenic theory of schizophrenia, and believes that an understanding of basic genetic principles will lead to improved methods of treatment. He contends that schizophrenia is an inherited disorder, and that the incidence is greater for closer relatives of parents than for more distant relatives.⁴ However, Meyer and others, while recognizing the importance of hereditary factors, believe that they are not sufficient to account for schizophrenia.⁵ On the whole there seem to be very few investigators who share in Kallmann's profound optimism. As we have

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¹ Mott, Art., (1922), 333.
³ Hoskins, BS, 92.
⁴ See in Landis and Page, MSM, 81-85.
⁵ Meyer and others, ES, 162.
said elsewhere, such a view only leads to a fatalistic state of therapeutic activity, in spite of Kallmann's assurance that schizophrenia can be prevented by "management and mobilization of constitutional resistance."¹

v. Somatic Types

Kretschmer and Sheldon have pursued an interesting and promising line of inquiry in body types, and they find a certain correlation between physical habitus and type of psychosis. Kretschmer correlates schizophrenic patients with the astheno-pyknic type of constitution. Sheldon correlates them with ectomorphic physique and cerebrotonic traits. Ectomorph represents fragile, linear and slender physique, while cerebrotonia includes traits such as exclusiveness, sensitivity, shyness and other inhibitory behavioural characteristics.² These investigations are, however, in their experimental stage. They may have some relevancy in the particular geographic area or racial grouping in which they have been attempted, but this does not explain the etiology of schizophrenia as such. If these somatic types could be universally applied, then all Nepalese, who inhabit the mountainous regions of North India and admirably fit into Sheldon endomorphic category, can be subject, if at all, to only one kind of psychosis, i.e., manic depressive! However, the incidence of schizophrenia seems to be greater in these regions.

vi. Psychoanalysis

In psychoanalysis we come to dynamic interpretations of mental illness. Indeed the fundamental error of other disciplines lies in the fact that they often attempt to inter
if at all, to only one kind of psychosis, i.e., manic depressive! However, the incidence of schizophrenia seems to be greater in these regions.

vi. Psychoanalysis

In psychoanalysis we come to dynamic interpretations of mental illness. Indeed the fundamental error of other disciplines lies in the fact that they often attempt to interpret human behaviour in exclusively physiological terms. We have already shown how the psychogenic concept gradually won its way into psychiatry. Freud's discoveries gave a great impetus to this development. He formulated a comprehensive psychology of mental content and revealed the experiential origin of specific limitations of personal awareness. By this achievement, he cleared the way for the scientific study of people, in contradiction to mind, or society, or brain, or glands.¹

According to Freudian psychology schizophrenia represents a phallic personality, and its nucleus lies somewhere in early childhood, possibly between the years three and five.² The theory of Oedipus complex assumes that during this period the child cathects the parent of the opposite sex and feels 'hate' for the other. This arouses feelings of guilt (and fear of punishment, if the 'hated' parent retaliates).

2. Alexander, FP, 252-259. He has an excellent discussion of the psychoanalytic theory of schizophrenias.
These feelings are intensified by a number of complicating factors: (a) a strong superego acquired through strict moral upbringing; (b) disowned instinctual cravings which are neither controlled nor acknowledged; (c) some traumatic event such as death of the 'hated' parent; and (d) the presence of some predisposing constitutional factor. The mechanism of repression then comes into play and drives the conflict or anxiety-linked impulses into the subconscious. Or, in other words, the superego, perceiving the instinctual impulses to be hostile to its accepted code of behaviour, forces the ego to repress them. Thus there is a constant conflict between the id and the superego, between the instinctual cravings and the organized social mores. The ego is constantly exposed to these two opposing forces, and its function is to achieve a working compromise between the two. In so far as this is achieved the individual is enabled to make satisfactory social adjustment. But under unfavorable conditions, when the ego or the social self is too weak to modify or suppress instinctual urges, a spurious solution of the split forces of personality takes place in terms of neuroses or psychoses. Mental illness thus represents a spurious solution of the problems which one has not been able to solve in a natural or normal way.¹ But how account

¹. Alexander FP, 253.
for this weakness of the ego? Various possible causes are given: unwillingness on the child's part to give up his infantilism and accept adult ways of reacting to life situations; extraordinary demands for a difficult adaptation for which one is not prepared; or as a result of weakened resistance to stress consequent upon physiologic changes, such as occur at puberty, adolescence, involutional period, pregnancy, or following various physical illnesses. Or other social, economic or emotional crises may serve as the precipitating cause. Whatever way the break comes in, the weakened ego allows repressed desires into awareness, either frankly (as in hebephrenia) or in disguised forms as paranoid delusions and hallucinations. The catatonic may enter the world of fantasy and thus find satisfaction for unfulfilled desires or ambitions. This, in brief, is the psychoanalytic theory of schizophrenia.

vii. Psychobiologic Approach

The psychoanalytic theory tends to overemphasize the intrapsychic aspect of mental illness. Adolf Meyer proposes a psychobiologic approach to schizophrenia and interprets it as the end result of faulty habit patterns and defective thinking. Not only the individual's psychic mechanism but his environment determines his total adjustment. Heredity, disease and other physiological factors may also serve as contributing causes. The environmental factors include family,
social relationships, economic adjustment, and so on. Accumulation of maladjustments all along the line brings about mental disturbance. The individual fails to meet life situations and withdraws into himself or projects his inadequacies on to others. Where the first pattern becomes habitual, feelings of inferiority and incompetence increase, and the individual finally withdraws into a world of fantasy. If the second pattern predominates, he gradually develops a delusionary world of extreme self-deception. In both cases, however, certain developmental factors precede the actual onset of psychotic breakdown; the patient becomes increasingly withdrawn, precocious and neurotic.¹ Sullivan's interpersonal psychiatry of schizophrenia has brought out the full implications of Meyerian psychobiology. He regards schizophrenia as a failure in interpersonal relationships.

viii. Sociodynamic View

Boisen makes a sociodynamic approach to the problem of schizophrenia. He has achieved a remarkable synthesis of psychiatry, sociology and religion. Schizophrenia, according to him, represents a failure in social relationships. Its primary evil lies in a sense of personal failure consequent upon one's inability to socialize and thus assimilate

¹ Meyer, Art., (1937), 725-751. This is a special number dealing with Meyerian psychobiology.
new experiences. We will, in the following pages, discuss his point of view in much greater detail.

6. Developmental Factors

We have briefly discussed the etiology of schizophrenia from the standpoint of histogenesis, heredity, constitution, early influences, psychological reactions and interpersonal relationships. While the exact etiology is still unknown, certain things seem to be clear: (a) psychogenic factors may bring about a schizophrenic reaction in constitutionally normal or otherwise predisposed individuals; (b) in most cases schizophrenic reactions occur between the ages of fifteen and twenty-five; (c) certain conditions of stress and strain, for which one is not psychologically or physiologically equipped, may precipitate the breakdown; and (d) the schizophrenic represents a shut-in or "schizoid" character. Let us consider some of the developmental factors antecedent to schizophrenic reactions.

1. Childhood Origins

Psychoanalysis has demonstrated the importance of early influences on mental disturbances. Whether the nucleus of neurotic conflicts lies in repressed sexuality (Freud), repressed hostility (Horney), constitutional predisposition (Kallmann), or in some basic organ or psychic inferiority (Adler), we do not propose to discuss now. We assume that
such conflicts exist in the prepsychotic personality of the schizophrenic and are intensified by strong instinctual urges or some traumatic events.

English and Pearson, in discussing the emotional disturbances of the phallic period, point out that the child needs security, love, and an optimum period of gratification for his infantile sensual desires. Any threat to these basic needs is bound to create anxiety and fear; and thus to ward off anxiety, radical defenses are applied in childhood to replace basic needs by substitutionary compensations. This mode of adaptation may become a habitual life pattern in the absence of corrective influences. If the basic anxiety is centered around, say, a threat of desertion by the mother, the individual learns to substitute a bond of love for the physical presence of the mother, and to replace his dependence onto other symbols of security, such as his wife, his friends, his band. But his life must be built up in such a way as to minimize the possibility of being directly and forcibly reminded of the threat of desertion. This limits the freedom and spontaneity of his whole development. His growth is pervaded by the necessity of avoiding situations that resemble desertion. Outwardly he may do well, making a good adjustment to his exaggerated fear. But he is always vulnerable to a primitive desertion stimulus....

2. White, AP, 247.
From the point of view of interpersonal psychiatry, the child develops a concept of self or "self-dynamism" in terms of others' concept of himself. If he has been brought up in an environment where derogatory and hateful attitudes prevailed, the child incorporates them into himself; and thus his own attitude toward himself and others becomes derogatory and hateful. Sullivan thus explains the various schizophrenic syndromes in terms of this nuclear process. Following the Chicago School of Social Psychology, Boisen interprets schizophrenia in terms of a basic sense of personal failure and guilt. These feelings arise from the individual's inability to assimilate new experiences. There is a constant conflict between one's accepted ideals and disowned instinctual cravings, or between one's accepted ideals and his natural limitations. That is why the analysts represent psychosis as "a conflict between the different structural parts of the mental apparatus," and the neurosis "a disturbance in the personality in its relation to the outside world." Or we may say that the psychotic "represses" his painful or "improper" impulses into the subconscious, while the neurotic makes use of the mechanisms of

1. Sullivan, MCP, 97.
2. Alexander, FP, 252.
suppression.\textsuperscript{1} Boisen makes a similar distinction between the mental patient and the delinquent or the criminal.

\section*{11. Environmental Influences}

Friedlander studied the childhood background of twenty-seven psychotic patients and found the following syndromes of interpersonal relationships: rejecting, overprotective or over-solicitous parents; family frictions; general apprehensiveness; easily upset emotional balance; and introversion and day-dreaming.\textsuperscript{2} A study of the mothers of schizophrenic patients shows them to be neatly dressed, tense and anxious, insecure, and matrimonially unhappy.\textsuperscript{3} Similar studies have been made elsewhere, and they all show the importance of environmental influences in schizophrenic psychosis.\textsuperscript{4} The significance of economic distress in the production of mental illness, especially schizophrenia, has been discussed by Boisen.\textsuperscript{5} In brief, schizophrenic breakdowns usually occur in an unfavorable environment including: disturbed relationships in the family, unwholesome sex or social attitudes, maternal overprotection or paternal rejection, rigid but inconsistent moral and religious ideals or inferiorities and frustrations.\textsuperscript{6} If, in

\begin{enumerate}
\item Hsu, Art., (1949), 223-242.
\item Friedlander, Art., (1945) 330-335.
\item Tietze, Art., (1949), 55-65.
\item Brown and others, Art., (1949), 422-428.
\item Boisen, Art., (1939, 185-194.
\item See Liber, PM.
\end{enumerate}
addition to these, the individual has other physical or mental disabilities, a psychotic reaction easily follows.

iii. Early Manifestations

The early manifestations of schizophrenia are not distinguishable from neurotic traits in very early years. But, as the individual grows, certain marked tendencies begin to show themselves. Meyer's psycho-biological concept of "shut-in" personality illustrates the chief characteristic of the schizoid personality. Such an individual is usually serious, sensitive, shy, seclusive and sullen. Hoskins describes a study of 33 schizophrenic cases reported by Malamud and Malamud. Their long-standing personality traits included sensitiveness, serious-mindedness, shyness and rigidity. Marked homosexual tendencies with heterosexual maladjustments were also noticeable. Some were seclusive and insecure with exaggerated feelings of inferiority. Another study made at the Elgin State Hospital corroborates these findings. In a study of 173 patients, Boisen also arrived at somewhat the same conclusions and found the major difficulties in the field of self-expression, including sexual and vocational maladjustments. Cameron finds two distinct trends of behavioural problems and

2. Hoskins, BS, 75.
3. Wittman and Steinberg, Art., (1944), 251-259.
mannerisms. One shows itself in such problems as enuresis, temper tantrums and emotional imbalance; the other is characterized by exhibitionistic, suicidal or ecstatic tendencies. These symptoms increase and multiply, finally landing the individual in a mental institution. Summarizing these conclusions, we may enumerate the following distinguishing features of the schizoid personality which, under conditions of stress is particularly vulnerable to schizophrenic reactions: (a) general withdrawal of interest from the outside world; (b) emotional instability; (c) defective sex or vocational adaptation; (d) cerebrotonic traits; (e) precociousness and over-conscientiousness; (f) marked feelings of inferiority or resentment; and (g) day-dreaming and over-ambition.

7. Dynamics of Schizophrenia

In this section we propose to discuss some of the studies that deal with the dynamic processes that are involved in schizophrenic thinking and behaviour. Various attempts have been made to understand the meaning of the schizophrenic's behaviour and mental content.

1. The Concept of Regression

We have already mentioned the psychoanalytic contribution

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1. In Hoskins, BS, 76-79.
to the problem of schizophrenia. Freud's view was that this psychosis is a narcissistic disorder and represents a regression to infantilism. It is a spurious solution of the split forces of personality. The sublimatory activities of the ego suddenly fail, and thus the repressed primitive urges break through in an attempt to secure satisfactions. The individual, unable to cope with the demands of his environment, enters a world of fantasy, where nothing is beyond one's reach; he uses autistic escape mechanisms and hallucinatory devices to falsify reality. The paranoid schizophrenic, on the other hand, uses projection to keep out of consciousness a sense of inadequacy and inferiority, and his delusions provide him with a substitutionary satisfaction for unacceptable hostile and sexual impulses. The ego loses its synthetic function, and thus "sudden unmotivated aggressive attacks and self-destructiveness are clear signs of disintegration in the structure of the ego." The self-mutilations of the schizophrenic are described as symbolic of self-castrations and of isolated feminine wishes which are released after the synthetic function of the ego is destroyed. The view that schizophrenia represents a regression to earlier stages of development is generally accepted

1. See Freud, CP I and II
2. Alexander, FP, 252ff.
by Alfred Storch, Sullivan and other psychiatric writers. But, in our view, to conceive of it only in terms of regression to infantile sexuality is an over-simplification. Besides, we raise this question: If schizophrenia really represents a disruption of the synthesizing activity of the ego and the breaking forth into awareness (in disguised or open forms) of repressed instinctual urges, how is it that the super ego still exercises its punitive role and calls for self-mutilations?

11. Infantile Behaviour and Thinking

Shakow conceives of schizophrenic regression as a falling back on previous tendencies and forms of behaviour, when available forms of reaction become ineffective. He believes that the concept of regression as a gradual backtracking over the steps of the developmental process does not give a clear picture.\textsuperscript{1} The mannerisms, peculiarities of speech and behaviour, and coprophilic activities of schizophrenics have often been compared to children's behaviour. Both seem to be characterized by a general immaturity in thinking processes and in reality testing. Piaget's studies of children's thinking have shown that the child's immaturity arises from his inexperience in social interaction. But, as he grows in his interpersonal relationships, his competence with language

\textsuperscript{1} Shakow and others, Art., (1945), 154-174.
and logical thinking correspondingly increases, his moral realism giving way to the adult moral relativism.¹ Thus, as Boisen has shown us, language is a product of social interaction. The schizophrenic, following a pattern of social isolation and finally losing all interest in communicative speech, naturally falls into infantile concretistic habits of thinking. Boisen, therefore, points out that in the use of language, we can find a key to the understanding of schizophrenia.²

iii. Dream Processes

Jung explained schizophrenia as a regression to the collective unconscious, a habitual introvertive tendency. His interpretation of dreams differed from both Freud and Adler, in that he saw in them the manifestation of the collective unconscious.³ He also pointed out that dreams not only represent the escape of repressed material but also the upsurge of inspirational material—a point of view which strengthens Boisen's theory that acute schizophrenia is very often a constructive experience. But we are here primarily concerned with Jung's application of Freud's interpretation of dreams to schizophrenic thinking. He finds very close similarity between normal dream processes and

¹. Piaget, LTC; MJG.
³. Jung, PDP.
schizophrenic mental content. He goes even so far as to say that if the dreamer walked about and acted like one awakened, we would have the clinical picture of dementia praecox. While this is certainly an over-simplification of the matter (a mistake which Bleuler later avoided), the analogy between the two cannot be denied. In both there are some very close similarities; symbolization through condensation, displacement, concrete imagery and secondary elaboration; both constitute an escape from unpleasant experiences and hard realities into a world of make-believe where all desires can be realized. Other investigators have carried these researches further afield. Mintz has made an interesting analysis of schizophrenic speech and sleepy speech.\(^1\) This line of inquiry has important theoretical implications for the problem of schizophrenia.

iv. Primitive Thinking

Storch's studies in schizophrenic and primitive thinking have made an outstanding contribution to the problem of schizophrenia. From the standpoint of this study, his studies are of special interest and will occupy our attention in a subsequent chapter. Storch finds common features in the thinking of schizophrenic patients and primitive people:

\(^1\) Mintz, Art., (1948), 548-549; See also Cameron, Art., (1939)\(^2\), 256-270.
thinking in complexes, magic self-exaltation, magic efforts at self-defense, objectification of parts of the personality, reduction or exaggeration of the ego, and ideas of cosmic catastrophe and cosmic identification.¹ He describes in dynamic terms the onset of acute schizophrenia and believes that these processes correspond in general to the mental processes in the evolution of the religious cult. He accepts the Freudian theory that in schizophrenia "the synthesis of the functions of the personality" is destroyed. This dynamic disturbance accounts for the disappearance of the boundaries of the ego, the abolition of the consciousness of self, and the outbreak of primitive magic feelings. The primitive archaic formations make their appearance "when the psychic waking life has almost ceased" and they "break in only here and there where the psychic superstructure has been rent."² The disruption of rational superstructures is "caused by the schizophrenic pathological process, enfeeblement of the 'higher cerebral function' (Gross), or the higher intentional spheres (Berze, Kronfeld)." This, in brief, is Storch's dynamic theory of schizophrenia and is highly speculative. In explaining the psychogenic factors (so well analyzed) in the accepted currency of histopathology, he has achieved a remarkable confusion of psychiatry, pathology and anthropology.

¹ Storch, PAF.
² Storch, PAF, 101-106.
v. Interpersonal Psychiatry

Sullivan is the most outstanding exponent of interpersonal psychiatry and has woven into a remarkable conceptual system the dynamic concepts of his predecessors, especially Meyer and William A. White. The journal of Psychiatry is itself an expression of Sullivan's major research insight and a vital force in present psychiatric practice and investigation.¹ His language, however, has obscured the otherwise therapeutically pregnant implications of his theory. He regards schizophrenia as a regression to the earlier modes of behaviour wherein the patient finds a richness of emotional content lacking from everyday experiences. The different schizophrenic reactions are interpreted in terms of the need for satisfaction and security. The paranoid schizophrenic suppresses his doubt-provoking feelings and resorts to extensive rationalization. The hebephrenic sheds the troublesome demands of living, but, since he cannot escape the proximity of people, he belittles "them to his own level of existence." The catatonic achieves the same end by a radical withdrawal into himself and, as a self-conscious person, is preoccupied with regaining a feeling of security. Thus all schizophrenic states are distortions of interpersonal relationships and represent an attempt to preserve one's personal security and achieve

¹ Hall (gen. ed.), AP, 191.
Satisfaction.¹ Sullivan recognizes the fact that schizophrenia (non-organic forms) is primarily a disorder of living, and that, in some cases, it may have constructive effect. We thus see that Sullivan comes close to Boisen's view that acute mental disorders are not necessarily evil, although, like Boisen, he has not attempted to explore the religious implications of these synthesizing experiences.²

vi. The Conflict Theory

In Boisen's writing we find one of the most comprehensive statements of the conflict theory of schizophrenia. He views schizophrenic reaction as a desperate attempt to reorganize one's self in the face of an overwhelming sense of failure. The primary difficulty lies in an intolerable loss of self-respect, a sense of inadequacy and personal failure. Schizophrenia represents an inability to assimilate and socialize new experiences. This isolates the individual from his social group. The inner tension grows, and, under certain situations of stress and strain, a breaking point is reached. The individual then meets his frustration by complete withdrawal, demoralization or aggression. The different schizophrenic reactions are explained as defenses to ward off the basic sense of failure. The hebephrenic

¹. Sullivan, MOP, 72-82, 137-139.
². cf. White, AP, 536-538. These pages contain a discussion of Boisen's dynamic theory of schizophrenia.
and the heboidphrenic give up the struggle and drift down the path of progressive disintegration. The paranoid accepts defeat by denial and covers up his inadequacies and failures by delusional misinterpretations. The acute catatonic stupors and excited states are desperate attempts at reorganization, which may make or break, depending upon one's personality resources and other situational factors. In certain cases the issue is constructive, and the patient emerges from his psychosis as "a creative artist." The following pages will contain a detailed consideration of this point of view.

8. Therapeutic Aids and Methods

In this last section of our discussion we propose to discuss some of the most important therapeutic formulations and procedures that bear on the problem of schizophrenia. But, before we go into it, something must be said about the prognostic implications of our discussion so far.

1. Prognosis

We have already remarked that there is generally an increasing optimism as to the prognosis of schizophrenia. With modern treatment facilities and development of psychotherapeutic techniques, the incidence of remissions in schizophrenia is greater today than in former years. The outlook is especially favorable in schizophreniform reactions, and Sullivan, Kempf and others have demonstrated that cures
can be effected even in hebephrenic and paranoid cases. Prognosis, however, depends primarily upon factors inherent in the individual patient, rather than upon either treatment with shock therapy or upon the type of therapy. There are some factors which can be considered as favorable prognostic indications: (a) acute and sudden onset of symptoms, including a strong element of struggle against one's external circumstances; (b) good prepsychotic personality; (c) presence of emotional factors as precipitating causes; (d) good affective responses; (e) freedom from organic and hereditary predisposition; (f) favorable life situation; and (g) attitudes of frankness and acceptance of responsibility.

Of the various types, the catatonic seems to have a more favorable outlook for social recovery; the simple type generally runs a chronic course and the patient often makes a good institutional adjustment; the hebephrenic easily finds his way into the mental hospital because of rapid deterioration in his behaviour and habits, and the outlook for recovery in most cases is rather poor. But, in cases where hebephrenia involves catatonic or manic-depressive features, the prognosis is relatively favorable. The paranoid is able to achieve some measure of integration on the basis of delusional misinterpretation and makes a satisfactory adjustment to the

1. Wittman and Steinberg, Art., (1944), 244.
hospital life. In some cases, however, where the patient having an extreme persecutory complex begins to translate his delusions into actual realities, he gets into trouble. Boisen discusses three types of development: complete social recovery, arrested development, and progressive disintegration.1

ii. Medical Therapies

Since the discovery by Moore and Noguchi of the spirochetae palladium as the cause of general paresis and its successful treatment by induced malaria fever and other arsenical preparations, there has been accelerated interest in the use of similar methods in the treatment of other mental illnesses. A great deal of progress has been made in this direction,

(1) Narcosis Therapy

Since 1920 there has been a great deal of interest in the drug treatment of schizophrenia, and sedatives and hypnotics have been used primarily for symptomatic treatment. In 1922 Klaesi reported good results by narcosis produced by the administration of somnifen.2 In 1930 W. J. Bleckwenn reported the therapeutically beneficial effects of barbiturates in the treatment of psychotic patients.3

1. Boisen, EIW, 158f.
This led to use of these drugs as adjuvants to psychotherapy, for, under the influence of narcosuggestion, the otherwise uncommunicative and withdrawn schizophrenics became accessible to psychotherapy. Narcosynthesis is now being used successfully in several mental hospitals and goes well with brief psychotherapy. During the last war it was used widely in the armed forces.¹ Whether narcosynthesis or hypnosis can effect any permanent results in cases where psychogenic causes are deeply embedded is a debatable point.

(2) Insulin Therapy

Sakel first introduced insulin therapy in psychiatry. In 1930 he reported remarkably high incidence of recovery in schizophrenic patients subjected to insulin hypoglycemia. In using this drug in the treatment of morphine addicts he discovered that the shock or coma produced by it, exercised a beneficial effect in the confused mental condition of his patients.² Since then various modifications of the method have been used. Insulin shock treatment is given intramuscularly, the dosage depending upon the patient's tolerance. This gradually produces the symptoms of hyperglycemia, followed by deep coma. Awakening is accomplished by administering glucose. During the two phases preceding and following the coma, a remarkable clearing up of mental confusion

1. Rennie and Woodward, MMH, 34f.
is effected and, with a systematic course, a favorable reaction is promptly achieved and the patient becomes accessible to psychotherapy. Frequent dosage of insulin over a period of months extends the beneficial effects into the post-shock periods.¹ Success with insulin treatment is said to depend upon a number of factors: treatment must begin early, acute florid symptoms, absence of constitutional defects and deeply rooted psychologic factors, optimally intense treatment and proper psychotherapeutic management.² Insulin treatment is said to be particularly successful with catatonic and paranoid patients. Insulin treatment is still the treatment of choice in schizophrenia, and is routinely administered in mental hospitals. Many psychiatrists use it without concomitant psychotherapy and then wonder why the dramatic results claimed for it do not accrue. Many relapses following the treatment reduce the gains that are temporarily noticeable. There are also some dangers that may follow any careless administration of insulin. Its most serious complication is irreversible coma.³ Other serious complications include nephritis, primary oliguria, and pulmonary oedema.⁴ The shock of the treatment and hasty use of psychotherapy may throw the patient into the depths of psychosis.

¹. Pennington and Berg, IPC, 520.
⁴. Henderson and Gillespie, TBP, 249.
with disastrous effects.

On the whole the results do not indicate that the hypoglycemic treatment has a degree of specificity sufficient to warrant belief in it as the key to resolving a supposed specific process causing schizophrenia. It appears rather that the use of insulin makes it possible to subject the patient to a series of remarkable experiences under the psychiatrist's control, which may be individually timed and utilized in a broadly organized plan of treatment.1

(3) Convulsive Therapy

In 1935 Ladislaus von Meduna introduced metrazol as a convulsive agent in schizophrenia, basing his theory on the questionable assumption of a biologic antagonism between epilepsy and schizophrenia. He observed reduction of schizophrenic symptoms after the administration of convulsant drugs. Metrazol has certain advantages over insulin treatment: it takes only about half an hour and requires little nursing care; convulsions last only a minute or so, being followed by a comatose state.2 Metrazol shock treatment is no longer used in the treatment of schizophrenia and only rarely used for manic-depressive and involutional psychoses. Its use is contra-indicated for a number of reasons: Metrazol creates a fearful aura before the convulsive attack begins and the deep anxiety thus engendered is

1. Hall (gen. ed.), AP, 188.
2. White, AP, 557.
not without its harmful effects; and there is risk of vertebral fracture and possible memory impairment. Its use has been more or less discarded in favor of electric shock treatment which produces therapeutically the same effects, and with much less unpleasant results.

(4) Electro-Convulsive Therapy

The electric convulsive shock treatment was introduced in 1938 by Carletti and Bini and serves the same purpose as Metrazol. Its comparative ease of administration and usefulness has made it very popular, and it seems to be replacing other shock treatments. It consists in attaching electrodes to the head and then passing controllable electric currents through the brain. The patient is thrown into a violent convulsion and immediately passes into a comatose condition.

It has certain advantages over other methods: it is especially useful in affective disorders; it is less unpleasant in its effects; it is easy of application; and it is more useful than other shock methods. Its effects are said to be more lasting. In depressions uncomplicated by psychotic factors, from 40 to 80 per cent of remissions have been reported. However, its usefulness in the treatment of

1. Henderson & Gillespie, TBP, 259.
2. White, AP, 559.
3. White, AP, 558.
schizophrenia seems to be doubtful. In brief, when used early in conjunction with psychotherapy, it may have some beneficial effects. Whether or not electroshock produces permanent brain damage is a serious question. Electroencephalograms and projective tests have, in some cases, revealed some brain damage. Unless more effective methods for measuring complex mental processes are perfected, all shock methods, especially in cases where emotional factors are primarily involved, should be used with great care. Any indiscriminate use of such methods should be thoroughly discouraged.

(5) Surgical Therapy

Prefrontal lobotomy is a surgical method of attack upon the frontal lobes and has been found useful in relieving the anxiety of chronic agitated patients without impairment of intellectual capacity. It was first introduced by the Portuguese surgeon Moniz in 1936, and has been followed in this country by Freeman and Watts. The technique consists of making bilateral openings in the skull and then destroying some of the connections between the frontal lobes and other parts of the brain. Technically, the performance is said to be safe and perhaps safer than lobectomy in which one or both frontal lobes are surgically

1. Freeman and Watts, PSY.
removed for pathological reasons. On the basis of their findings, Freeman and Watts advance the hypothesis that the frontal lobes are involved in abnormal mental conditions, especially affective disorders. In the mentally ill individual the interconnections between the frontal lobes and other parts of the brain become somehow fixed and rigid and this fixation results in abnormal functions such as delusions, obsessions and agitated depressions. Psychosurgery separates the frontal lobes from the rest of the brain, and thus reduces nervous tensions, self-consciousness and crippling obsessions. This is only a hypothesis and only future research can clarify the role of the frontal lobes in mental disorders. The psychological processes that effect behavioural changes in lobotomized patients have not yet been fully understood or explained.¹

That prefrontal lobotomy effects apparent behavioural changes in the lobotomized patients cannot be denied and its striking success lies with highly agitated and stubborn obsessive states. Extremely agitated, tense and unhappy patients show a marked improvement. But there are many dangers associated with this operation and it should be only performed where other methods have completely failed.

¹ For a critical appraisal of surgical therapy, see White, AP, 471-479.
Some of the dangers associated with it are: impairment of foresight, deliberateness, attention confusion, loss of perspective, distortion of normal perceptions. Rose and Solomon, in a follow-up study of 147 lobotomized patients, report that lobotomy affected all the patients generally in the direction of easier hospital management. In most of the patients disabling symptoms continued, while in others new personality traits appeared such as anergy, lethargy, lack of interest and proprietary control. They conclude that lobotomy may "remove the sustaining power of emotionally charged energy, which is needed for initiative and drive, for repression and conflict, as well as for appropriate utilization of past experience."

In the light of these and other similar findings, it is incumbent that such a radical method of treatment should always be used sparingly and with great caution. The logical function of surgery is to treat surgical conditions only.

iii. Psychotherapeutic Techniques

The employment of psychotherapeutic techniques in the treatment of mental ills is a development of recent date. Freud believed that such narcissistic disorders as schizophrenia are not suitable for psychotherapy, although in his
works and in the works of his predecessors, we find therapeutic implications of great import. But while Freud, Bleuler, Jung, Storch and others have advanced psychiatric understanding of schizophrenia, they have contributed little in terms of therapeutic formulations. Progress in this direction has come from Meyer, Sullivan, Fromm-Reichmann, Hill, Eissler, Chassell, and others. With the evolution of mental hygiene movement and the provision of social, recreational and occupational activities in mental hospitals, there are signs of increasing interest in the meliorative aspects of mental illness. A few important aspects of this development need to be considered.

(1) Problem of Psychotherapy

While the former belief that schizophrenia cannot be psychotherapeutically treated no longer exists, there are difficulties which cannot be minimized: (1) Autistic barrier. The schizophrenic reactions are in one way or another attempts to create an autistic barrier between one's self and the outside world. This explains the indifference of the hebephrenic, the silliness of the hebephrenic, the stupor of the catatonic, and the suspiciousness of the paranoid. (b) Anxiety. Sullivan explains the schizophrenic

states as an attempt to preserve one's security and ward off anxiety by distortions of interpersonal relationships. Any situation that tends to integrate this relationship makes the schizophrenic extremely anxious and he makes a hasty retreat. Especially unwelcome and anxiety-laden is the attempt by a therapist to make inroads on his isolated world, wherein alone lies his security and imagined satisfaction.\textsuperscript{1} The problem of the management of anxiety therefore becomes very important. (c) Rejection of external facts. Alexander makes the point that the psychotic rejects external facts, whereas the neurotic rejects psychological facts. This makes it extremely difficult to create a therapeutic relationship with the schizophrenic, for the therapist stands rejected and can do nothing unless this relationship is somehow established.\textsuperscript{2} (d) Reality and fantasy. For the schizophrenic these two things are confused together, and psychotherapy can have no meaning so long as this confusion persists. Fantasy and planning are products of human imagination, and they have many things in common; in fact, human insight originates in fantasy, which is then translated into plans of action. It is only when fantasy fails to be corrected by experience and is employed interchangeably with

\textsuperscript{1} Donald, Art., (1948), 142-144; From-Reichmann, Art., (1939), 412-427.
\textsuperscript{2} Alexander, MVP, 151.
reality that it loses its creative function.¹ This is exactly the problem with the schizophrenic. Communication. One of the greatest difficulties encountered in psychotherapy with schizophrenics is in the realm of communicative speech. Language symbols lose their original significance and acquire meaning and content which the average psychiatrist does not understand. There are some who have come to believe that there is a kind of "schizophrenic language" which the patients understand among themselves but whose meaning is hidden from those who are outside of the esoteric group. It is a common experience for the psychiatrist to have a schizophrenic explain to him what other schizophrenics are saying.

In the light of these therapeutic problems, how are we to approach the schizophrenic patient? Lewin points out that the success or failure in psychotherapy depends upon the constitution and psychologic organization of the patient, the nature of his life problems, the type of therapy selected, and the personality and individual approach of the therapist.² Mann and Semrad, who treated 165 psychotic patients in twelve groups for the purpose of instituting group therapy, give special importance to the patients' need of warmth and

¹ Slavson, PCT.
sincerity, and helpfulness towards reconstruction of interpersonal relationship.\(^1\) A number of other approaches may be briefly mentioned.

(2) Modified Psychoanalysis

While psychoanalysis has exercised tremendous influence in all modern methods of psychotherapy, and its techniques of rapport, catharsis, and transference are widely used, in itself it is not a therapeutic method of wide application. The psychoanalyst considers a number of points before selecting his cases: age, intellectual equipment, personality make-up, capacity for self-help, and life situation. Recently, however, modified forms of psychoanalysis have been used with some success. Hinsie reports some success with incipient cases of schizophrenia.\(^2\) Alexander advocates the method of emotional reeducation in supportive therapy.\(^3\) Psychoanalytic treatment can only be carried on after the patient has accepted at least one person—the analyst—in his environment. What he needs is not insight but acceptance of external facts and assurance that they can be made bearable. Lindsay, however, suggests direct interpretation of the patient's speech and mannerisms, "which produces immediate relief of anxiety and permits

2. Hinsie, TS, Chaps. 3-8.
3. Alexander and French, PT, 165-172.
conscious realization of the conflict. In spite of his isolation, every schizophrenic is a lonely and isolated individual who is looking for understanding and tolerance which he has not found in his relationships with other people. Genuine interest in the patient coupled with patience, tact and sympathy, are important elements in psychotherapy with schizophrenics.

(3) Psychobiologic Approach

As we have already pointed out, Meyer's objective biology deals with the functions of the total personality, and conceives of mental illness as a disturbance in the balance of forces which blend to form the personality reactions. It has to do with faulty habits in the instinctive-emotional life and the attitudes of the person. Hence, in the psychobiologic approach to schizophrenic patients, there are utilized the anamnesis, personality study and psychiatric interviews. This synoptic approach is especially useful in incipient psychoses and affective disorders, and in certain types of schizophrenia.

(4) Interpersonal Psychotherapy

Sullivan has elaborated on the Meyerian techniques and has especially emphasized the interpersonal aspects of psychotherapy. The problem of psychotherapy consists in bringing

1. Lindsay, Art., (1948), 142-144.
2. Muncie, PP.
to the patient's awareness information which will clarify the more troublesome aspects of his life.¹ The therapist may provide information, correct misinformation, rectify impractical evaluational systems, reduce or augment personal distance, reorganize the effective potentialities of the patient, and reintegrate dissociated and suppressed experience-systems.² The psychiatrist must become acquainted with the frame of reference of the patient and learn to orient his observation and thinking "to successful participation in the therapeutic and other situations which make up the psychiatric way of life."³ Recently non-directive techniques of psychotherapy have been used in schizophrenia. Rogers emphasizes the importance of assuming the internal frame of reference of the client, to perceive the world as the client sees it, and to lay aside all perceptions from the external frame of reference.⁴ In dealing with schizophrenic or other mental patients, the principle of flexibility needs to be applied.⁵ Techniques and methods are not so important as the establishment of rapport and friendly relations with the patient. Techniques are important only in so far as they contribute to the skillful handling of the interpersonal relationship between the psychiatrist and the patient.⁶

¹ Sullivan, MCP, 91.
⁴ Rogers, Art., (1949), 82-94
⁵ Alexander & French, PT, 25-66.
⁶ Cf. Rank, WT, 149, 235ff.
(5) Group Therapy

The importance of group therapy is beginning to be realized. The psychotic patient has to be reintegrated into the society from which he has broken away. Group therapy provides opportunities for reeducation and socialization. Schizophrenia, according to Boisen, represents a failure in interpersonal relationships. Readjustment in even a narrow area of these relationships can be a step in the process of recovery. Through patient-to-patient transference, catharsis and intellectualization, group treatment can be more effective in certain areas untouched by individual treatment.

Besides, "group psychotherapy is effective preparation for individual therapy and in many instances breaks resistance quicker than the latter."¹

Rosen, Semrad and Mann are carrying on intensive group therapy with schizophrenics at Boston State Hospital. Rosen uses what he calls a participation technique with groups of ten to fifteen schizophrenic patients. The therapist acts as a "catalyst rather than lecturer, evangelist, or leader" and the aim is to help patients to discuss their problems and attitudes. Rosen and Chasen point out that everything that happens in the group is always in relation to the therapist. "The therapist is the subject of many of the

¹ Slavson, PGT, See section on "Didactic Group Psychotherapy with Psychotic Patients."
present issues, after a clarification of which patients can
deal with anamnestic material."¹

(6) Adjuvants to Psychotherapy

The mental hospital is not a place of social sequestration; it is a school where the patients are retrained in the art of living together. It is a laboratory in socialized living and human relations. Looked at from this point of view, every aspect of the mental institution assumes therapeutic significance. Myerson has emphasized the need of what he calls the "total-push therapy" in the treatment of schizophrenia.² This method calls for an effective mobilization of all the resources in the mental hospital for building mental health and for providing interesting and varied activities. Occupational therapy uses the talents the patient represents, provides constructive outlets for emotional needs, and gives opportunities for interpersonal relationships. Recreational therapy promotes bodily health, builds self-confidence, and encourages co-operative enterprises. These activities, when wisely planned and directed by trained personnel, become therapeutically significant. Modern mental hospitals provide many interesting occupations such as occupational and industrial therapies, recreational and musical

² Myerson, Art., (1939), 1197-1208.
therapies, social and religious activities, self-help cafeterias, and so on. It is our experience, however, that in many cases there is neither an effective co-ordination of these varied activities nor a clear awareness of the goal toward which they are directed. Indirectly, these activities do have therapeutic values, especially when they permit acting out inner tensions and repressed emotions. But, as Slavson points out, release and abreaction are not enough. "Therapy must find means to re-integrate the personality, reshape attitudes and give the patient means for dealing with his life in new ways."¹

The religious activities in the mental hospital have more significance than many other activities, provided the religious leader is aware of the therapeutic values that inhere in them. Wisely planned and executed, they help the patient relate himself to other patients in terms of mutually shared ideals and loyalties. Leslie has shown therapeutic values of religious activities.² Boisen has used religious groups for therapeutic purposes.³ Johnson's interpersonal psychology provides the rationale for the healing powers of religion.

¹. Slavson, PCT, 264.
². Leslie, GTM.
The health of persons and societies depends upon the relations of persons to each other. When interpersonal relations are insecure, hostile and predatory the society declines and its members suffer nervous and physical disorders. When interpersonal relations provide security, love and mutual aid the society prospers and its members have a more satisfactory wholeness.

This concludes our survey of the psychiatric literature on schizophrenia. We have discussed the psychosis of schizophrenia in terms of its etiology, symptomatology, dynamics, and therapy. With this orientation, we proceed, in our next chapter, to give a brief sketch of Boisen's life and mental illness.

CHAPTER III

A BRIEF SKETCH OF BOISEN’S LIFE

1. The Family History

Anton Theophilus Boisen was born in 1876 in the town of Bloomington, Indiana. He comes from a highly distinguished family of leading churchmen and educators in American history. His father, Herman Balthasar Boisen, was the son of Judge J. F. O. Boisen and Marie Boisen of Leck, Germany, and was born in 1846. After receiving his education at the Gymnasium at Plon and at the University of Wurzburg, he came to this country in 1869. He taught for a year in some of the German settlements in Minnesota and then went to Indiana where he was appointed superintendent of the Bellevue Schools. In 1870 he was offered the chair of Modern Languages in Indiana University. Two years later he resigned from that position and accepted a teaching post in Williams College, Massachusetts. In 1881 he went to Boston where he was engaged in writing his two books for publication—First Course in German and German Prose. The following year he was appointed sub-master of the Eliot School in Boston and also elected to the board of directors of the Martha’s Vineyard Summer Institute. In 1883 he went to New Jersey and became a master in the Lawrenceville School. He died
on January twenty-first, 1884, at the early age of thirty-seven. Anton was thus only seven years of age when his father died.

Herman Boisen’s life illustrates the truth that a life should not be measured in terms of its length. Among the many glowing tributes paid to his memory we may include the following:

Many people pass their three-score and ten, and some four-score, whose lives, so far as character and usefulness are concerned, are one long blank... Such was not the life of our deceased friend. It was crowded with action, progress, efficiency. Whatever he studied was mastered—mastered so as to be loved, so as to be made his own, so as to be used, so as to be taught. Half-way work did not comport with his natural temperament. For he was highly emotional, far too much so for both his mind and body, and that not at intervals, but always and everywhere. He always acted under pressure, high pressure. And this fact made him what he was, both in his strength and in his weakness. Indeed, it cost him his life at last... He would fix his burning thought upon an object or topic, as the man of science does the focus of his glass, and it would blaze up under the intensity of his gaze, making all around him, friends of students, to share in his enthusiasm.

The first woman graduate of the Indiana University wrote a poem in his memory, from which the following lines may be quoted:

1. Indiana University, IS. This is the main source of information for the preceding material.
2. Woodburn, HIU, 357.
He ran his race too passionately
Nor reached the goal;
But dropped midway upon the plain,
A vanquished soul:
Conquered, indomitable power,
Resistless will:-
His mind has soared beyond our ken;
The throbbing heart is still.

He was a great teacher and a "warm hearted, generous, enthusiastic Germanized Dane from Holstein." He was remarkably successful as a teacher and was sincerely loved by his students and friends alike. He was a great lover of nature and an enthusiast for out-door life. He took much interest in birds, trees, flowers and children.

It was as a professor of Modern Languages in Indiana University that Herman Boisen came into contact with the illustrious Wylie family and was united in marriage with Louise Wylie, daughter of Professor Theophilus A. Wylie. She was graduated from Indiana University in 1871 and seems to have been an outstanding student in her class. She was called "scientificarian" by her classmates, for having won the award for the scientific oration, offered by the faculty. One of her two sisters, Margaret Wylie, still living (June, 1936), said that she was one of three young girls who were the first to attend the Indiana University.

1. Indiana University, IS.
2. Woodburn, HIU, 356.
The Wylie family represents a remarkable history of achievements in the fields of American education and Church life. Anton's great-grandfather, Samuel Brown Wylie, who came from Ireland in 1798, was the first Covenanter to receive ordination in America. He became a minister of the Reformed Presbyterian Church in Philadelphia and a professor of languages in the University of Pennsylvania. He was an outstanding linguist and knew fourteen languages. Among his writings was The Faithful Witness for Magistracy and Ministry upon a Scriptural Basis, which gave the position of the Covenant Church. He carried on a relentless anti-slavery campaign on behalf of the Reformed Presbyterian Church.¹ His son, Theophilus and his nephew Andrew played an equally significant role in the early history of American Protestantism.

Andrew Wylie became the first president of Indiana University in 1829. He was of Irish descent, being the son of a small farmer, a Presbyterian immigrant from North Ireland. He spent a good part of his boyhood days on his father's farm, where under his mother's care he received strong moral and mental discipline. He studied theology under his eldest brother and was licensed as a Presbyterian minister in 1812. However, he soon rose to distinction and in 1829 was elected

¹ Addison, POR, 9.
to the presidency of Indiana University—a position which he continued to occupy until his death in 1851. Dr. Andrew Wylie was a remarkable personality—clear-headed, conscientious and truth-loving man. He was a tall, graceful, grave and dignified personality.

...He was born to lead, not to follow...He possessed many qualifications to make the leader of men. He usually saw his way clearly and went straight to his goal. The greater the difficulty, the more determined and the more certain he was to surmount it. What he lacked was in tact. He was not given to persuasion but to command...There was nothing vacillating or uncertain about him. After a fight was over, he never spoke evil of his enemy, but was a good hater nevertheless. Taken all in all he was rigid, masterful, and uncompromising.

Theophilus Adam Wylie, grandfather of Anton, bore many of the remarkable characteristics of his cousin. Since it was at his home that Anton spent most of his early years after his father's untimely death it is necessary to study his life in greater detail. Theophilus was born in Philadelphia, in 1810. His father, as has already been mentioned, was the pastor of the Reformed Presbyterian Church in Philadelphia at the time of his birth. After graduating from the University of Pennsylvania in 1830, he became a student at the Seminary of the Reformed Presbyterian Church and was

1. Woodburn, HIU, 42, 81, 204–208.
ordained at the Presbytery in Princeton, Indiana, in 1838.\(^1\) Entering the ministry was somewhat against his own personal inclination and he considered himself unfit for it.

The office was not one of my own choosing. Had I my own way I never would have been in it, but it seems it was my fate. I was thrown into the current. I made some exertions to extricate myself. I found these vain and at last determined to let matters take their course and to submit to whatever might happen. I have been sometimes so vain as to think that in my difficulties I have had divine aid. But still there is something wanting.

Yesterday I preached, but such preaching! I am sure if it were possible I would not listen to such a preacher; how, then, can I blame others if they stay away? Oh, that it were otherwise.\(^2\)

Writing about his impressions of those early years, Anton Boisen gives us some significant insight into these conflicts of his grandfather:

Samuel B. Wylie was a remarkable combination of forcefulness together with warmth and tenderness. He was moreover a man of great importance in the eyes of his family....He was both feared and loved. My grandfather did indeed sometimes indulge in irreverent mirth over his father's efforts at song during family prayers....But his father's disapproval of his own ambition to study art was sufficient to put an end to that ambition and his father's wish that he should study for the ministry prevailed even though he shrank from it so much that for many years he never entered the pulpit without a certain

\(^1\) Woodburn, HIU, 343.

inward protest. We thus see parental influence at its strongest.\(^1\)

It would seem that Theophilus Wylie, as a young man, was a modest and retiring man, quite timid and diffident. When President Andrew Wylie offered him the chair of Natural Sciences at Indiana College, he suggested that he first be put on probation for a year. This was done and within a year his appointment was confirmed and he was made professor of philosophy and chemistry.\(^2\) He occupied the position for nearly half a century. In addition to his regular teaching he bore the brunt of extra duties and cares that came from the changes and ups and downs through which the institution was then passing. At various times, when there was need, he taught almost all the subjects offered in the curriculum. It was said of him by one of the men of his time that "he knows almost everything." Adding further to his heavy duties and out of his generous disposition, he became the pastor of the New Side Reformed Presbyterian Church in Bloomington, from 1838 to 1869. After serving for some years as acting president of the university he accepted an invitation to a professorship in Miami University in 1852. But he returned to his former position early in 1855 and

\(^1\) United Presbyterian Church, \(P(1934)\), 59.
\(^2\) Woodburn, HIU, 175, 344.
served actively in teaching until 1886; he then became emeritus professor until his death in 1895. In 1890 his book, *Indiana University: Its History from 1820 when Founded, to 1890*, was published. It contains important historical data, but is not of a literary character.

Matthew Elder, who graduated in 1840, tells in his autobiography something about the versatility of this great scholar:

> Mr. Wylie was stout, had a fine healthful appearance, slightly tinged, however, with sadness which only disappeared entirely when in a mirthful mood he became a boy again. He was very intellectual, his mental faculties naturally strong being developed into powers by long and careful study. He was thoroughly conversant with all the metaphysical theories that had agitated the world, was one of the finest Belles Lettres scholars, read Latin, Greek, Hebrew, French, and German as fluently as he did his native language, and he was one of the best readers of English I ever heard. When he walked the streets he appeared abstracted, never shaking hands nor conversing with anyone, a nod of recognition being invariably his habit...

He was an effective teacher and was very exacting in his requirements. He was, however, respected by his students and affectionately called "Pap" Wylie.

Such in brief is the history of the illustrious ancestry which Anton Boisen represents. He has absorbed the best from the two streams of culture represented in his family. As we study his life and contribution, in the light of his family background, we can get a better insight into the

1. Woodburn, HIU, 478.
dynamics of his personality. In the next section an attempt will be made to trace the religious influences and attitudes into which he was brought up. Not much is known about the facts of his early development and training apart from the fact that after his father's death in 1884 the family moved to Bloomington where they lived with Theophilus A. Wylie.

2. Religious Background and Development

In order to have a better appreciation of Boisen's social and religious backgrounds, we may well cast a hurried glance at the history of the religious traditions and beliefs in which he was brought up.

1. Historical Antecedents

The Protestant Reformation in England developed chiefly along three lines: Anglicanism, Puritanism and Separatism. The Anglicans, while holding to the old English Church, discarded the papacy; the Puritans, along with the Presbyterians and some Anglicans, called for a sweeping reformation within the Church, which would insure a more educated and spiritually minded ministry and a larger measure of autonomy within the local church; while the Separatists decided to withdraw entirely from the Established Church. This separatist movement gained increasing momentum in spite of attempts at suppression. This movement spread to this country and with the arrival of the first band of Pilgrim Separatists in 1620, the first Congregational Church was founded upon
American soil. The Puritan immigration soon followed and increased rapidly. The differences between these two originally separate bodies began to disappear and they soon combined in Congregationalism. After "The Great Awakening" of 1734 the Congregational Churches of New England gradually extended westward and came into close contact with the Presbyterians of the Middle States. These contacts gradually materialized into a plan of union between the two bodies before the end of the eighteenth century. This development was made possible because of the doctrinal affinities that existed between them.¹ Socially also the two churches stem from the same strata of society. The Presbyterians today are more conservative than the Congregationalists, although small groups of both liberals and conservatives are found in both churches. Anton's father belonged to the Congregational Church; hence this brief account of the latter is given. But Anton himself was raised in the Presbyterian Church, in his grandfather's home. The fact that he finally joined the Congregational ministry was not due to any religious preferences, but merely incidental—"that's the way things opened up."²

2. Some of this information was obtained in personal interviews with Boisen.
We may here turn to a brief account of the Presbyterian Church, as it is of special interest from the standpoint of this study. These Presbyterians were largely composed of the early settlers who were of Scotch-Irish and English stock. Of special interest are the Scotch-Irish psalm-singers, who began migrating to this country in the middle of the eighteenth century. Among these were two dissenting groups—"Reformed Presbyterians" (or "Covenanters") and "Associate Presbyterians" (or "Anti-Burghers"). Both of these groups rigidly adhered to the position that church music should be confined only to the Psalms of David. "Human hymns" and instruments of music were sternly forbidden in their services of worship as being unscriptural, and Sabbath keeping and church attendance were strictly enforced.1

In 1782 these two dissenting branches united into Associate Reformed Presbyterian Church. A small group of dissenters in both churches refused to join the union and "so instead of the two churches becoming one, they became three."2 This was the situation when Anton's great-grandfather, Samuel Brown Wylie, arrived in America late in 1797. Shortly after his arrival he met others of his own faith (Reformed Presbyterian Church) and organized a Reformed Presbyterian

1. Boisen, Art., (1940), 359-381.
2. Woodburn, Art., (1934), 16.
Presbytery in New York, in 1798. This body grew rapidly through new arrivals in this country of others of the same faith. In 1832 there occurred a schism in the new church. The dispute was as to whether it was right or permissible for Covenanters (Reformed Presbyterians) to vote and to exercise the rights of citizenship under the Constitution of the United States, in which God is not explicitly recognized as supreme ruler of the nation. And just as Samuel Brown Wylie had a part in reorganizing the new church, he also had a part in splitting it up. At this time he was the chairman of the Eastern Sub-Synod which published a "pastoral epistle" affirming the right to vote and declaring in favor of accepting full citizenship. This brought about the division of the church into two branches: the "New Side," which represented Wylie's group, allowed its members to vote, to sit on juries, to hold offices and to take oath to support the Constitution of the United States. The "Old Side" adhered to the traditional view and in a new covenant of 1871 directed its members to "pray for and labor for peace and welfare of our country and for its reformation by a constitutional recognition of God as the Source of all power and of Jesus Christ as Ruler of Nations."2

1. United Presbyterian Church, P(1934).
2. Woodburn, HU, 18.
When in 1837 Samuel Wylie came to Bloomington (after having already served the First Reformed Presbyterian Church in Philadelphia) to take the chair of "Mixed Mathematics" in the Indiana University, he found all four of these psalm-singing churches—Reformed Presbyterians, Associate Reformed Presbyterians, the New Side Covenanters, and the Old Side Covenanters. These churches represented, in main, three types of groups: (1) A liberal group consisting mostly of college people; (2) a very conservative group characterized by great loyalty to family and clan, by their emphasis on the Old Testament morality, and (3) the group representing the new revivalistic movement which sprang out of the spontaneous religious fervor of the common people. It was actuated more with the desire to grapple with the pioneer conditions and moral problems of their days than with the desire for culture or status.\(^1\)

Dr. T. A. Wylie himself took charge of the Reformed Presbyterian Church in Bloomington as its pastor—a charge which he held for thirty years without any remuneration. About the same time his brother, Theodorus, was pastor of the Reformed Presbyterian Church at Philadelphia which his father had served earlier.

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1. Boisen, Art., (1940), 359-381.
In 1858 the Associate and Associate Reformed Presbyterian bodies merged into a national union and thus formed the "United Presbyterian Church." This national merger was marked by the usual separatist tendencies on the part of the minority groups. However, in 1869 the two major bodies—the New and the Old Sides Convenanters—disbanded their separate organizations and joined the United Presbyterian Church. In Bloomington the New Side Convenanters followed suit and under the advice of their pastor T. A. Wylie joined the new national organization in 1869. This union with the United Presbyterian Church was the result of certain developments in the church at Philadelphia.

The leading layman in that church, George H. Stuart, had been during the Civil War the national president of an inter-denominational organization known as the Christian Commission, somewhat like the Y.M.C.A. of the World War. It was thus his duty to visit other churches and to take part in their services. This was alright so long as the war lasted, but when he continued this practice after the war, the Synod raised objections and charged him with the sin of "occasional hearing" and of singing "human hymns" of non-Davidic origin. On his refusal to discontinue the practice he was expelled from membership. The old First Church, with T. A. Wylie's brother as its pastor stood by him and severed their connection with the General Synod, and the Bloomington Church, in
accordance with T. A. Wylie's advice, did the same. The same considerations led Anton's grandfather, T. A. Wylie, later on to withdraw himself from the United Presbyterian Church and to join the regular Presbyterian Church, following the example of the Philadelphia Presbytery of the Reformed Presbyterian body. Writes Anton T. Boisen:

In thus permitting his church relations in Bloomington to be so largely determined by what happened in Philadelphia my grandfather was following a pattern which is characteristic of the Psalm-singing Presbyterian Church, that of loyalty to family and clan..."1

11. Religious and Social Backgrounds

The foregoing pages give us some idea of the social and religious traditions in which Anton T. Boisen has been brought up. In spite of their differences, the early psalm-singing Presbyterians of Bloomington were a group of virile and vigorous people, characterized by their strong loyalty to family and clan and by their common religious fervor and seriousness. They were pioneers in the field of American education and churchmanship; they were attempting to grapple with the moral problems of their day. From the beginning of its existence in this country, the Covenanters Church had been strongly opposed to slavery in any shape or form.

Shortly after 1800 the Presbytery formally declared itself against slave-holding and in 1802 Thomas Donelly and Samuel Brown Wylie were commissioned to visit the Carolinas in order to take counsel with the brethren regarding the sin of slave-holding. This attitude with reference to slavery they carried with them. We thus see the Bloomington Covenanters as active participants in the underground railroad before the Civil War, and they even received negroes into their fellowship. When war was declared they gave vigorous support to the Union Side.

We have already made reference to the fact that the psalm-singing Presbyterians attached much importance to the Davidic Psalms and that the split in their ranks was caused by questions relating to the right of voting, "human hymns," and the "sin of occasional hearing." In spite of these differences for all the Covenanters the creed was a vital matter and was stressed in all its details. Their Sabbath services usually consumed most of the day. They had two long services with a brief noon intermission. The sermons were long and usually contained a defense of the traditional beliefs. The singing of psalms itself formed an important part of the service. Of his early impressions Boisen writes:

1. Boisen, Art., (1940), 261. In a sermon entitled "Fidelity and Vision" delivered at the Bloomington United Presbyterian Church Centennial, 1934, he writes: "I remember going there (Reformed Presbyterian Church of South Walnut Street) as a very small youngster in the company of the faithful old Negro woman who for 50 years worked in our home and whose membership in that church is a reminder of its early enlistment in anti-slavery cause..."
I remember particularly what happened when the congregation raised its voice in song. There was something terrifying in that singing and I also raised my voice—but not in song. I was promptly removed, but the experience has remained in my memory. My other early recollections of Church go back to this old United Presbyterian Church, where I came in company of my grandfather. The memories are somewhat hazy, but I recall particularly Mr. McNary with his long beard and choir...standing in front. Apparently their singing made a favorable impression upon me. At least I do not recall any recurrence of terror I had felt at Reformed Presbyterian Church and some of the fine old time tunes they sang still remain among my favorites.

These psalm-singing Scotch-Irish Presbyterians were a strict, close-communion church. They jealously debarred from their membership those who did not subscribe to their creed or lapsed from their standards by their misconduct or "neglect of the ordinances" or by "breaking the Sabbath."

Woodburn goes on to say that

They were very strict Sabbatarians, and trials before the session were frequent for Sabbath-breaking and not infrequent for over-indulgence in Scotch whisky. They were usually quite thorough in what they took, or undertook. Three-point-two beer would have had no attraction for them. "Occasional hearing" was the sin of attending the Church of another denomination and listening to an heretical minister who was outside the fold.2

Such were the religious influences that shaped the life and personality of Anton Boisen during his early years.

Soon after the death of his father in 1884, when he was only seven years old, he moved with his mother and his only sister to his grandfather's home in Bloomington, Indiana. Thus the most formative years of his life were spent in the academic atmosphere of the Indiana University. His grandfather's towering personality and vast learning must have made a great impression upon young Anton. Indeed he represents in his own personality a remarkable synthesis of the many and varied cultural refinements and potentialities of his distinguished ancestry. He still retains many of the vivid impressions of his early days in his grandfather's home.

iii. Academic and Vocational Activities

Anton's school and college days were spent mostly in Bloomington, Indiana. Details are lacking concerning his high school days, but from what we know of his later achievements, we can safely infer that he must have been a bright and intelligent student. The foundations for his diversified career were laid at Indiana University, under the care and tutelage of his grandfather, Theophilus Adam Wylie. He was graduated from Indiana University in 1897, a year after the death of his grandfather. His sister, Marie (now Mrs. Morton C. Bradley), was also a student there; she was prominent for her scholarship and also served as editor of Junior Annual. Anton himself was a prominent student in his class
and was well liked and respected by his fellow-students. He is mentioned as a "distinguished alumnus" in the University chronicles. Woodburn, himself a distinguished alumnus and teacher at Indiana University, writes:

Eight men prominent in the academic world I recall...Anton Theophilus Boisen (1897) as a student of Religion and Society and a professor in the Chicago Theological Seminary. He is deserving of the highest recognition.1

His scholarship and superior intellectual endowments soon engaged the attention of the University Faculty, and within less than two years following his graduation, he was appointed as instructor in Romance Languages—a position which he continued to occupy until 1903. We can well see here the influence of his great-grandfather, grandfather, and his own father, who were all richly endowed with great linguistic abilities. Anton Boisen has continued his interest in languages. Few men in his field compare with his mastery of the English language and he fluently reads German, French and Latin. He has made several original translations from German and French into English. He resigned from Indiana University in 1903 and entered the Yale Forestry School. It was probably while here that his interest in photography and survey work began—skills which he has scientifically developed and maintained all through the years.

1. Woodburn, HIU, 447, 473.
He was graduated from the Yale School in 1905 with an M. F. degree and entered the United States Forestry Service as Forestry Assistant. The three years' experience in forest surveys prepared him initially for the great tasks which awaited him in the near future. It was here that he wrote his first scientific paper "The Commercial Hickories," which was later published by the United States Forestry Service Department.¹ The paper reveals the scientific precision and objectivity which characterize most of his writings.

In 1908 Boisen entered the Union Theological Seminary in New York. No information is available as to what made him give up his forestry career with its great financial prospects and turn his attention to the Christian ministry. Of course, in entering forestry he had chosen a line of career for which there was no precedent in his entire family history. But what lured him again to the path which his fathers had trod before him? Was it a sense of inner compulsion, a desire to achieve the ambitions of his parents, or a feeling of "something lacking" of which he speaks so often in his writings on schizophrenia? We have already pointed out that Boisen's grandfather entered the ministry against his own personal wishes and as a result of parental

¹ Boisen, CH., (1910).
pressure. Could we say that in Anton's case there was an inner pressure which compelled decision in favor of the ministry and thus represented a solution of some internal conflicts? Whatever might be the reasons that prompted him to enter a theological school, we can be sure that it must have been a momentous decision for him. As a theological student Boisen was liked by the staff and students alike.

Dr. George A. Coe writes:

My opinion of Boisen is based in part, as you already know, upon the work that he did with me in the psychology of religion at Union. There was no other student in his day who combined his ability to use the tools of research and his thoroughness in detail.¹

In another letter to Boisen concerning his book Exploration of the Inner World, Coe says, "...you are one of the few old students of mine who have done creative work of distinction..."²

Dr. William Adams Brown had a very high regard for Boisen and considered his work both in the Seminary and since of a high order.³

After his graduation from the seminary in 1911, Boisen served for a year as Field Investigator for the Presbyterian Department of Country Church Work. He made several field investigations and surveys for the Presbyterian Board of

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¹. In a letter to Mr. Galen Fisher, Executive Secretary, Committee on Social and Religious Surveys, New York City, written on November 11, 1923.
². In a personal letter, written on December 4, 1936.
³. In a personal letter to Boisen, written on November 2, 1923.
Missions, two of which were published in 1912. These dealt with rural surveys of certain rural churches in Missouri and Tennessee and were undertaken with the purpose of determining the conditions in the rural communities, to discover the needs of such communities, whether these needs are being met by the Church and other agencies, and finally to offer constructive suggestions designed to make the Church work more efficient.\textsuperscript{1} These surveys acquainted Boisen with the problems and possibilities of rural church work. From 1912 to 1917 Boisen served as rural pastor in three country parishes in Congregational and Union churches—in Iowa, Kansas and Maine. His experiences in these rural churches gave him a firsthand knowledge of the conditions under which religion flourishes or declines, and of its relationship to mental illness and economic distress. The results of these observations are embodied in an article published in 1916, under the title, "Factors in the Decline of the Country Church."\textsuperscript{2} During the World War I Boisen served overseas in the Y.M.C.A. and had the opportunity of studying the role of religion under crisis conditions. That this experience made a deep impression upon him can be read into the pages of his works; it might have been a factor in his mental illness which came upon

\textsuperscript{1} Boisen, RST.
\textsuperscript{2} Boisen, Art., (1916).
him two years later, although we have no facts to justify this inference. After the war we find him back in this country, engaged in supervising the Rural Survey of North Dakota for Interchurch World Movement.

In 1920 Anton suffered a nervous breakdown of such a serious nature that he had to be confined in a mental hospital for a period of fifteen months. The story of his mental illness and his subsequent recovery makes a most fascinating reading and will be dealt with in the next section. That Boisen regards this temporary breakdown not as a misfortune but as a great synthesizing and constructive experience is understandable in the light of his great pioneer and productive work subsequent to his illness.

Following his recovery from the schizophrenic episode in which he was temporarily involved, Boisen spent three semesters in a special study of the religious aspects of mental illness, under the direction of Dr. Macfie Campbell, Dr. Richard C. Cabot, Dr. William MacDougall, Dr. W. F. Dearborn, Dr. F. L. Wells, and Dr. Elwood Worcester. Another term of four months was spent in special research in Boston Psychopathic Hospital. During this period he took additional courses in Abnormal Psychology, Psychopathology and Psychology of Religion. In 1923 he received the degree of Master of Arts from Harvard University. It may be interesting to note briefly the estimate of his abilities and attainments
made by those under whom he studied. In a letter, recommending Boisen's project to the Committee on Social and Religious Surveys, Dr. C. Macfie Campbell, Director of Boston Psycho-pathic Hospital, writes

I have had the opportunity during the past two years of seeing a great deal of the work of Mr. Boisen and of getting to know his personality. He is a serious student, hard-working and persevering, with a very definite program of research, and with a very good equipment for carrying on that research.1

From Dr. Richard C. Cabot's letter we learn that Boisen attended his classes and seminars for two years. He wrote,

Mr. Anton Boisen...has, in my opinion, now entered upon an especially promising and valuable piece of work, the study of what religion...can do for the insane and for those bordering on insanity.2

Dr. F. L. Wells writes

Your work in this department, which was entirely satisfactory, covered the chief methods of clinical psychometrics; more especially, the Stanford Revision of the Binet Scale and a group of the most serviceable Performance Tests.3

When Boisen presented to William MacDougall his research project for study of the relationship between religious experience and mental illness, he replied,

1. In a letter written on October 16, 1923.
2. Richard C. Cabot, Professor of Medicine, Harvard Medical College; Professor of Social Ethics, Harvard University, Cambridge, Mass. This letter was written to Mr. Galen Fisher of the Committee on Social and Religious Surveys, New York City, on October 9, 1923.
3. F. L. Wells, Chief of Psychological Laboratory, Boston State Hospital, in a letter to Committee on Social and Religious Surveys, November 1, 1923.
I am inclined to accept your formulation of the relation between religious conversion and some not uncommon forms of mental disorders....I may add that your work under me here all showed one that you are well prepared to take up the line of work you propose. 1

In 1924 Boisen took up the chaplaincy work at Worcester State Hospital—a position which he held until 1931. His eight years' stay there was a unique demonstration of a trained religious ministry to the mentally ill. It also enabled him to carry on his research in close association with trained psychiatrists. The results of this collaborative inquiry into schizophrenia have been brought together by Hoskins in his Biology of Schizophrenia, in which Boisen's contribution finds an important place. 2 In 1925 Boisen was made Research Assistant and Lecturer in Psychopathology at the Chicago Theological Seminary (a position he continued to hold until 1942) and from 1928 to 1931 he was Lecturer at Boston University School of Theology. In 1932 he became Chaplain of Elgin State Hospital and it has been the scene of most of his activities since that time. During these years he has carried on extensive surveys and research projects, in addition to his chaplaincy work, clinical training program and teaching responsibilities. He has written

1. William MacDougall, Psychology Department, Harvard University, in a letter to Boisen, written on October 23, 1923.
2. Hoskins, BS. Boisen's contribution is discussed in pages 83-91.
extensively in scientific and religious journals. Among his numerous articles, the following are of special interest from the point of view of the present inquiry: "Personality Changes and Upheavals" and "Experiential Aspects of Dementia Praecox," American Journal of Psychiatry; "The Sense of Isolation in Mental Illness" and "The Problem of Values in the Light of Psychopathology," American Journal of Sociology. In 1936 appeared his most important psychological study, Exploration of the Inner World which several writers have described as one of the most important contributions to the study of the psychology of religion since the publication of William James's Varieties of Religious Experiences more than thirty years ago.¹ This book embodies the results of his research at Worcester State Hospital with interpretations that he has tested and verified in various ways. This was followed with some important papers in Psychiatry, including "Types of Dementia Praecox," "Economic Distress and Religious Experience," "The Form and Content of Schizophrenic Thinking," "Religion and Personality Adjustments," and "Onset in Acute Schizophrenia." In 1946 Boisen brought out another book, Problems in Religion and Life which is a very helpful social survey guidebook for religious workers. Several other

¹ Shaw, Rev., (1937) 112; Sullivan, Rev., (1939) 424.
articles have also appeared which emphasize the psychotherapeutic aspects of religious work. Another significant book is almost ready for publication, *Religion in Crisis and Custom*. It is a sociological and psychological study of religion with special reference to American Protestantism. In the foreward Boisen says

(\text{The book) brings together the results of 35 years of endeavour to study religious experience in social situations...I have in particular made use of my observation of nature's experiments with the forces of love and hate and fear and anger in the experiences of the mentally ill...It is here that I have found the key with which I have sought to open other fields...This key...is to be found in the proposition that religious experience arises spontaneously when men are forced to think and feel intensely regarding the things which matter most and that it is rooted in the social nature of man. It is the sense of fellowship raised to the level of the abiding and universal, the attempt at orientation with reference to that which is supreme in the system of loyalties and the response to that in the universe upon which we feel ourselves dependent for love and protection...}

Elsewhere we will attempt to discuss Boisen's important writings and summarize his important contributions to religion and psychiatry. Here we are merely concerned with his academic achievements. We have briefly summarized his academic qualifications, his psychiatric experience and some of his most important writings. We have touched on his research activities, chaplaincy work and teaching experience. In

1. Boisen, RCC, 4.
1942, the year he retired from both the teaching and the chaplaincy work, he was honored with the degree of Doctor of Divinity by Washburn College. In 1947 he was recalled from retirement to become Acting Chaplain at Elgin State Hospital and to resume his work as Research Consultant for the Council for Clinical Training of Theological Students—a position which he continues to occupy up to the present time.

3. The Schizophrenic Episode

In this section we propose to study the history and experience of mental illness in which Boisen was temporarily involved. An attempt will be made to study his mental illness in terms of its etiology, onset and course and its end-results. We will be especially interested in his experiences as a patient in the mental hospital and in his activities subsequent to his recovery. Studying the meaning and significance of Boisen's temporary breakdown we are reminded of Fromm-Reichmann's statement:

A person can emerge from a severe mental disorder as an artist of rank. His previous liabilities in terms of his pathogenic history, the expression of his subsequent mental disorder, that is, symptomatology, or his inner responses to either of them, can be converted into assets.1

She cites several instances of men in history who converted their liabilities into assets and emerged from their mental illness as artists of great rank. Among others she mentions Schopenhauer the philosopher, Hoelderlin the poet, Tchaikowsky the composer, Van Gogh the painter, Dresden the dancer, and Clifford Beers and Anton Boisen as founders of mental hygiene and pastoral clinical movements respectively. Boisen converted his liabilities into assets not only in spite of his illness, but because of it. It is this fact which makes him stress again and again the constructive aspects of schizophrenic reactions.

1. The Causative Factors

Not much is known about Boisen's early life and development, apart from a few facts. The first seven years of his life were spent with his parents, first in Bloomington and later in Massachusetts and New Jersey. From what we know about the family's social and religious background, there is reason to believe that he was brought up in a religious environment where high, perhaps very rigid, moral standards were expected and enforced. In his love for birds, trees, and flowers and in his remarkable capacity for sustained effort and thought he has probably absorbed much from his father's personality. Boisen tells us that his mental conflicts had their roots in what he calls "a precocious sexual
sensitivity, dating from my fourth year." His father's early
death in 1884, when he was only seven years old, must have
been quite a traumatic event in his childhood days. Follow-
ing this, the family moved back to Bloomington to live
in the grandfather's home where Anton spent his adolescence
and youth. The inner struggle of his early days continued
and became more severe in adolescent years. There was no
physical ailment or trouble connected with it; it was an
intra-psychic or interpersonal conflict.

Before the severe nervous breakdown in 1920 which neces-
sitated hospitalization, there were five previous periods
of inner conflicts each of which represented for him re-
ligious experiences. The first of these occurred on Easter
Sunday, in 1898 and was what he calls a sharply defined
"conversion experience," which cleared up the sever inner
struggle through which he was passing at that time. He
says:

With the onset of adolescence the struggle became quite severe. It was cleared up on
Easter morning in my twenty-second year through a spontaneous religious conversion
experience which followed upon a period of black despair. An impulse, seemingly from
without myself, bade me not to be afraid to tell. I was thus set free and given a new
start in life.3

1. Boisen, EIW, 2.
2. Boisen, SLK, 125.
We may note that his grandfather died in 1895 and he was graduated from Indiana University in 1897, so that the experience which Boisen relates here occurred not very long after these two events. Two years later the conflict was revived and "a desperate struggle to get free again" followed. This was probably partially resolved, following a decision to give up the teaching of languages, in which he was then engaged, and to enter upon the profession of forestry. These conflicts were caused or rather intensified by a love affair in which he was involved about this time. This inner struggle came to a head in 1905, perhaps soon after his graduation from the Yale Forestry School. It again was a constructive experience for him—a "call to the ministry." The love affair, as he tells us, also played a part in the decision to enter the Christian ministry. After this decision to join the ministry, what made him enter the United States Forestry Service instead, we have no means of knowing. Two other periods of conflict soon ensued—one in 1907 while he was in the forestry department and the other the following year; but again he was able to resolve them and entered the Union Theological Seminary—a decision in which the woman he loved again figured. He says:

The woman I loved was a religious worker of the finest type. On her part it was a source of great embarrassment, but she gave me a helping hand at the critical moment and stood ready to undertake what for her was a task of
great mercy. But I failed to make the grade. Then followed nine years of wandering. All this time I was hoping to be re-instated with her. It was as though my life depended upon it.¹

On his return from the overseas service in the Y.M.C.A. in 1919, he was again faced with a severe inner conflict. This one was prior to the break-down which finally landed him in a mental hospital. Perhaps the young friend again played a part in this conflict, and it was perhaps further accentuated by the problem of vocational choice on his return from the war. Of these periods of severe conflict Boisen writes:

These (last) three had to do with a difficult personal problem and a moral failure, a failure to stand the test at the time of the experience in 1905. More than this it is not necessary to say. While I was well aware of the morbid elements in these experiences I had not actually crossed the line which separates the normal from the abnormal in that I had never surrendered the critical attitude.²

The break-down finally came in 1920, when Boisen was engaged in supervising a survey in North Dakota for the Interchurch World Movement. About this time he was faced with the problem of his vocational goal. He had an opportunity to continue his survey work but he decided for the pastorate. Since the

¹. Boisen, EIW, 2.
². Boisen, SLK, 124.
call was not soon forthcoming he decided to go east and spent his time in writing a statement of his religious experience. It was about this time that his long-cherished hopes appeared to be on the point of fulfillment, for he was reinstated with the woman he loved. But all these hopes vanished at one stroke when he found himself suddenly thrown into "the wilderness of the lost." Just how unexpectedly this catastrophe came upon him can be seen in the two incidents Boisen describes. Just a few months before his break-down he inquired of a fellow-passenger on a train he was riding about the group of buildings that appeared off to the south. He was told that it was a mental asylum. He thanked him and forgot all about it. He goes on to say:

It did not occur to me that I ought to be interested in those buildings or in the problem which they represented...Probably I should have remained uninterested for some time longer, if, less than a year later, I had not found myself plunged as a patient within the confines of just such an institution.¹

Again, just a few weeks before his illness, he was introduced to a young woman who had just accepted a position as head-nurse in a mental hospital. After the nurse had left, Boisen remarked to a friend that he could imagine no outlook so dismal as that of a worker among the insane or among the

¹ Boisen, EIW, 2-3.
feebleminded. And yet just about the time of his mental illness his mind became excessively preoccupied with the problem of mental illness. On the evening before his admission to the hospital he informed his family that he had come to the conclusion that the most important problem before the world was that of insanity and he had decided to investigate it. Two days later following admission he told one of the doctors that he had broken through the wall between religion and medicine.¹

11. Acute Schizophrenic Breakdown

The onset of Boisen's mental disorder was marked by a set of strange ideas which, however, developed gradually and centered round a difficult personal problem. It was only after several days of concentrated thought and sleepless nights that abnormal conditions began to lay hold of him. We have already mentioned the fact that at this time Anton was facing perplexing problems of vocation and of love. He decided to reduce his religious experiences to writing. The task became so absorbing and important that he spent many sleepless nights in an attempt to understand the ideas that began surging through his mind with increasing rapidity and force, until at last he was simply overwhelmed by them. With the idea that came to his mind that he was called upon

¹ Boisen, Report (1930).
to surrender the hope which he had cherished for years, he completely lost whatever rational control he had on his mind. The idea seemed to have come from an extra-mental source and carried a "super-natural" authority with it. Then followed a train of ideas which were as strange as they were terrifying:

...there came flashing into my mind, as though from a source without myself, the idea that this little planet of ours, which has existed for we know now how many millions of years, was about to undergo some sort of metamorphosis. It was like a seed or an egg. In it were stored up a quantity of food materials, represented by our natural resources. But now we were like a seed in the process of germinating or an egg that had just fertilized. We were starting to grow. Just within the short space of a hundred years we had begun to draw upon our resources to such an extent that the timber and the gas and the oil were likely soon to be exhausted. In the wake of this idea others followed.¹

He thought he was more important than he had ever dreamed of being. In the impending cosmic disaster everything including himself would be destroyed, save only a few individuals; but he would somehow be used to help others. Then came another terrifying idea, that of hostile and mysterious forces of evil which threatened destruction to his being and his great plans. His family became much alarmed and suggested that he see a physician but he refused. On the same evening

¹ Boisen, EIW, 3ff.
he found himself in a psychopathic hospital, being forcefully taken there by six policemen. He goes on to say:

It may be noted that in accordance with the advice of the physician who had been consulted "knock-out drops" had been placed in my coffee at supper but they had no effect. I had not up to that time shown any violence, nor did I then offer the slightest resistance, but the result was to throw me into a violent delirium. I felt as though I were falling through space. I thought I was dead. I was bound and helpless and with me all those whom I loved. We were all in the power of evil spirits in the guise of human beings...\(^1\)

This violent delirium continued for three weeks. The diagnosis at the hospital was "catatonic dementia praecox" and his people were told that he was not expected to recover. This made his situation more difficult, as we shall see later.

Evidently Boisen was not informed of this bleak prognosis; for he proceeded to recover. However, at first he had trouble convincing his family that the unexpected had taken place so that he was obliged to remain at the hospital longer than would otherwise have been the case.\(^2\)

The idea that hostile forces in the form of human beings were trying to destroy him and the rest of mankind, save a few, struck terror in his heart. The fellow patients would make efforts to help him, but whenever he recognized one and sought

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See also pp. 161-170 wherein the author discusses Boisen's theory of schizophrenia.
to speak to him he would be thrown down by the attendants and choked. Finally he was thrown into a cell and locked up. The experiences through which he passed in one week made him much terrified. Strange, uncanny ideas circled through his mind:

...I felt myself one with some other personality... But there was confusion in this and I was at different times different personalities. And part of the time I was nothing and part of the time one with infinity. Part of the time I thought I was in some strange subterranean caverns held there a prisoner drugged with "bismuth." And then I was an old stallion way back before the flood... And again I was not on the earth but in the moon and it was very strange and uncanny there and one of the first things they tried to determine... was whether I was a man or a woman. (...and they were very much astonished that I was neither one but a "perfect neutral"). And then there was the idea... that I was part of some great circulatory system in which human beings were like corpuscles in the blood and they kept streaming in four directions to a common center there to be sent some in one direction some in another in accordance with some peculiar system of passwords representing choices. Each individual as he arrived at the parting of the ways has three chances, i.e., a first, a second and a third. The game was to find out the right password, for the one which represented the third choice meant condemnation. This game had been going on for ages. My hope however lay in disregarding the passwords and telling the exact truth. This however I found very difficult and I was continually getting things balled up.¹

At the end of a week Boisen was sent to Westboro State Hospital, being taken there in a straight-jacket. At Westboro

¹ Boisen, SLK, 10ff. Most of the material contained herein is drawn from this unpublished manuscript.
two things were in his favor. There was no solitary confinement and the doctor who received him was a kindly man. But his delusions continued as before. He began to think of all his fellow patients as actors in a drama; some of them were friends and others foes. The food came to have a symbolic meaning for him. Several times the idea came to him that it was poisoned and so he went without taking his meals many a time. Another persistent delusion concerned the tub treatment. He thought it was an instrument of torture and became very much concerned when some of the patients, whom he regarded as friends, were given this treatment. He would continually run to the door of the tub room and would request the attendant to let him take their place. This brought severe beating which left him so weak that he was confined to bed for several days. Within three weeks he lost thirty pounds in weight. Boisen tells us something about the manner of this beating which was administered to him by the two attendants:

My theory of that beating is that the two young attendants were merely experimenting with it. I saw them shortly after do the same thing to another patient who was at the same time quite inoffensive. There seemed to be some system about it. I was thrown flat on the floor, face down, while the blows were placed mostly on the small of the back, but were continued higher up as if following certain nerves. I was told later...
by another attendant who knew of the affair that it was what was known as "the old bug-house knock-out."1

The second night after the beating he made an important "discovery" that helped him come back to reality. Throughout this period the idea had persisted in his mind that all humanity was involved in a cosmic disaster and the proof for this he found in the moon, which, whenever he looked at it, appeared centered in a cross of light. He goes on to say:

I took this as confirmation of my worst fears. Did not the cross stand for suffering? What else could it mean than this, that the moon—which, as so often happens in acute disturbances, I had personified—is in mourning over the coming doom? In order to be sure I called an attendant and inquired if he also saw the cross. He said that he did. I was greatly impressed and agitated.2

As he lay that night on his bed in the sleeping porch, greatly terrified and agitated over the prospects of the impending world disaster, he made a discovery. He realized that when he shifted his position to a certain place the cross no longer appeared. He was greatly puzzled over it and started to make some investigation. He soon found out that at that particular spot there was a hole in the wire screening through which he could look, and it was the screening which was responsible for that cross. This discovery shattered one of

1. Boisen, SLK, 16.
2. Boisen, EIW, 4.
the premises which has given a certain amount of plausibility to his delusional belief about the impending cosmic cataclysm. This delusional system finally crumbled to pieces when two days later he received a visit from his sister and from a friend of his, for this timely visit helped him re-establish connections with the outside world from which he had felt entirely cut off. He recovered from the three weeks' delirium and almost immediately became as well as he had been before. However, he was somewhat stunned by the unexpected catastrophe that had overtaken him and spent much thought in trying to understand its cause and meaning for him. Some of the fears still lingered in his mind, but they temporarily ceased to have sway over him.

Five months later there came a recurrence of the previous delirium which lasted another ten weeks. He was then much weaker than he had been the previous time. The "solution" of his problem that he seemed to have reached by the discovery concerning the moon, appeared to be a spurious solution. The old ideas and delusions reappeared with further elaborations. As soon as he was removed from the observation ward to Upper Codman (one of the Westboro wards) old associations and suggestions came surging in upon him. A book which had come to his hand at this time further served to re-awaken his anxieties and fears. He began to lose sleep and felt terribly helpless. He wrote urgent letters to his
people, imploring them to take him away from the hospital. It will be seen that he had some insight into his condition, and through card games and in other ways he tried to distract his attention. But he could not long indulge in these games, for it was the week of Easter which held a peculiar significance for him. Finally came the idea that he had committed a serious offense and with that he again made his entry into the old delusional world. The same constellation of ideas reappeared, which had occupied his mind the previous fall: ideas of an imminent world disaster, of a cosmic struggle between the forces of good and evil. The delusions regarding the food reappeared. It took on a symbolic meaning. He would, for instance, eat no meat, no milk, no fruit or any sweet stuff, and for ten weeks he lived on little else but bread and water.

To have eaten any of the other things would have meant misfortune to my friends, and it was always a difficult matter to know what to eat and what not to eat. 1

1. Cf. Beers, MFI, 38ff. Beers had similar delusions regarding food. "At each meal, poison was still the piece de resistance, and it was not surprising that I sometimes dallied one, two, or three hours over a meal, and often ended by not eating it at all...To eat or not to eat perplexed me more than the problem conveyed by a few shorter words perplexed a certain prince, who, had he lived a few centuries later (out of a book), might have been forced to enter a kingdom where kings and princes are made and unmade on short notice."
The tub treatment, which he had so much hated at first, assumed a new significance and he felt himself obliged to take it. He felt that the destinies of the world depended on those tubs. This time he was allowed to have his own way, and of the ten weeks he was in that ward, full six weeks were spent in the tubs.

New, fantastic ideas kept coming in on him. For instance, he came to the conclusion that some of the patients whom he regarded as the Devil's representatives were his mortal enemies, trying to devise ways to destroy him. To frustrate their sinister purposes he felt it necessary to remain in a state of constant watchfulness and allowed himself no sleep. Another idea that persisted in his mind was that he must destroy himself in order to save the situation. On two previous occasions he had dashed his head against the corner of the brick wall, seriously hurting himself. He had also tried to drown himself in the tubs and at one time had nearly succeeded. And now again he made several attempts to kill himself. He felt that in order to achieve his aims he must go to the lowest region. He says:

I had the idea that the way was down and not up and that I had to descend against my will to the lowest possible level. I remember on several occasions lying for hours during the night on the cold cement floor in order that no one might be able to get below me and that the enemy might be discomfitted.¹

¹Boisen, SLK, 16.
He was also led to imagine that his brain was a sort of wireless receiving station to be used as a tool against the crafty devices of the detectives who were supposed to be in his track. They were agents of the evil forces and went around in pairs, seeking information which they might later use against his friends. He would hear them tap-tapping on the walls and floors, trying to locate him or his friends. Gradually, however, the acute phase of his delirium subsided and he felt that some sort of a solution was shaping itself:

The terror was disappearing and I was learning "to stay out" and not keep plunging around throwing everything in confusion. I was also getting fearfully tired, and I began to question some of my premises. But I kept going to the tubs until I felt that nothing further could be accomplished, staying out only on the assurance that I might "be able to help." Then I was transferred down-stairs. Immediately then the old fears and the old ideas vanished, which so long as I remained up-stairs I picked up from the other patients or were suggested by the old associations.

As Boisen began to recover from the effects of his violent delirium his thoughts again turned round the nature of his mental illness, as they had done after his recovery from the previous delirium. He became interested in finding out

1. These experiences find remarkable parallels with those which Clifford Beers had as a patient nearly twenty years ago. (Cf. Beers, MFI, 20ff).
2. Boisen, SLK, 18.
just what exactly had happened to him. He first made efforts to gain some information about his own case from the doctors but met with no success. The doctors, being advocates of the constitutional theory, did not believe in discussing such matters with the patients. He says:

The doctors did not believe in talking with patients about their symptoms, which they assumed to be rooted in some yet undiscovered organic difficulty. The longest time I ever got was fifteen minutes during which the very charming young doctor pointed out that one must not hold the reins too tight in dealing with the sex instinct. Nature, he said, must have its way. It was very clear that he had neither understanding nor interest in the religious aspects of my problem.1

He, therefore, took his problem into his own hands and began by observing the patients around him. He soon discovered that aside from a small number of patients who seemed to have some organic basis for their mental illness, the majority of the inmates appeared to be physically alright. But most of them seemed to be a rather discouraged lot of people, and the institution seldom seemed to offer anything to make life happy or cheerful for them. He came to the conclusion that what had happened to him had also happened to them. They had also probably some inner conflicts or tensions which became so severe that they too finally landed in the mental institution. It also occurred to him that such inner counting.

1. Boisen, EIW, 5.
conflicts can have happy as well as unhappy solutions. Many of these patients appeared to have stopped struggling against the things which could not be helped and became apathetic and hopelessly discouraged; while there were others, too, who without losing hope, accepted the conditions as they were and made the best of them. About three months after coming to Westboro, while he was still feeling bitter over certain things, Boisen expressed to one of the doctors a rather unfavorable opinion of their methods of treatment. He was told that he should remember that a patient's attitude toward the institution was one of the things which was taken into account, in determining his fitness to go out. As Boisen thought about it, he was led to the conclusion that the first step in successfully meeting a difficult situation was to give up the struggle against those things which could not be changed, to accept the situation as it was and to make the best of it, finding new hopes and new interests to make life worthwhile. Whatever the end-results of the inner struggles and conflicts that men faced, Boisen concluded, they are rooted in some spiritual or religious difficulties. It was in this light that Boisen viewed his mental illness and achieved a solution of his vexing personal and vocational problem.

The present catastrophe has, however, definitely broken down any line of demarcation between my own experience and that of the insane patient... And yet that experience had been for me a religious experience. Even though it may have seemed
to the doctors an evidence of continued dis­
order, I still believe that it has all come
to pass in accordance with a plan, and that
this catastrophe, fearful though it has been,
has been merely a necessary and logical step
in the working out of my particular problem
and that it has served a useful purpose. I
hold therefore that a man can be absolutely
insane and yet fundamentally right in that his
abnormality is merely an incident or a by-
product of inner conflict and a mutation of
the personality. And believing this I hold
that the entire problem of insanity is one
that concerns the religious worker more than
it does the medical man.1

Thus Boisen emerged from his fifteen months' sojourn in the
mental hospital with a new vision and a new purpose in life,
truly as an "artist of rank." This newly-formed purpose
was expressed in a letter which he wrote to one of his friends
a couple of months after his discharge from Westboro Hospital:

...My present purpose is to take as my problem
the one with which I am now confronted, the
service of these unfortunates with whom I am
surrounded. I feel that many forms of insanity
are religious rather than medical problems and
that they cannot be successfully treated until
they are so recognized. The problem seems to
me one of great importance not only because of
the large number who are now suffering from
mental ailments but also because of its reli-
gious and psychological and philosophical as-
pects. I am very sure that if I can make to
it any contribution whatsoever it will be
worth the cost.2

1. Boisen, SLK, 112.
2. Boisen, EIW, 7.
iii. Hospital Experiences

In the concluding two sections of this chapter, we will first discuss some of the experiences and activities of Anton Boisen during the period of his hospitalization, and then offer some observations on the nature of the schizophrenic episode in which he was temporarily involved.

A week after the second phase of the delirium had subsided and he was transferred to Codman Lower (in Westboro) he asked for something to do and was told that he was still too weak to do anything. He then wrote a letter to the superintendent of the hospital to this effect:

It is now eleven days since I came to Codman Lower. During the first week I was chiefly occupied in recuperating from the ten weeks of tub treatment upstairs, and I did little but eat and sleep. This week however I am beginning to accumulate a little reserve of energy and I am looking around for some way of spending it to good advantage. To my surprise I find this no simple or easy problem...The striking feature of this ward as compared with the other wards with which I am familiar is the lightness of the ward work and the lack of occupation of most of the men during the major portion of the day.

He then goes on to describe a typical day and how most of the time the patients sat around doing nothing. He concludes the letter with some suggestions for supplying additional equipment for recreation: larger library facilities, occasional talks on mental hygiene and opportunities for daily walks

1. Boisen, SLK, 115.
around the campus. Three possibilities were suggested to him by the hospital authorities: checking in the laundry room, work in the marking room, or some occasional photographic work. The first two tasks did not appeal to him, but he was inclined to combine the more or less irregular photographic work with some other activity. He asked, for instance, for the job of making ring-toss or bean-bag outfits for different wards, or bulletin boards or book cases—things in which he had been interested in early days. He also made suggestions for a possible Fourth of July program. These suggestions were approved and he was given the job of hospital photographer and was also authorized to go ahead with the Fourth of July program. This program met with great success and was followed with other programs on Labor Day and Christmas Week, in which the patients and several of the physicians and their wives participated.

In addition to the time spent in preparing such programs, Boisen put in most of his time on the photographic work. His task was to take the patients' pictures for the hospital records. This took him in almost all the wards. He was also authorized to take pictures of the buildings, grounds and activities of the hospital. He even attempted a fully complete survey of the institutions in pictures and compiled a rough topographic survey of the grounds. All
these activities kept him delightfully occupied and also enabled him to study the hospital in its methods, organization and equipment, from a patient’s point of view.

As he went about doing his daily assignment, he made many significant observations. He came to realize that the inmates of the hospital were no different from those outside and that there was no clear line of demarcation between them except the legal one. He further observed that many of the inmates were institutionalized there, not because of any feeblemindedness or anti-social behavior on their part, but perhaps because of "a temporary or permanent derangement of minds which may otherwise be highly developed."

Among the hospital inmates, Boisen found representatives of all social classes and of all degrees of education, a large group of them being of alien birth or alien parentage. The ward group seemed to be the most important unit in the social life of the hospital community. The group influence was very potent and the individual patient tended to blend with the group. While he rarely heard the patients complain about their work, the work given them was usually of a nature that offered little opportunity for creative activity or self-expression. There was lacking the stimulus of reward. Whether patient worked well or ill he received the same food and the same state clothing. Further, the work was not often of his choosing or interest and was for the most part "just
monotonous drudgery done under orders and under the eye of a task-master in order to keep the machine going. Work done under such conditions, as Boisen rightly points out, can have no therapeutic value. The recreational activities provided some diversion from the monotony of the institutional life, but their chief weakness lay in the poor provision for recreation in the less fortunate wards.

One of the grievances often voiced by the patients was the feeling that uniformity and appearance were placed above their welfare. The well-kept dining rooms, bed-rooms and polished floors made a very favorable impression upon the visitors or relatives who came on visiting days, but they did not tell the whole story. For instance, the flower vases, table sheets and napkins used to be carefully removed from the dining-tables before each meal and then replaced after the meal was served. There was also a lack of privacy or of any place where the patient could keep his personal belongings, no place which he could call his own. This was quite a discouraging situation for many of the patients.

The patients' contacts, so far as the hospital authorities were concerned, were mainly with the attendants or nurses or with the boss of the working gang. The physicians used to visit the wards once or twice a day, but the patients had very little chance to talk with them. Many of the attendants did not encourage any contact with the physicians and in the
less favored wards made little use of the methods of kindness or courtesy. The patient might be a Harvard or Brown graduate and yet to each young attendant he was just "Jimmie" or "Charlie." Most of all, however, the patient felt his detention, a feeling that he was being unjustly or unnecessarily detained without a chance to gain a hearing. There was a tendency on the part of the staff to find evidence of insanity in any and every case and the patient was in most cases not allowed the benefit of the doubt.

What Boisen felt, in particular, was a lack of really satisfying religious ministrations. The Protestant religious work was particularly disappointing; there were no pastoral contacts, and the services were uninspiring and ill suited to the needs of the mentally ill. The sermons that were preached to the patients were usually those that had already been used with the ordinary congregations, and some of the hymns were of such a nature as to intensify the patients' conflicts and terrors or to strengthen their delusions. The ministers who came from the neighboring communities had no understanding of the inner conflicts and needs of the mentally ill. As a result of these observations Boisen took upon himself the task of bringing into being a clinically trained religious ministry which would adequately meet the challenge of the mentally ill.
As he envisaged the lack, it was not a mere absence of familiar liturgy or pleasing ritual to be introduced in order to make institutional life more bearable to the patients; it was a situation directly related to the problem of mental illness.1

As these ideas gradually became crystallized in his mind and resolved themselves into definite convictions, Boisen made efforts to secure his release from the hospital in order that he might be able to translate his convictions into a program of action. But it was not an easy battle. He tried hard to convince his friends that he was no longer insane and laid his plans before them. But, he writes, "the harder I tried the less they believed. The result was to increase my own fears and my own helplessness."2 The doctors looked askance at his plans and doubted his sanity. Some of his friends thought that for his own good he should remain in the hospital all his life; others suggested some simple form of manual work. After making some fruitless efforts at release, he changed his "tactics and said nothing about the release." This unnecessary confinement nevertheless gave him an opportunity to think through

2. Cf. Beers, MFI, 221-225. Notice what a difficult time Beers had in trying to convince his own brother that he was no longer insane and that the plans he presented and which later resulted in the founding of the Mental Hygiene Movement, were not ravings of an insane man, but a well-conceived program of action based upon discovered needs. His brother had him committed again to an insane asylum!
his plans and vocational future. Then he wrote a letter to his friends outlining his plan and imploring their support to secure his release. This time fortunately, after some delay, his plan went through and he was discharged from the mental hospital. A few months later, with the consent of his mother and as a result of a series of personal conferences with Dr. Elwood Worcester, he proceeded to secure clinical training for chaplaincy work. To this end he enrolled for special courses in Andover Theological Seminary and Harvard University Graduate School. He took intensive courses in abnormal psychology, psychiatric social work and psychopathology, under such eminent men as Dr. Richard Cabot and Professor William McDougall. These courses included clinical work at Boston Psychopathic Hospital and furnished him with unique opportunities for intensive study with schizophrenic patients, under the expert guidance of Dr. Macfie Campbell, Dr. F. L. Wells and others. He did clinical work at Boston Psychopathic Hospital for two years, at the end of which he was faced with the problem of finding a chaplaincy in a mental hospital.

But despite the excellence of his work and the breadth of his preparation, he found it impossible to locate a position. The specialty he had carved out for himself had never been heard of by hospital superintendents and they failed to register enthusiasm when Boisen outlined its nature for them. So far as they were
concerned there was no justification for changing established hospital routine by adding a psychiatrically oriented chaplain to the official staff.\footnote{Klein, MH, 162.}

However, in Dr. William A. Bryan at last he found a sympathetic friend of broad views and progressive ideas. He called him to the Worcester State Hospital and created a full-time chaplaincy for him. He was of course severely criticized by his fellow-superintendents for such unheard of innovation, to which he replied with the classical remark 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.\footnote{Boisen, EHW, 9.} Thus started a career which has proved a boon and a blessing to the Church.

iv. Some Concluding Observations

In the absence of definite details concerning Boisen's early development, it is not possible to reconstruct any adequate picture of the causes and developmental factors that finally precipitated the schizophrenic breakdown. It is also risky to trace the dynamics of his personality on the basis of such fragmentary and somewhat obscure details as we can trace in his writings. His delusions just before and following the acute phase of his illness do follow certain patterns of thinking but again they lack significant details.
We, therefore, do not propose to offer any interpretation of his mental illness. What we are attempting here is to give a few observations that are based on the material we have presented in the preceding pages.

We cannot help pointing to the striking similarity that seems to exist between Anton Boisen and Clifford Beers—both pioneers in their respective fields. Of course, Beers' contribution is confined to the founding and initial organization of the Mental Hygiene Movement, whereas Boisen's contribution has been twofold. On the one hand, he has made a definite contribution to psychiatry by his studies with schizophrenia. On the other hand, his contribution to religion consists in his interpretation of the religious significance of mental illness and in the founding of the clinical pastoral movement. The significant point of interest, however, lies in the experience of mental illness and its end-results in both cases, and it is this point that we wish to bring out in our discussion of Boisen and Beers.

At the outset let us note the remarkable somatic similarity that Anton Boisen bears to Clifford Beers. Anyone who compares the picture of Beers as it appears on the frontispiece of his book with that of Boisen as we know him, cannot help but be struck with the likeness in their features
and body build. According to Sheldon's description both 
could be described as predominantly mesomorphic with pro-
nounced somatic structures. With this body type Sheldon 
links the temperamental trait of somatotonia which is charac-
terized, according to him, by vigorous assertiveness, push 
and preference for action. Whatever might have been their 
temperamental traits in early years, it is clear that both 
of them have been characterized by these traits in their 
later years. Of course, we know that in his early years 
Beers was shy, sensitive and uncomfortable in social situ-
atons; however, he used to mask these troubles "under a 
camouflage of sarcasm and sallies of wit, or, at least, 
what seemed to pass for wit among my immature acquaintances." We do not know anything about Boisen's early years, but if 
genogenesis is a factor in personality development, we can 
assume that he too has been shy, sensitive and uncomfortable 
as a child—traits which he might have acquired from his 
mother, certainly not from his father who "was highly emo-
tional, far too much for both his mind and body, and that not 
at intervals, but always and everywhere."3

Boisen and Beers were both graduated from college in 
1897. However, Boisen was early recognized for his superior

1. Sheldon and Stevens, VT.
3. Woodburn, HIU, 357.
intelligence and scholastic aptitude and represented a distinguished ancestry and social background. This fact, combined with the puritanical morality and authoritarianism in which Boisen was probably brought up, served to make his mental conflicts all the more keen and a much longer period of stress and strain preceded his nervous breakdown. On the other hand, in Beers' case, mental conflicts were at their minimum and religious concern was almost nil. The main causes leading to his mental illness, as he describes them, are sufficiently clear: a tendency to excessive worry in childhood, an ambitious nature, a morbid fear of epilepsy (with which his elder brother was afflicted), turning into a delusion of being actually stricken by it soon after his brother's death, and an attempt at suicide. Such are the main causes that brought about Beers' breakdown and his institutionalization. No such clear etiology is traceable in Boisen's case. There seems to be no doubt, of course, that the nucleus of his trouble lies somewhere in early childhood. The difficulty was rooted in an inner struggle arising out of a precocious sexual sensitivity, dating from his fourth year. According to Freud sexual excitability reaches a peak in the fourth and fifth years and has its basis in the Oedipal situation. His classical illustration of the five year old boy Hans is well known in this connection.¹ Sexual difficulties

¹ Freud, CP, III.
may arise when feelings of inferiority, shame, disgust and especially fear are associated with sex. White cites an interesting case of a young college freshman who suffered from frequent nocturnal attacks of anxiety, the content of which was the fear of going insane. It seemed that when the boy was four or five years old his mother tried to stop him from masturbating by telling him that he would go insane, should he continue the practice. This threat was reinforced when the family happened to drive by a state mental hospital. The boy saw the patients behind barred windows making terrible noises, and she explained to him that they were insane people, a condition worse than death. This was a real threat and as the child grew up he developed a morbid fear of sex and renounced it in all its forms. He did not permit himself to masturbate and his only sexual outlets were wet dreams from which he awoke with anxiety attacks. Arriving in college he shunned all company with women and made desperate attempts to suppress the rising tide of sex, a defense which he could maintain during the day but not at night. 

During his college years he fell in love several times but broke off each affair with the decision that full devotion to his life-work required celibacy.

Whether Boisen's inner struggle, associated with a precocious sexual sensitivity, was due to some repressed sexuality or repressed hostility, it is difficult to say.  

Whatever might be the case we can safely say that Boisen's conflicts were rooted in the presence within him of certain cravings—sexual or otherwise—which could neither be controlled nor acknowledged, for fear of parental or social condemnation.  

If Boisen's own interpretation of mental illness is a guide in this connection, we can say that in his case too the conflicts were rooted in sexual maladjustments, for as he says:

> The fact that the sex drive is surrounded with taboos and inhibitions, and that, at least in our culture, it is something about which one does not talk freely, means that maladjustments in this field are likely to be kept to one's self. This at once intensifies the emotional charge and increases the sense of shame and isolation.

These words of Boisen become significant if we add to them what he has to say regarding the problem of guilt in mental illness:

> The sense of guilt is, then, due to something which we are afraid to tell... Its essence is

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1. Cf. Horney, NPT, Chap. 4. According to this writer, neurotic conflicts arise in the attempt to repress aggressive rather than sexual tendencies, in order to avoid parental punishment or rejection.
2. Cf. Alexander, PTP, Chap. V.

* The italics are mine.
not to be found in any mere infraction of a code but in a rupture of the interpersonal relationships as inwardly conceived. The sense of sin is thus the social condemnation which we have accepted as our own. It carries with it the sense of isolation and estrangement.¹

We have italicized certain portions to emphasize the point that in Boisen's thinking and perhaps in his own personal experience sexual conflicts and feelings of guilt that go with them, involve interpersonal relationships. But, whence arises the feeling of guilt in Boisen's early experience? Here we tend to agree with Horney that feelings of guilt arise as a result of the aggressive feelings that the child experiences by dint of excessive parental demands. We are further tempted to believe that these guilt feelings in Anton were intensified when three years later his father died. English and Pearson tell us how feelings of guilt tend to arise or intensify by such traumatic events for which the child, having a repressed hostility toward his parent, feels personal accountability.²

Boisen himself assigns a secondary role to repressed hostility in the etiology of mental illness, and as applied to his own case it might be true, although we would assign equal importance to it along with the sexual factor. Although

2. English and Pearson, EPL, 91-94.
the feeling that sex is a dirty, disgusting and dangerous urge may generate feelings of guilt within the individual, as this powerful urge gathers strength and clamors for expression, the very fact of the ensuing conflict may release creative forces dormant in the individual. As White points out:

Fortunately there are strong forces on the side of growth. One of these is the sex urge itself, which activates fantasy and inquiry even when behavior is blocked.¹

Whether or not we agree with the sexual theory of religion or with the proposition that excessive religious concern is the result of perverse eroticism, as Oscar Pfister puts it,² there is no doubt about the fact that sex life or sex love, in its higher manifestations, comes very close to religion. As Hocking rightly points out, sex love has close relationship to religion.³ Not that religion is rooted in sex, but that sex love at its best approaches religion. "It wants what religion wants—union with an idealized other-than-self... Because it is associated with the greatest of values, it is also a source of great danger and anxiety."⁴ We may, therefore,

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¹ White, AP, 122.
² Quoted in Brill (ed.), BWS, 955. James has a very good discussion of the sexual theory of religion. See VRE, 10-11.
³ Hocking, HNR, xlii.
⁴ Boisen, Art., (1942)¹, 288-301.
rightly conclude that Boisen's sexual difficulties, though a source of constant conflict in his life, have nevertheless provided a strong stimulus to remain ever concerned with that which is supreme in our system of loyalties. The very repression of sex life has enabled him to achieve sublimation and expression on a plane which, like true love, represents concern with the highest values in life.1 As we go through Boisen's writings we are impressed by how closely linked together in his thinking are the concepts of love and religion and how he explains the concepts of sin and guilt, and of salvation and forgiveness as facts of experience, representing integration or rupture of interpersonal relationships.

One more point needs consideration before we deal with the striking ideational similarity of both Beers' and Boisen's thinking as mental patients—an inquiry with which we began our discussion. Although we do not have many essential facts concerning Boisen's adolescent and school years, we can yet point out certain traits—almost familiar patterns—in his personality. We can note in him what Munroe calls the conscientious or rigid student.2 She studied the social behaviour

1. Professor Pinard seems to think that sex and spirituality are facets of the same thing. A man in love experiences, perhaps for the first time, selflessness of love. Arts and crafts all come as a result of sex; all organisms prepare for the act of sex. In terms of sex life man glimpses the higher road to a transcendental life—from notes taken in W. I. Pinard's Class, Boston University, Jan. 12, 1949.
2. Munroe, TI, Chap. 6-10.
and academic performance of a large number of college students, and discovered certain characteristic patterns of behaviour and thinking. She describes as conscientious or rigid students who show great reliability and self-control, set very high standards for themselves, and work very earnestly and conscientiously; they crave social approval but lack warm human contacts; they work under constant strain and tension and are given to moods of discouragement. They suffer from a fear complex and distrust their own spontaneous impulses, feelings and judgments. While we do not mean to imply that this picture holds entirely true of Boisen, it does point to some interesting parallels. Working back through his career we find temperamental qualities that seem to constitute a distinct familiar trait. His father, grandfather and uncle, all seemed to have been characterized by a certain over-ridden quality in themselves, a drive toward power, leadership, action and efficiency—which, in psychoanalytic terminology, is said to constitute a protective mechanism against feelings of guilt, aggression and insecurity. In Boisen's case the most remarkable thing is that most of his inner conflicts or disturbances came at certain crucial periods in his life: the first attack came soon after his graduation from college; two years later another attack came when the problems of vocation and love-affair were uppermost in his mind; a fifth disturbance followed on his return
from overseas; the final nervous breakdown followed when, with the uncertainty of his future vocational goal, came the certainty of being reinstated with the woman who represented the hope of many years. Thus we see that it was when success and superiority seemed to be blocked, or when the questions of major decisions or responsibilities were forced upon him, that he suffered acute disturbances, though from each such period he emerged with renewed power and with clearer insight.

Coming back to our initial comparison between Beers and Boisen, we find some interesting parallels in their delusions during the acute phases of their illness. There is a certain dramatic quality about Beers' nervous breakdown which is lacking in Boisen's case. Moreover, Beers' delusions were richly developed and well systematized and persecutory elements were very predominant. But for both their hospitalization was a painful experience and they suffered rather rough treatment at the hands of the attendants—although Boisen is rather silent on these matters and is concerned primarily with the constructive aspects of his hospital experience. To summarize Beers' delusions, we may begin by saying that just as the fear of epilepsy for Beers became a delusion of being actually stricken by it, so later on the fear that he might be put under arrest for the attempted suicide turned into a delusion of being actually under legal
arrest—a delusion which served as a basis for all his later delusions. In other words, a very large part of his delusional system hinged on this one grand delusion concerning the Third Degree criminal charge against him. The hot poultices and saline solutions used to soothe his injuries were interpreted as a part of some "inquisitorial process" designed to increase his sufferings and thus force confession; the strips of court-plaster, in the form of a cross, placed on his forehead where he had sustained slight scratches were interpreted "as a brand of infamy;" the nurses and attendants around made him conclude that he was under police surveillance and that even his own brother and other relatives were in league with other detectives to hasten the doomsday. In fact, ordinary incidents, noises and movements were misconstrued and appeared to him as part of vast persecutory schemes.

Beers' delusions regarding food are interesting and remind us of the delusions that Boisen entertained with regard to it. Both regarded food as poison though with different reasons. To Boisen, eating of certain articles meant misfortune to his friends, whereas Beers believed that it represented a method of detection by the police or detectives.

They (detectives) now intended by each article of food to suggest a certain idea, and I was expected to recognize the idea thus suggested. Conviction or acquittal
depended upon my correct interpretation
of their symbols, and my interpretation
was to be signified by my eating, or not
eating, the several kinds of food placed
before... One day to eat a given article of
food meant confession. The next day, or
the next meal, a refusal to eat it meant
confession.¹

These ideas correspond to Boisen's delusions concerning the
game of passwords which represented different choices and the
game, which was going on for ages, was to find the right
choice, for a wrong choice meant condemnation. Although
we do not find in Beers' case much reference to delusions
of cosmic disaster or cosmic struggle between the forces
of good and evil, his delusion of vast persecutory process
being set against him does have such cosmic implications.
One significant point of contrast lies in the fact that
while Beers conceived himself as being the object of the
world's persecution, Boisen took upon himself the role of the
"suffering servant" and "savior" through whose instrument-
ality the impending world disaster could be stayed; he was
intensely concerned with the world's welfare, whereas Beers
was intensely concerned with his own personal safety. The
ideas centering around a world mission characterized Boisen's
ideation right from the beginning, but in Beers they appeared
after he had passed through the acute phase of his illness.

¹ Beers, MTP, 39.
Beers made several attempts at suicide, in order, as he believed, to escape the disgrace and shame of his impending trial. Boisen made similar suicidal schemes in the belief that he might thereby be able to stop or at least delay the impending cosmic catastrophe.

We may also point out another striking fact—the process of reality testing by which the delusional systems of both these men began to crumble. For a long time Beers persisted in the delusion that his relatives—especially his brother whom he called his "conservator" were spurious persons, not his real relatives. To find out the real truth, he called a fellow patient and gave him a list of the names and addresses of his father, brother and uncle; he asked him to find out if these names appeared in the New Haven Directory. When this was confirmed and it was proved that the persons who came to visit him were his own relatives who lived in New Haven, he devised another test; that is, he wrote a letter (the first in twenty-six months) to his brother, asking him to bring the letter back with him on his visit as a passport to prove his bona fide identity. The very minute his brother appeared with the "passport" Beers delusionary world was shattered to pieces and thus it saved his life.

1. Beers, MTI, 75.
The very instant I caught sight of my letter in the hands of my brother, all was changed. The thousands of false impressions recorded during the seven hundred and ninety days of my depression seemed at once to correct themselves. Untruth became Truth. A large part of what was once my old world was again mine.1

Boisen had a very similar experience, though his release came in a different way. His delusions centered round the idea of a coming world catastrophe. The moon which shone through the wire screening in the sleeping-porch seemed to him centered in a cross of light. That cross symbolized suffering and confirmed his belief in the coming disaster. Then one night as he lay in his bed contemplating the oncoming tragedy, he discovered that it was the wire screening which gave the impression of a cross of light! "With this discovery the edifice I had raised upon the basis of the original premise began to fall. And only a few days later I was well again."2

A few days later his sister and a friend came to visit him and that further served to prove the falsity of his dream world and brought him back to reality. As we follow the autobiographies of these great men we find that soon after their delusional worlds had crumbled to pieces they began to raise new structures on these ruined foundations, which today have become fountainheads of two significant movements.

2. Boisen, EIW, 4.
in history—the mental hygiene movement and the clinical pastoral movement. We may here apply to these men the words that Hutchinson uses to describe the birth of creative insight in the scientist, the artist and the practical thinker who have before them a problem involving some creative production or decision in life situations. For months or years, it may be, this problem has remained unsolved, this creative intention unfulfilled. Attempts at solution have ended in bafflement (and indeed in these two cases in wanderings through the "wilderness of the lost"). But suddenly, usually in a moment when the work has been temporarily abandoned, or when the attention is absorbed, comes an unpredicted insight into the solution usually interpreted as a recognition of the perceptual field, especially in regard to the relationship between means and end. As if "inspired," "given," arise ideas which constitute a real integration of previously accumulated experience—an answer, a brilliant hypothesis, a useful "hunch," forming, it seems a short cut to artistic or scientific advance...1

In the foregoing chapters we have reviewed the essential facts concerning Boisen's life and experiences and have tried to understand the dynamics of his personality in the light of his social and religious background. We have also seen that Boisen's interest in the problem of mental illness was born in the crucible of his own personal experience and his scientific investigation of it began in an attempt to understand the meaning and significance of that experience. In the following two chapters we will deal with the importance of Boisen's contribution, his primary hypotheses and his methods of research, followed with a detailed consideration of his basic studies. The chapter will conclude with a critical evaluation of Boisen's theory of schizophrenia.

1. The Importance of His Research

In our introductory chapter, in emphasizing the importance of the present inquiry, we dealt in part with the significance of Boisen's work. We pointed out that while the problem of schizophrenia has been tackled from various points of view, its religious aspects and their implications have never been seriously and scientifically considered. To Boisen goes the credit for initiating this inquiry from a point of view which is refreshingly different. In some
Boisen's understanding of schizophrenia is more direct and personal than that of the average psychiatrist or psychologist for, as Klein says:

Having himself passed through an intense schizophrenic episode he obtained an insider's view of the disease... As a result of his own breakdown plus his subsequent years of study Boisen has both kinds of knowledge at his disposal when he writes about the problem of schizophrenia. In this respect he is better equipped than most students of the subject, so that what he has to say about the inner dynamics of the schizophrenic's mental life merits serious consideration.

Boisen's studies in schizophrenia, therefore, cover a ground which has been largely neglected in the past. He has made a most thorough study of the subjective aspects of the disease, in terms of his own experience and of the experience of hundreds of other patients whom he has studied. Several psychiatric writers have drawn upon his investigations in describing the ideational content and reaction patterns of schizophrenic patients. Hoskins, for instance, accepts Boisen's data and conclusions in describing the mental life of the schizophrenic. Of Boisen's studies he says:

The most comprehensive investigation of the subjective aspects of schizophrenia of which I am aware is that made by Boisen, who cooperated with us at the Worcester State Hospital in a study of the 173 patients previously alluded

This observer brought to bear not only the critical attitude of a trained scientist and the technical sophistication in psychology and sociology but also the insight that he had gained from having himself passed through an acute catatonic episode.

Apart from his contribution to psychiatry as such, Boisen's studies are of special significance to psychology of religion, for they seek to establish a fundamental similarity between schizophrenic reactions and certain types of religious experience, both being attempts, as he argues, at reorganization of personality. This view needs to be seriously considered, for if it can be established it will have considerable interest for our understanding of religious experience and mental illness. As we have already pointed out, several writers have hailed Boisen's *Exploration of the Inner World* as the most significant contribution to psychology of religion since William James's *Varieties of Religious Experience*. To quote just one writer:

One of the most distinctive contributions to the psychology of religion since William James, this book will doubtless stir a great deal of interest and discussion. James cast a new light on religious experience when he examined it from the viewpoint of psychopathology; Boisen attempts to illuminate not only the religious experience from the point of view of the abnormal but, conversely, the abnormal experience as seen in its religious implications.

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1. Hoskins, BS, 83.
In other words, Boisen's view that the study of mental illness provides an important approach to an understanding of spiritual forces that are operative in human life is truly significant. Just as in psychiatry the study of abnormal behaviour is an important method of approach to the problems of human behaviour, a study of the religious behaviour and thinking of the mentally ill can furnish important clues to our understanding of normal religious behaviour. William McDougall in a letter to Boisen, which we have already quoted, was inclined to accept Boisen's formulation of the relation between religious conversion and certain forms of mental disorder, and wrote to him in this connection:

If this view were established and generally held it would lead to a much more active treatment of the psychotherapeutic type, involving efforts to understand the psychological conditions that have led to the disorder and efforts to readjust the patient's mental attitude towards his difficulties. 1

Of particular interest is Boisen's point of view that feelings of guilt, blame and self-condemnation that recur in the experiences of many schizophrenic patients are not necessarily damaging or harmful. On the contrary, patients characterized with such feelings often show better prognosis than those who resort to the mechanisms of projection, withdrawal and concealment. Boisen would agree with Johnson

1. In a personal letter to Boisen, written on October 23, 1923.
that "we need tension enough to work for progress, guilt feelings to promote striving, effort and growth; within bounds we see that they are a healthy and normal experience."¹ This is a point of real issue which needs to be seriously considered.

Furthermore, if religious concern is associated with acute schizophrenic reactions, it follows that pastoral ministry has a place in the therapy of schizophrenia and other allied forms of mental illness, and conversely, the psychiatrist needs to take these religious factors into account in his attempts to treat mental patients. In the past this aspect of mental illness has been largely neglected. The reason for this neglect seems to be that neither the psychiatrist nor the minister, except in rarest instances, combines the necessary knowledge and outlook in the two aspects of mental illness. Richard E. Cabot, although he disagreed with Boisen's primary thesis concerning the functional nature of mental illness, did recognize the importance of his studies. In a letter to Boisen he wrote:

The doctors in contact with mental sufferers are trained as a rule to regard all religion as a delusion, harmless in the sane, dangerous to mental health in the insane. Hence the

patients in hospitals for mental diseases have practically no sympathetic consideration for their religious life and their religious struggles. No one studies how to make religion a blessing rather than a puzzle or a torment to the insane. Mr. Boisen prosecuting such studies is alone.¹

Thus, Boisen's pioneer studies in schizophrenia have resulted in a technically equipped ministry to the mentally ill as well as a technically equipped research into the nature of religious experience.² Indeed the importance of Boisen's work can properly be appreciated in the light of its end results: the institution of Protestant religious ministry in mental hospitals and the evolution of the clinical pastoral training movement. It is especially significant that Boisen has carried on his research in close association with some of the leading researchers and clinicians in the field of psychiatry. This collaborative effort has done much to bring about a better understanding and closer cooperation between psychiatrists and clergymen.

Those who are engaged in the work of ministering to sick souls have, as a general rule, approached the question either from a scientific or from a religious point of view. Rarely have these two methods of approach been emphasized...It is the genius of Dr. Boisen's book that he shows how these two methods of

¹. Quoted from a letter to Boisen, written on October 9, 1923.
². Coe, Rev., (1937), 146.
of approach can be used together. Psychiatry and religion can and must supplement each other if society is going to deal effectively with one of its most pressing problems.\(^1\)

These considerations, therefore, stress the importance of Boisen's studies, to a discussion of which we will now proceed.

2. Previous Studies of the Relationship of Mental Illness to Religious Experience

The beginnings of scientific investigation into the pathological aspects of religion or the religious aspects of the pathological, do not go much further back than the beginning of the twentieth century, or the close of the nineteenth. Previous to this, the main interest of the writers centered either in a speculative inquiry into the psychological origins of religious phenomena or in their outward manifestation in abnormal behaviour.

1. Psychology of Religion

Towards the close of the nineteenth century Leuba\(^2\) and Coe\(^3\) published brief studies which dealt with the psychological aspects of religious phenomena. The most complete investigation of this problem began with the publication of Starbuck's works.\(^4\) He tabulated the results of

1. Patterson, Rev., (1937), 146-147.
3. Coe, SL.
4. Starbuck, Art., (1897)\(^1\), 268-308; Art., (1897)\(^2\), 70-124; PR.
his inquiry and discovered two types of religious experience: one type of conversion experience represented cases of gradual and unbroken growth, a normal and relatively uneventful process of development; the other type represented a sudden and complete change in the direction of one's development, "an eruptive breaking up of evil habits and abnormal tastes by a turning of the life forces along new channels."¹ This more or less cataclysmic emotional upheaval represents "the healing of the breach between the present self and the ideal self which nature brings about not by lessening the conflict but by heightening it."² This eruptive type of conversion is preceded by a period of storm and stress, involving a sense of sin, a feeling of inner disharmony and a sense of isolation from God. Then comes the actual emotional crisis, followed by relaxation and a sense of peace. Some of Boisen's germinal ideas can be traced in Starbuck's works. But Starbuck failed to realize the full implications of his work and made no attempt to understand the pathological aspects of religious experience.

It does not occur to him that inner conflicts between the ideal and actual selves may have unhappy as well as happy solutions, and that the

1. Starbuck, PR, 158.
happy solutions which he is studying might be better understood if they were considered in the light of those unhappy solutions which we term psychoses and psychoneuroses.¹

William James elaborately described the process by which the "sick soul" achieves integration or conversion, using the biographies of religious persons as his source of data.² He confined himself to a consideration of the more radical type of religious experiences. Following his pragmatic point of view, he was more interested in the practical utility of a particular belief than in its origin, and agreed with Coe that

the ultimate test of religious values is nothing psychological, nothing definable in terms of how it happens, but something ethical, definable only in terms of what is attained."³

He saw in the abnormal or psychopathic conditions possible media for the perception of highest truths. "In the psychopathic temperament we have the emotionality which is the sine qua non of moral perception."⁴ In another place he says:

Insane conditions have this advantage, that they isolate special factors of the mental life, and enable us to inspect them unmasked by their more usual surroundings...Morbid impulses and imperative conceptions, 'fixed

¹. Boisen, EIW, 91
². James, VRE.
³. Coe, PR, 144.
⁴. James, VRE, 25.
ideas,' so called, have thrown a flood of light on the psychology of the normal will; and obsessions and delusions have performed the same service for that of the normal faculty of belief.\footnote{James, \textit{VRE}, 24.}

We thus see that Boisen draws from James in his view that an understanding of the pathological may furnish us with important clues for our approach to normal human behaviour. But, as we have already pointed out, Boisen goes a step further in that he studies the religious experience not only from the point of view of the abnormal but, conversely, the abnormal experience as seen in its religious implications.

Coe began his studies about the same time as Starbuck and his first book, \textit{The Spiritual Life}, appeared in 1900, in which he showed the relationship between temperament and types of religious experience. This was followed by his more comprehensive study, \textit{Psychology of Religion}, appearing in 1916. He showed that "the mechanism of striking religious transformations is the same as the mechanism of our automatic mental processes."\footnote{Coe, \textit{SL}, 128.} He further found that the persons experiencing conversion and the sensory and motor automatisms were of the "passive" or suggestible type, while those never undergoing these experiences were "spontaneous" or non-suggestible.\footnote{Coe, \textit{SL}, 132f.} The automatic mental processes which he
describes as automatisms, represent "ideas or thought processes which, after an unrecognized period of incubation, dart suddenly into consciousness and tend to be interpreted as of supernatural origin." He also established a correlation between radical conversions and hallucinations and motor automatisms. While viewing with disfavor the extreme forms of religious mysticism which are associated with certain forms of hysteria and delusional insanity, Coe asserts that the possession of positive religious nature implies, among other things, that nothing short of union with God can really bring a human being to himself. Coe's studies, therefore, help us to understand the psychological processes involved in religious experiences. However, he does not deal with the significance of these processes in abnormal human behavior and has confined himself to a mere description of certain abnormal phenomena associated with radical conversion experiences.

We may also refer here to Henri Delacroix's excellent book, Etudes d'Histoire et de Psychologie du Mysticisme. The author discusses the religious experiences of three outstanding mystics. He goes on to show how in the process

1. Coe, PR, 103.
2. Coe, ERM, 62.
3. See the Bibliography for further data.
of growth these individuals achieve unification of their personalities and through crisis experiences attain solutions to their problems. Thus these experiences have a certain teleological aspect, which Boisen also emphasizes in his interpretation of mental illness. James Bissett Pratt agrees with Delacroix in assigning constructive values to certain forms of mysticism; in fact, he defends the type of mysticism which stresses the feeling aspect of religion and makes room for emotional values. But he does not see much use for the extreme forms of mysticism, which, he believes, are "in part induced by the suggestions of a conventional theology and in part purely imaginative, existing in expression rather than experience." While Pratt does raise the important question of the role of theology in determining types of religious experience, he makes no effort to understand the meaning of its pathological manifestations. On the contrary, he seems to belittle the importance of the scientific investigations of religious experience made by his predecessors. Leuba's book, *Psychology of Religious Mysticism*, which appeared in 1925, is more relevant from the point of view of this inquiry. Leuba, in the main, agrees with Delacroix's conclusions and follows

1. Pratt, RC, 153f.
2. See the Bibliography for further information.
his method of inquiry. He sees certain constructive forces at work in crisis or mystical experiences, through which the individual is enabled to attain unification of his personality; the pathological features that may arise in this process are merely incidental and tend to diminish as the mystic reaches the goal of his seeking. But Leuba does not see any significant values in this mystical experience, from the standpoint of society, nor does he try to understand the meaning of their pathological manifestations. In an earlier book Leuba pointed out that the future of religion will be secure only when it is in accord with the accepted body of scientific knowledge, and is concerned with the creation of an ideal society.\(^1\) Mention must also be made, in this connection, of McDougall's works. He has pointed out the pathological character of certain forms of religious experience, in which there is an exaggeration of the instinct of self-abasement. He goes on to say:

In many cases of mental disorder the exaggerated influence of this instinct seems to determine the leading symptoms. The patient shrinks from the observation of his fellows, thinks himself a most wretched, useless, sinful creature, and, in many cases, he develops delusions of having performed various unworthy or even criminal actions; many such patients declare they are guilty of the unpardonable sin, although they attach

\(^1\) Leuba, PSR, 366.
no definite meaning to the phrase—that is to say, the patient's intellect endeavours to justify the persistent emotional state which has no cause in his relations to his fellow-men.

McDougall's astute observations, however, were not supported by any clinical studies of mental patients and he did not inquire into the meaning of these negative self feelings. Boisen's contention that mental patients who are afflicted with exaggerated feelings of guilt and blame show a much better prognosis than other types, will be an interesting point of inquiry in our study.

11. Psychiatric Studies

Turning our attention to the psychiatric literature, we note the important bearing of Freudian psychology on our present inquiry. In Freud's theory of the psychic causation of personality disorders Boisen finds support for his view of the functional nature of mental illness. The conflict theory of schizophrenia which Boisen propounds has its obvious roots in the Freudian concept of neurosis as representing a conflict between the instinctual desires or wishes and conscious purposes. Boisen states that "the theory of the wish as the key to the problem (of mental disorder) and of the conflict of wishes as explanations of functional type of

1. McDougall, SR, 68.
mental disorders, seems particularly important from the standpoint of religious worker...1 These ideas are usually associated with Freud, although Boisen traces them to Saint Paul "who recognized the law in his members which warred against the law which he had accepted as his own." Here we find an interesting point of departure from Freud. Freud held that a psychosis represents a conflict between the ego and the outer world, whereas neurosis results from a conflict between the ego and the super-ego.2 Boisen changes this order in his description of the psychosis of schizophrenia:

First of all it is to be noted that the schizophrenic is characteristically a "good boy." This means that he has accepted for himself the role of his parents or teachers. His "generalized other"—a term used by Mead3 years before the concept of the super-ego was invented—is the representative of organized society and he judges himself in accordance with its standards. In this he contrasts with the delinquent, who characteristically has not accepted the authority of his parents or teachers.4

In other words, in Freudian terminology, Boisen views a psychosis as representing a conflict between the ego and the super-ego, and delinquencies and anti-social patterns as resulting from conflict between the ego and the outside

2. Cf. Freud, CP, II.
3. Mead, MSS.
world. Boisen finds "erotic involvement" as a basic problem in pre-psychotic schizophrenic personality, and sees in repressed sexuality (Freud) rather than in repressed hostility (Karen Horney) a major cause of neurotic difficulties. Boisen quotes from Freud: "The idea of a coming end of the world, which appears in so many of our case histories during the stormy phases, is the projection of the inner catastrophe. The subjective world has gone to pieces..." In these words Boisen finds the first formulation of the view that in acute mental disturbances the ideas of death and world catastrophe are very prominent. Boisen's therapeutic formulations directly emanate from Freud's concepts of catharsis, emotional re-education and empathy. However, Freud's views of religion are in sharp conflict with Boisen's basic hypotheses which regard religious concern not only as a recurring phenomenon in acute functional disorders, but also as a meliorative factor in the process of recovery. Freud's aversion to religion is well-known. He regarded religion as a "really serious enemy" of science and as a collective or cultural neurosis which protects the individual from a personal neurosis. He regarded religion as an illusion opposed to external reality, as wishful thinking, and explained God

1. Boisen, EIW, 36-37.
3. Boisen, EIW, 103.
as an extension of the real father-figure. Freud's Moses and Monotheism\(^1\) is a good illustration of how he throws over-board his own scientific objectivity and critical approach in an attempt to fit the facts into the procrustean framework of his theories. Freud referred to himself as "religiously unmusical" and could not find an iota of religiosity in his own awareness. Yet we see that he early recognized the fact that so long as the traditional religions had exerted a dominating influence in the world, the psycho-neuroses of our time did not exist to any appreciable degree.

One important development in Freud's thinking was his discovery that it was necessary to make a place for conscience and religion, for he could not explain the behaviour of many of his patients in terms of his original concepts.\(^2\)

In 1923, therefore, he introduced the concept of the "super-ego" which he equated with conscience; he explained it as a product of parental influences, as something fixed and rigid, to be broken up or transcended in a mature personality.

The role which the superego undertakes later in life is at first played by an external power, by parental authority. The influence of the parents dominates the child by granting proofs of affection and by threats of punishment which to the child mean loss of love and which must be feared on their own account.\(^3\)

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1. See the Bibliography.
2. Cf. Freud, EI.
3. Freud, NIL, 89.
Later on, Freud goes on to say that through a process of introjection, the super-ego takes the place of the parental function and is responsible for all the irrational guilt feelings, compulsions and scruples of later life.¹ Some writers have tried to differentiate the super-ego from the ideals and conscience of later life.² But Boisen does not recognize this distinction, except in pathological cases. He follows Hocking in regarding conscience as an organized system of meanings and moral judgments that the child takes over from the group, particularly parents and early guides; it is, however, not something rigid or fixed, except in pathological conditions; it lies "on the growing edge of human nature."³ From this brief discussion of Freudian concepts it is sufficiently clear that Freud's insights in understanding the psychological processes and mechanisms in mental illness are most significant; and they have influenced Boisen's theories considerably. But Freud's views on religion⁴ have contributed nothing either in terms of insight or inspiration to Boisen's theory of the relationship of mental illness to religious experience. A therapist to whom religion is a gross illusion based on wishful thinking or one who regards

¹. Cf. Horney, NWP, 208ff.
². Alexander, PTP, 20 ff. In his later work Alexander doubts the validity of such a distinction, see FP, 82-84.
³. Hocking, MNR, 123ff.
⁴. See Zilborg, MMM, 313-314. The writer discusses the confusion between "psyche" and "seele" in which Freud was involved.
the God-idea merely as an exalted father-image transference
cannot have much sympathy with patients who are involved in
religious conflicts or concerned with religious values.¹

Jung has contributed much to Boisen’s thinking. In
centering his problem about the important role that a philo-
sophy of life plays in determining mental health Boisen
allies himself with the Jungian emphasis on Weltanschaunng
as synthesizing factor in psychic development.² While Jung
recognizes the fact that the ethically worthless religious-
ness may approach neurosis³, he nevertheless criticizes
the onesidedness of Freudian and Adlerian theories, in
ignoring the religious needs of the patient.⁴ He stresses
the importance of having a religious outlook on the part
of his patients.

Among all my patients in the second half of life
there has not been one whose problem in the last
resort, was not that of finding a religious outlook
on life. It is safe to say that every one of
them fell ill, because he had lost that which
the living religions of every age have given to
their followers, and none of them has been
really healed who did not regain his religious
outlook on life.⁵

He emphasized the integrative function of religion in

¹ Kluge, Art., (1942), 59-64.
² Wegroeki, Rev., (1938), 341
³ Jung, PU, 42-43.
⁴ Jung, MMS, 259.
⁵ Jung, MMS, 264.
health and illness. Jung was an eclectic psychologist and incorporated many psychologies in his analytical system. He maintained that the unconscious has its basis not only in the repressions of early childhood (Freud) but also in experiences before birth (Otto Rank\(^1\)), in conditioning (Alfred Adler\(^2\)), and in recapitulation (K. Groos\(^3\)). This he called "collective" or "racial unconscious." Mental disorders constitute a regression to this racial unconscious and psychotic behaviour and thinking can be explained in terms of this regression. Psychotherapy consists in helping the patient achieve a proper balance of integration between the personal and the collective.\(^6\) Elsewhere we have pointed out that Jung was the first to make a scientific study of the ideational content of schizophrenic thinking and to point out that schizophrenia represented a failure in emotional adjustments.\(^5\)

Boisen's view of mental illness has many points of contact with Adolf Meyer's psychobiology.\(^6\) This psychodynamic conception views mental disorders as dynamic patterns or types of reaction to life situations.

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1. Rank, ME.
2. Adler, SI; PN.
3. Groos, SM.
4. Jung, TEA.
5. Jung, PDP, 89.
6. Muncie, PP.
Mental disorder, according to this conception, represents a disturbance in the balance of forces which blend to form the personality reactions: it has to do with the abnormal or unhealthy ways in the instinctive-emotional life and the attitudes of the person rather than with a disorder of any special organs. In the mental patient, the facts of development, life experiences, habits, emotional attitudes and somatic disturbances will when completely revealed, account for the mental disorder and point the way for a constructive therapeutic handling.

Thus, according to the Meyerian approach, mental disorders, especially schizophrenia, are faulty habits of reaction which are determined by the external and internal factors related to the individual. Indeed Wegrocki points out that in viewing the schizophrenic break-down as an unsuccessful attempt at reorganization of the patient, Boisen seems but to be affirming what has already been said by others. But, strange as it may appear, in viewing his psychobiology as an approach which deals with the functions of the total personality, Meyer does not give any attention or importance to religious aspects of mental disorders. He does, however, emphasize the importance of the ideas and attitudes of the patient. White further helped to extend the scope of psychiatry and included within its domain not only a study of mental ills but all the social processes and situations

that bear on them. Sullivan has well summarized his contribution in the following words:

It was White's ineffable zeal in teaching us to 'determine what the patient is trying to do' his indomitable energy in training and in encouraging psychiatric investigators, and his vision and sagacity in the executive, administrative and promotional aspects of psychiatry in the broader sense, that gave us most of our profit from Freud and from Meyer... 2

Sullivan has elaborated on the views of Freud, Meyer and White, and has developed the psychiatric concepts into a well-knit theoretical system. He defines psychiatry as a study of interpersonal relations and personality as the hypothetical entity which accounts for interpersonal relations. Under the diagnostic syndromes of interpersonal relations he includes the psychopathic, the negativistic, the stammerer, the ambition-ridden, the inadequate, the homosexual, and the chronically adolescent. This reminds us of the different categories into which Boisen classifies his schizophrenic patients. Again, Boisen's view of the successive stages to the development of acute schizophrenia is more or less similar to Sullivan's description. According to Sullivan, there is a progression from the sudden

1. See White, OP.
3. Sullivan, MCP.
5. Sullivan, MCP, 38-42.
failure of a sublimatory process to an ecstatic absorption, panic, then finally to delusional or regressive activity.¹

Boisen gives the following stages: (1) a period of preparation or frustration, (2) period of narrowed attention, (3) an upsetting idea, (4) period of elaboration, and (5) schizophrenic reaction and malignant involvements.²

There are several other points which bear comparison such as Sullivan's description of different types of schizophrenia including world-disaster psychosis.³ Boisen's point of view is in consonance with the implications of Sullivan's theories. The latter, like Boisen, recognizes the non-organic, purposeive and constructive character of most of the schizophrenic episodes.

(Schizophrenia) is primarily a disorder of living, not of the organic substrate. The person concerned becomes schizophrenic as one episode in his career among others, for situational reasons, more or less abruptly... It may be that he finds a way of life such that the schizophrenic stands alone, only marking a turning point from which a not very changed career-line has proceeded successfully.⁴

As Boisen points out, Sullivan has also given attention to

2. Boisen, Art., (1947), 159-166.
the social factors and implications of mental illness; he has, however, never paid any serious attention to the religious implications of schizophrenic conflicts.

Hoch and MacCurdy in their book, *Benign Stupors,* have dealt with the ideas of birth, death, and world-disaster that characterize acutely disturbed patients. While certain rebirth fantasies, in their view, may be constructive, the benign stupors as a whole represent an escape mechanism and as such can hardly be constructive. They, however, emphasize the importance of these ideas to the patients themselves, and maintain that they must be taken into account in any therapeutic endeavor with such patients. In 1924 Alfred Storch published his important book, *The Primitive Archaic Forms of Inner Experiences and Thought in Schizophrenia,* in which he discussed the relationship between the experiences of schizophrenics and primitive peoples. Earlier Freud had emphasized the relationship between dreams and primitive thinking. In 1906 Jung, applying Freud's interpretation of dreams to schizophrenia, showed its closeness to dream activities. Bleuler, in 1911, made similar attempts. In 1918 Schilder's *Wahn und Erkenntnis* established similarities between schizophrenic thinking and primitive magical

1. See the Bibliography.
2. See the Bibliography.
beliefs. Storch has carried on these investigations a step further. He finds striking similarities between schizophrenic thinking and primitive motivation of thought and motor tendencies—such as conjuring by pantomime, identification with the cosmos, reincarnation, and primitive sexual symbolism.¹ Other similarities consist of thinking in complexes, undifferentiated volitional life, primitive magic self-exaltation, magic efforts at self-defense, objectifying parts of the personality as carriers of magic powers, the fear of touching connected with taboo, and taboo radiation.² An interesting section appears on the thinking in geniuses, suffering from schizophrenia.³ Then Storch describes the "stadium preceding the appearance of the fully developed psychotic behavior."⁴ First, there is an insane mood, an indefinite feeling of reference, a "panic of fear" without objective reference. Then comes the uncanny belief in the demoniacal domination of things, followed by a certain clarification in which the psychotic mood begins to condense about certain delusional ideas, the supernatural sphere assuming more circumscribed limits. A wealth of mythological forms enters in. This mythological stage finally makes way for a religious and speculative one, and there is more

1. Storch, PAF, 4.
2. Storch, PAF, 42.
extensive rationalization. These four stages are described in terms of a biographical account of Strinberg. Storch further shows how these processes correspond to the mental processes found, in general, in the development of religious cults. The book concludes with a consideration of the constellation of ideas associated with magic change of sex, mystic union, cosmic identification, rebirth, and catatonic stupor and mystic ecstatic self-brooding. Those ideas, Storch points out, are characteristic of schizophrenic as well as primitive beliefs.¹ The thing that strikes us as most significant is that this important work with ideas which seem so similar to Boisen's, finds no reference in the latter's writings, except in a brief notice in an article entitled "The Form and Content of Schizophrenia."² Of course, as in the case of other writers we have dealt with, Storch has no interest in the religious aspects in mental illness. He accepts the current organic view of mental illness and ends with saying:

The appearance of the magic-primitive thought structures in schizophrenia must naturally, in the last, have its foundation in the biological pathological processes; it must stand in close relation with the inner-somatic disturbance which is the cause of schizophrenia.³

1. Storch, PAF, 66-95.
In a series of lectures at the University of Copenhagen, Schou undertook to throw light on the relation between religious life and morbid mental states by going through the principal disease groups and showing the manner in which mental trouble affects the religious life of the individual. He studied the religious ideas of mental patients and concluded that each type of mental illness represented a distinct constellation of ideas. As to the reason for the prevalence of religious ideas in mental illness, he put forth the view that they can be attributed to the deeply imbedded primitive character of religious life. However, Schou looked for no constructive elements in the religious conflicts of the mentally ill; on the contrary, he found a close correspondence between radical conversions and diseased nervous states and warned the psychiatrist and the clergy alike to view with some scepticism all sudden conversions occurring after long periods of depression. He declares depression and conviction to be marks of a pathological condition, self-reproach being the predominant symptom of pathological melancholia. These views, as we shall see later, are opposed to Boisen's clinical findings. However, in so far as Schou stresses the need of closer

1. Schou, RMM.
2. Schou, RMM, 132-133.
cooperation between religion and psychiatry he is one with Boisen. We may in concluding make reference to similar investigations carried on by Charles Maofie Campbell¹, Schroeder², Bowman³, Farr and R. L. Rowe⁴.

3. Boisen's Methodological Assumptions

We have briefly considered the importance of Boisen's contribution both to psychiatry and religion, and have summarized the previous studies that bear on the problem of our inquiry. We now propose to discuss Boisen's fundamental hypotheses, his preliminary studies and his methodological assumptions.

1. The Primary Hypotheses

The essence of Boisen's theory of schizophrenia is that the acute schizophrenic reaction represents a desperate attempt at reorganization of personality in the face of overwhelming sense of personal failure and guilt. As such it must be distinguished from the malignant reactions of withdrawal and concealment. It is comparable to fever or inflammation in the body and closely related to certain types of religious experience. Such experiences:

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¹. Campbell, DB: DD.  
². Art., (1929)², 48.  
³. Art., (1929), 635.  
should not be looked upon as evils, but rather, at least in their initial, stormy phases, as desperate attempts at reorientation. They are thus manifestations of Nature's power to heal, analogous to fever or to inflammation in the body. Back of them lies a problem which needs to be solved, generally an intolerable sense of disharmony and of personal failure.¹

This, in brief, is Boisen's conflict theory of schizophrenia. Breaking it up into its component parts, we find the following propositions on which it is based:

(1) The stages in the development of acute schizophrenia are, according to this theory, similar to those of insightful thinking. Both involve intense preoccupation or "narrowed attention" and both are productive of new ideas and new insights which come as "inspired" or "given."

They have in common the period of preparation or frustration, the unpredicted insight which comes as 'inspired' or 'given', carrying authority because of the way in which it comes and producing a mood of exaltation and a sense of finality. In both there is the period of elaboration and criticism represented in the flood of new ideas and a consequent strain upon the critical faculties.²

In making this comparison Boisen has in mind Hutchinson's studies concerning the phenomenon of human insight.³ Hutchinson finds four stages in the process of insightful thinking: preparation, frustration, insight, and verification.

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We have also referred to Freida Fromm-Reichmann's contribution in this connection.\(^1\) We also find interesting parallels in J. F. Nisbet's study of "The Insanity of Genius"\(^2\) and Alfred Storch's study of schizophrenic thinking in geniuses.\(^3\) Coe\(^4\) and William James\(^5\) have described the phenomenon of "inspiration" or "automatism" in mystical experiences, in which after a period of preoccupation and sleeplessness, new ideas and thoughts come surging in upon the mind and are ascribed supernatural origin.

(2) The problem uppermost in the mind of the acutely disturbed patient is an intensely personal one and concerns his role in life. He is therefore peculiarly liable to the loss of perspective and balance. Unlike the normal creative thinking, the patient involved in an acute schizophrenic disturbance suffers a disorganization of personality due to the sudden impact of creative or intuitive forces that break in within him.

The main difference between the process of creative thinking, as Professor Hutchinson has described it, and the schizophrenic reaction is to be found in the intensely personal significance of the problem which is involved, in the profoundness of the emotion which is evoked, and in the loss of perspective and balance.\(^6\)

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1. Fromm-Reichman, Art., (1946), 293-357.
2. Quoted by James, VRE, 16f.
4. Coe, PR, 3, 284.
5. James, VRE, 478-483.
In acute schizophrenic disturbances, according to Boisen, the sufferer becomes seriously concerned with the problems of life, death and destiny; more specifically, he becomes acutely concerned about his own role and mission in the cosmos. ¹ Sullivan recognizes this intensely personal character of the ideas and beliefs of the schizophrenic patient and hence agrees with Adolf Meyer in assigning due importance to them. ² But, while Boisen regards this personal concern as involving religious values, Sullivan finds in it a mere preoccupation with questions of one's security. Alfred Storch accounts for the "profound inner resources" of the schizophrenic—which, he believes, are comparable to magic acts that arise in "the emotional factors and the primordial tendencies"—as defensive measures to preserve the ego. ³ Whatever may be the reason that prompt these desperate reactions in schizophrenics, there seems to be an intensely personal concern involved.

(3) The acute schizophrenic disturbance generally begins with a new idea which flashes into the patient's mind so vividly that it is interpreted as a manifestation of the superman.

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1. Boisen, EIW, 80.
2. Sullivan, MCF, 73f.
3. Storch, PAF, 52.
It begins generally with some manifestation of the subconscious processes which is interpreted as of supernatural or occult origin... Ideas and pictures flash into the mind as if from outside sources and constitute the "voices" and visions which loom so large in psychiatric examinations. Very commonly it is as though the conscious self had descended to some lower region where it is no longer in control but at the mercy of all the primitive and terrifying ideas and imagery which throng in upon it.¹

Storch describes this experience as an insane mood in which all things appear in an uncanny light, with a "panic of fear"; it has, however, a "germ of an objective value and significance, though without definiteness and clearness."² Such flashes of ideas, which Meyer has termed automatisms, are due to sudden "uprushing" in consciousness of latent energies drawn from "subliminal regions." They are

an explosion, into the fields of ordinary consciousness, of ideas elaborated outside of those fields in subliminal regions of the mind.³

In religious experiences as well as pathological conditions, William James believes, the doors to these subliminal or deep unconscious levels are widely open.⁴ He traces these experiences in the biographies of religious saints. Professors Coe and Leuba have shown the occurrence of such phenomena in mystical experiences and religious conversions of the "eruptive" type.

2. Storch, EAF, 61.
3. James, VRE, 234-235.
4. James, VRE, 478-484.
(4) The initial stages of schizophrenic outbreak are generally characterized by ideas of personal failure and guilt. When arrested at these initial stages the picture is one of depression or stupor. Frequently, however, the patient suddenly becomes aware of his unsuspected importance and then the picture is one of schizophrenic excitement.

The term "personal failure" is here used in the inclusive sense. It is intended to denote the sense of inner disharmony which extends from the "divine discontent" which is a pre-condition of effort and of growth to the loss of that which makes life worth living to the individual...In other words, it is the sense of moral failure and guilt which appears as the primary cause of difficulty in those cases which we have considered.

This negative self-feeling gives the patient an exaggerated notion of self-importance. He begins to feel that he has a great responsibility resting upon him and that his own personal failure has occasioned untold suffering to others.

Perhaps the entire world has been hanging in the balance, its fate dependent upon him—he has failed and it is about to be destroyed, but there may be a chance to save it. To do so he must sacrifice his own life. The readiness to make that sacrifice is commonly followed by a sense of identification with God or with Christ.

In the schizophrenic, says Storch, "the self becomes the world"

1. Boisen, EIW, 148f.
and this is shown in his behaviour, expansive gestures and his attitudes of pathos and long-suffering. This concentration of all values in the person's own self results, not from an infantile narcissism as the libido theory would have us believe, but from his perceptual mode of thinking, comparable to the primitive archaic ego-levels of thinking. But, whether there be an exaggeration of self or of its failures, there is a striking trend toward "vastness, immensity, endlessness, boundlessness."

(5) Other things being equal, the outcome of an acute schizophrenic reaction is likely to be constructive in so far as it represents an honest attempt on the part of the patient to grapple with his real difficulty. It is, however, likely to be unfavorable in so far as it is associated with the reactions of withdrawal and concealment and wishful thinking.

A sharp distinction must be drawn between those which represent the end results of malignant character tendencies, and the acute disturbances with their characteristic ideas of death, of cosmic catastrophe and cosmic identification. The latter...are to be regarded as attempts to break up the sets and attitudes which stand in the way of normal growth and functioning and to make possible a reorganization...In many cases

the acute disturbance serves to change a malignant formation into a benign reaction. The acute disturbances tend either to make or to break.¹

There is general agreement among psychiatric writers that the more sudden the onset and the more acute the disturbance, the more likely the patient is to recover. This we found true in the case of Clifford Beers. Recent researches carried on at the Elgin State Hospital corroborate the fact that in functionally psychotic patients prognosis depends primarily on the individual patient rather than upon either treatment with shock therapy or upon the type of therapy.² Of course, developmental factors prior to the breakdown must also be taken into account. The outlook is less favorable if exclusive and introvert tendencies were in evidence early and early adaptations were incomplete or unsatisfactory.³

Other writers make a distinction between "schizophreniform" reactions (schizophrenia) and "process" or "constitutional" dementia praecox, and find in the latter very little chance of recovery.⁴

(6) Religious concern is associated with schizophrenic reactions of the more constructive type. It represents an attempt at reorganization with reference to what for the

¹. Boisen, EIW, 55-66.
². Wittman and Steinberg, Art., (1944), 220.
⁴. Meyer, Art., (1921), 335. See also, Sullivan, MCP, 73 and Hoskins, ES, 72.
patient are the abiding values. Whether a particular attempt is or is not successful will depend upon the extent to which malignant reactions become dominant and upon the assets and liabilities in the patient's social situation. As Boisen says:

Pathological experiences are frequently attended by religious concern, and religious experiences of the dramatic type by pathological features. This is explained by the fact that both may be attempts to solve some vital and difficult problem. When the outcome is constructive, we are likely to recognize the religious value of the experience. When it is destructive or inconclusive, we call it "mental disease."

The outcome of an acute disturbance is dependent upon the assets and liabilities which the individual brings to the crisis experience and the nature and value of the insights which come to him will depend upon the problem with which he is grappling and upon his own previous preparation.

This association of religious concern with mental illness may be due to the fact that religion and insanity are both concerned with the "subliminal regions."

Pratt and Leuba saw no constructive values in mystical experiences of the pathological type. Storch found religious concern in his patients but attributed them to the "numinous primordial feelings" that characterize primitive thinking.

1. Boisen, RCC, 66.
2. James, VRE, 145, 431.
3. Storch, PAF, 63.
finds religion as a compensatory mechanism in neurotics.\textsuperscript{1} Schroeder views religion as neutralizer for delusional fear and guilt.\textsuperscript{2} Schou is sceptical of religious concern in morbid states,\textsuperscript{3} and explains it as an outburst of deeply imbedded primitive religious craving.\textsuperscript{4} Macfie Campbell assigns no particular significance to this concern in psychotics.\textsuperscript{5}

Boisen views acute schizophrenic reactions as representing failures in the realm of interpersonal relationships. These reactions involve concern with religion, because the latter represents personal loyalties and social values raised to the level of the cosmic and the universal. In the patient's idea of God

we see the symbol with which is associated the thought of those whom he counts most worthy of love and honor and which represents to him that in his social life which he feels to be abiding and universal. The idea of God thus represents to him that which is supreme in his hierarchy of loyalties. It represents the composite image of those whose fellowship and approval he seeks. He therefore judges himself by the standards which are imposed by his religion and associated with his idea of God.\textsuperscript{6}

Hence the primary evil in schizophrenia, according to Boisen's proposition, is a sense of isolation, consequent upon a

\begin{itemize}
  \item 1. Freud, CP, IV.
  \item 2. Art., (1929)\textsuperscript{2}, 373.
  \item 3. RMM, 62.
  \item 4. RMM, 132-133.
  \item 5. DB, 9.
  \item 6. Boisen, Art., (1932)\textsuperscript{1}, 51-63.
\end{itemize}
profound feeling of personal failure and guilt. The patient, having accepted the inherited loyalties and standards of his group, feels himself isolated from hisfellows, through a social judgment which he accepts and pronounces upon himself.\textsuperscript{1} From this self-condemnation arises an intolerable loss of self-respect, for he feels himself despicable in the eyes of those he loves.\textsuperscript{2} Furthermore, Boisen believes that crisis experiences, whether in illness or in health, are associated with religious concern. For crises force men to think and feel intensely regarding the things that matter most. They may thus bring about constructive changes both in personal life and social organization.\textsuperscript{3}

These then represent the fundamental hypotheses of Boisen, which we will elaborate upon in our discussion of his theory of schizophrenia.

\textbf{ii. Aims and Objectives}

After a period of intensive research in Boston Psychopathic Hospital in 1923, Boisen submitted a research project to the Institute for Social and Religious Research in New York. The project concerned a study of religious factors in certain types of mental illness\textsuperscript{4}, and was highly recommended and its importance emphasized by such eminent figures as

\begin{itemize}
\item \textsuperscript{1} Boisen, EIW, l4\textsuperscript{4}f.
\item \textsuperscript{2} Boisen, EIW, l49.
\item \textsuperscript{3} Boisen, RCC, \Ufour.
\item \textsuperscript{4} Boisen, PSC
\end{itemize}

The project called for an intensive psychiatrically supervised study of the religious aspects of mental illness, designed to test the following theory:

Mental disorders of the functional group and religious conversion experiences, may arise from a common situation, a conflict between opposing tendencies within the personality. The one represents a happy solution and the other an unhappy solution or perhaps no solution at all but a condition of unstable equilibrium with the issue still on the balance.¹

The project was supported with a study of five outstanding religious geniuses and seventeen mental patients. It was found that the cases studied represented some common characteristics: a sense of guilt, inferiority or failure; conflicting tendencies within personality; introversion; narrowing of attention; automatisms; a broken-up world within and religious concern as deterrent to regressive or degenerative tendencies. Valid religious experiences were characterized by the predominance of volitional, progressive and unifying tendencies; on the other hand, acute schizophrenic reactions involving malignant features, showed definite elements of constraint, regression and

¹. Boisen, PSC, 1.
progressive degeneration.

After twenty-five years of continuous study and research in religious factors in mental illness, Boisen's theory of schizophrenia, in its essential features, differs very little from his original formulations. It has undergone constant revision, modification and extension but its basic assumptions remain unchanged. The aims and objectives, which prompted Boisen's original inquiry found their culmination in the founding of the Council for Clinical Training of Theological Students in 1930.

Boisen initiated his inquiry with a view to test the validity of the hypothesis that took shape in his mind while he was still a patient in a mental hospital. It began as an intense personal problem and concerned the relationship of mental illness to religious experience—phenomena which be found strangely compounded together within the context of his own single individual experience. If mental disorder of the functional type is essentially a religious problem, then it logically follows that the former cannot be understood from the psychiatric standpoint alone. Furthermore, only as mental disorders and religious experiences are studied the one in the light of the other will it be possible to understand and to deal intelligently with either one. This was the basic problem that started Boisen on his extensive program of research.
If religious concern is associated with the functional mental disturbances, especially those that center around a sense of personal failure or guilt, it follows that religious factors must be taken into account in the therapy of such patients. Psychiatrists often fail to recognize these factors and thus fail to help those patients whose trouble is primarily mental or spiritual. The religious worker, on the other hand, has usually very little understanding of the religious significance of mental illness; he attempts treatment without diagnosis and applies to all the same traditional formulae. The result is that mental patients, involved in religious issues and conflicts, find no help either in psychiatry or in religion.

Boisen has always stood for a psychiatric approach to religion and for recognition by psychiatry of the religious aspects of mental disorders. He has sought to test the effectiveness of religious therapy for mental patients in modifying their fears and anxieties and in providing them motives which would make life worth living. It has, however, been made plain by him that his program does not constitute experiments in "healing," or establishment of new institutions. He has always insisted upon the need of working in close association with medical men and re-inforcing their efforts by supplying such insight and life-giving resources which organized religion has in its keeping.1 Through the

1. Boisen, EIW, 2.
organized religious agencies Boisen has tried to seek more effective means for the Christian solution of these conflicts which make for mental illness.

In brief, Boisen's initial research and subsequent studies have included the following objectives: (a) To explore the inter-relationship between mental illness and religious experience; (b) to discover the spiritual forces operative in mental illness and to formulate the laws of the spiritual life; (c) to arouse an intelligent interest among the churches in the nature and causes of mental illness and to enlist their support in its prevention; (d) to impress upon the medical men the importance of religious aspects of mental illness and their therapeutic implications; and (e) to train a psychiatrically oriented religious ministry in mental, general and correctional institutions.

The aims of the clinical pastoral movement, of which Boisen is the acknowledged founder, have well summarized in a recent catalog:

(1) To enable the student to gain a clear understanding of the sick and distressed, their deeper motivations and problems, their emotional and spiritual conflicts, their infirmities and strengths; (2) to help the student develop adequate methods of working with troubled people, and a working concept of his limitations as a clergyman with regard to all conditions of men and (3) to help the student to learn how to work cooperatively with the representatives
of other professional groups and community agencies toward the prevention and alleviation of human ills.1

iii. Methods of Research

Boisen's research studies in schizophrenia are based upon the assumption that in mental illness we are dealing with the results of Nature's own experiments in the laboratory of life and that these experiments must be recognized and evaluated.2 He also assumes that the realm of values, motives and meanings contains the key to an understanding of human nature and is as such a legitimate subject of scientific inquiry. He enumerates the scientific principles and procedures which are pertinent to his inquiry.3

(1). Scientific Principles

The data of experience, Boisen believes, are explainable in terms of certain scientific principles: Empiricism implies that the raw material of experience is the primary source of scientific investigation; objectivity requires that personal equation and bias be eliminated from scientific inquiry and reliance be placed on objective tests rather than upon persuasion or argument; continuity attempts to explain new phenomena in terms of previous observation

2. Boisen, PSR, 2.
3. Boisen, EIW, 181-192; Dewey, EN, 19ff; Burtt, PRT.
and generalization; new explanations are accepted only in terms of tested and ordered experience. In stressing this principle Boisen makes it clear that it does not mean scientific determinism. "A methodological principle must not be confused with a philosophical proposition."¹

The reciprocal principles of particularity and universality require that while the field of inquiry must be limited and specified, it must be related to the larger whole, for all scientific endeavor is concerned with the discovery of relationships that are universally valid.²

The principle of provisionality recognizes the fact that scientific findings are tentative and subject to revision or modification in the light of new knowledge. The law of economy is well expressed in the words of the old scholastic law, "Neither more nor more onerous causes must be assumed than are necessary to account for the phenomenon." Scientific disinterestedness requires that honesty, accuracy and objectivity must be the guiding principles in science—the desire to find truth must be supreme. Boisen recognizes the difficulty in applying these principles to the study of human nature. But, he argues that our methodologies must be

¹. Boisen, EIW, 185.
². Boisen, EIW, 184.
determined by the material with which we are dealing. The humanistic scientists who use the methodology of exact science in dealing with human personality are like "surveyors whose assignment calls for the use of compass and pacing, but who give their measurements in tenths of inches."\(^1\) Boisen believes that the methods of dynamic and organismic psychologies that deal with man as a whole are in the right direction.

(2). Scientific Procedure

The methods on which science relies to test its hypotheses may be grouped as follows: (a) Controlled experimentation which is designed to measure the influence of a given variable by excluding all external stimuli so as to determine the exact functional relationship; (b) naturalistic observation which involves an exact description with explanation in terms of relationship; and (c) statistical procedures designed to evaluate variables where controlled experimentation is not possible. In the study of human personality, as Boisen points out, the method of controlled experimentation is not possible because of the extreme complexity of human nature and the difficulty of isolating the variables. It is also difficult to tamper with living men or institutions as we would with other objects or

\(^1\) Boisen, EIW, 190.
animals under controlled observation. The only available method is that of naturalistic observation with statistical control. Statistical methods are used to verify suggested explanations that are gained through intensive study of particular cases or situations. Since this is the only method available, under the circumstance, great care and attention is called for in making and recording observations. In pursuing his inquiries Boisen has developed and followed three types of records: ward observations, interviews with patients and case studies.

(i). Ward Observations

The "ward observation" is a brief description of the behaviour and ideation of the patient over a period of time. This does not include any interview with the patient other than casual conversations, arising out of friendly relationships. Boisen has developed a very useful form for recording ward observations.1 It includes six types of observation: (a) Mood—whether placid, complacent, cheerful, euphoric, facetious, suspicious, irritable, sad, perplexed, indifferent, stuporous, etc.; (b) social attitude—cooperative, amiable, submissive, friendly, antagonistic, selfish, seclusive, self-pitying, etc.; (c) work period—general attitudes, efficiency,

1. See Appendix A.
skill, steadiness, interest, and so on; (d) leisure period—social intercourse, reading, writing, games, supervised play, revery; (e) response to specific situations—church, visitors, reprimands, withdrawals of privilege, etc.; (f) significant behaviour and utterances.

(ii). Interviews

Apart from their therapeutic uses which we shall discuss later on, Boisen has used personal interviews with schizophrenic patients for collecting information concerning their ideas, beliefs and interests. In general, his interviewing techniques are identical with those of Annette Garrett\(^1\) and Russell Dicks.\(^2\) But he does not believe in methods or techniques as such and maintains that psychotherapy is a matter of personal relationship.\(^3\) The focal point of his interest is the ideation of the patient, his thoughts and feelings rather than just his spoken words. Any method or technique that serves to throw light on the patient's ideation has a place in interviewing. Interviews with patients are often conducted through a series of detailed questions designed to bring out the ideational content. Verbatim or "proces" records of these interviews are made, representing accurate transcripts of what was said and done; each record

1. Garrett, IPM.
2. Dicks, PWP.
contains a graphic and interpretative summary of the interview. An example of such an interview is found in the appendix.1

(iii). Case Records

The case study is a basic method in Boisen's investigations in schizophrenia.

The case record is an attempt to assemble in orderly fashion all the significant information regarding a particular person. As such it constitutes the primary unit in any study of the personality and its disorders.2

Mental illness, he believes, represents to a large extent a failure in interpersonal relationships; the sufferer is in some way out of adjustment with the social group to which he belongs.

Our task is to determine the exact nature of this maladjustment and the factors which have determined it. Any decision or voluntary act, even the simplest, may be looked upon as a problem whose explanation is to be found in an intricate chain of cause and effect involving the personality in its totality. In the case of those difficulties known as mental disorders we are dealing with a complex set of peculiar beliefs and attitudes which involve the fundamental orientations and drives of the individual and the organized values of his group.3

Hence the importance of the case study method. As distinguished from social work or psychiatric case work methods,

1. See Appendix B.
Boisen's studies involve a careful study of the life history of the patient with special reference to his idea of himself and the external and internal frustration he has encountered, his habitual ways of dealing with frustration, and the reaction patterns as revealed in his present disturbance. The plan also calls for a follow-up over an extended period in order to determine the consequences which result from the various reaction patterns.

The case record, as Boisen has elaborated upon it,\textsuperscript{1} includes the following important items: social and religious background; personal history; sex adjustments; vocational adjustments; physical condition and health; characteristics of the disorder; religious attitude and orientation; diagnostic summary which includes life situation, reaction patterns, personality organization, clinical label, prognosis and plan of treatment.

(iv). Statistical Methods

Boisen's statistical methods may be explained by a reference to his first important work, \textit{The Exploration of the Inner World}, which appeared in 1936. In his subsequent writings he has consistently followed the same methods. In this book his basic findings are found in the study of 173 cases--a part of the Neuro-endocrine Research in schizophrenia carried on at the Worcester State Hospital, under

\textsuperscript{1} See Appendix C.
the direction of R. G. Hoskins. The results of this collaborative effort are summarized in Hoskins' *Biology of Schizophrenia*. The findings on which Boisen's conclusions are based are represented in the five charts included in the first chapter of his book.\(^1\) It will be noticed that Boisen's basic study in its methodology is similar to that of Starbuck in his *Psychology of Religion*. He does not indeed make use of the questionnaire and has fewer tables, but the study follows somewhat the same methodology.

However, Boisen does not follow the customary methods of presenting statistical findings, for he feels that in dealing with human beings as objects of inquiry, a different method has to be used. In following his plan Boisen has drawn from his forestry experience.

In estimating the present or the future value of a stand of timber, a well-known method is that of the sample plot. The surveyor first makes a careful reconnaissance of the tract and maps in the forest types. Then on the basis of inspection he selects a few sample plots of perhaps a half acre in size. He then measures up each tree within this plot, calculates the mean and on the basis of this calculation selects a sample tree. This tree is then cut down and its volume and rate of growth determined.\(^2\)

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1. Boisen, EIW, 32, 38, 41, 44, 52.
2. Quoted from a personal letter of Boisen's to Professor Aubrey, written on January 4, 1937.
Following this analogy, Boisen selects his sample cases on the basis of his findings (the cases of Albert W. and George Fox, for example). The use of the sample case serves as a base line from which measurements may be taken. This device gives life and meaning to the figures and in this way there is less danger of losing sight of human value. It may be noticed that Boisen uses the term "sample" or average in the same sense as "representative," or "type." His study of the 173 cases had shown that certain ideas tended to occur together. Mental disorders characterized by a sudden onset and frequently constructive outcome had a peculiar constellation of ideas in common. He, therefore, selected for his representative case one which would exemplify the tendencies revealed by his statistical study—one in which all these ideas would occur and which would further be characterized by a sudden onset and a clear attempt at reorganization. In other words, he was looking for types rather than averages. Boisen has followed this procedure in most of his research studies. For these reasons he has used the case of Albert W. for his analytical studies. He says:

Our first task will involve the use of statistics. It requires the checking of hypothesis derived first of all from my own experience and then from intensive work with certain other cases against this group of 173 cases. This I propose to do in the light of a particular experience which may be used as a sort of base line from which our
measurements may be taken. In this way there will be less danger that we lose sight of human values. We shall also be less likely to become confused as to what we are talking about, for concrete experience can to a large extent serve as substitute for an exactness of definition not yet warranted by the adequacy of knowledge.\(^1\)

**(v). Neuro-endocrine Research at Worcester**

Since Boisen’s major findings in schizophrenia as embodied in his first important work have come out as a result of his collaboration in the Neuro-endocrine Research at Worcester, some reference must be made to it. This project, which began back in 1928 at the Worcester State Hospital, represents one of the most comprehensive studies of the psychosomatic aspects of schizophrenia. It was carried on under the direction of Dr. R. G. Hoskins, Director of the Memorial Foundation for Neuro-endocrine Research. The results of these investigations are embodied in Hoskins’ *Biology of Schizophrenia* which was published in 1946. Boisen collaborated in these investigations and his findings are embodied in this book.\(^2\) Boisen was given the task of investigating the subjective aspects of schizophrenia with special emphasis on ideation and behaviour. Concerning this project he says:

> While concerned primarily with the physiological factors they (Dr. Hoskins and his

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2. Hoskins, BS, 82-89.
associates) have sought to approach the problem from all possible angles and have recognized that whatever the organic basis of dementia praecox may be it is to the sufferer himself primarily an experience.¹

The 173 cases on which Boisen's initial research is based, have been taken, for the most part, serially from the research group, and thus the possibility of any selective bias has been eliminated. The majority of patients selected for the research project have represented males of less than forty years of age, having no complicating gross organic symptoms. More than one third of the cases have been in the hospital for a considerable time and thus represent a large number of the chronic type. This experimental group of patients were placed on special wards, under the supervision of selected staff of nurses and attendants. They were treated with glandular medication over a long period of time and were provided with special psychiatric attention and with other kinds of therapies. Provision for individual conferences with the patients and for group conferences with selected cases was also made. A system of classification was carefully worked out and explained to the patients and at frequent intervals their names and ratings were posted. In other words, every effort was made

¹ Boisen, EIW, 16.
to stimulate pride, to foster self-respect, to provide incentives and to give recognition to each forward step. And these efforts have in some instances been continued for more than four years.¹

Thus Boisen's basic findings have grown as a result of intensive study of the ideation and behaviour of these 173 schizophrenic patients who were at the same time the subjects of exhaustive studies by other psychiatrists and medical men; while the latter studied them from the biological standpoint, Boisen studied them from the experiential angle. In subsequent years of continued study and research he has verified and tested his basic hypotheses in terms of hundreds of case studies of schizophrenia and the results of his work have appeared in several journals of psychiatry and sociology.

(vi). Summary

We have thus far concerned ourselves with some peripheral considerations relating to Boisen's inquiry. We have tried to see its importance in the context of the studies that have preceded Boisen's own research. Several investigators, as we have indicated, have given attention to the problem of mental illness and its religious aspects. But the most comprehensive work dealing with the subjective aspects

¹. Boisen, EIW, 16.
of schizophrenia has been done by Boisen. We have considered in detail his primary hypotheses and methodological assumptions. The essence of his theory is that acute schizophrenic reactions are best explained as desperate attempts at reorganization of personality in the face of an overwhelming sense of personal failure and guilt. Religious concern is associated with schizophrenic reactions of the more constructive type and as such it should be sharply distinguished from the malignant reactions of concealment and withdrawal. Boisen initiated his investigations with a view to testing the validity and implications of his hypothesis and to launch a program of clinical pastoral training in the service of the mentally ill. In his investigations he has closely followed the scientific principles of objectivity and experimentation, and has made statistical use of data gathered through ward observation, interview and the case study method. He has carried on his research in collaboration with medical and psychiatric staffs. In the next chapter we propose to make a detailed study of Boisen's theory of schizophrenia, concluding with an evaluation of its main features.

1. Hoskins, BS, 83.
CHAPTER V

BOISEN'S STUDIES IN SCHIZOPHRENIA (CONTINUED)

The unique feature of Boisen's theory lies in the fact that he sees in mental illness not only nature's attempt at reorganization of personality but also, in its cataclysmic experiences, a reflection of the same struggles that arise in certain types of religious experience. This view at once gives importance and meaning to the experiential aspects of schizophrenia and thus makes "sense out of nonsense" of delusional beliefs and ideas. In viewing schizophrenia as a break in social relationships, and in finding its primary evil in a sense of isolation and failure, Boisen brings it within the matrix of our social values and experiences. Let us begin with a consideration of Boisen's sociodynamic approach to schizophrenia.

1. Sociodynamics of Schizophrenia

Boisen's theory of schizophrenia is rooted in sociology. He views schizophrenia as primarily a failure in interpersonal relationships. The sense of isolation, consequent upon a loss of self-respect, is a primary evil in this disorder and is best explained as resulting from maladjustments in the sphere of social relationships. This view thus raises important questions concerning the interpersonal aspects of schizophrenia.
Boisen agrees with George Mead\(^1\) in regarding man as essentially a social being and part of a social organism, though he is careful to stress the unique features of personality. In his view personality is the "total make-up of the individual with special reference to the distinctive features, as contrasted with those that are common to the group."\(^2\) It represents an integration of temperamental and intellectual traits as well as beliefs and attitudes. It grows and develops through the incorporation of new experiences into an existing organization. Boisen thus recognizes the importance of the unique and dynamic qualities of personality and the role of environmental influences playing upon it.

Personality grows through introception of new experiences into an existing organization. This presupposes the existence of an original framework around which the personality organizes and extends itself. Man seems to be born with a biological equipment and a vast set of potentialities.

We may think of original nature as a sort of heredity-determined framework, a personality skeleton on which environment may put on the flesh in a variety of different forms or contours. The framework material must not be regarded as analogous to the steel used in an

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2. Boisen, EIW, 302.
office building, for that would be too rigid and would fix the shape of the personality structure unduly...Original nature does supply form to personality, but only in a most general way.¹

The original framework consists of simple reflexes, activity drives, goal-seeking propensities, and native aptitudes or capacities. The interaction of these native tendencies and physical environment, in the context of interpersonal relationships, largely determines the formation of personality.

In emphasizing the social nature of personality, Boisen closely follows the viewpoint of George Mead and the Chicago School of Social Psychology. According to this view all animate life is essentially social. In the evolution of social tendencies two distinct forms of social organization have come into being. One of these is represented in the ant hill and in the bee hive. Here social organization is based upon physiological plasticity and differentiation which determine the types of individuals and their respective social functions. In man the basis of social organization is found in the principle of intelligent cooperation, not physiological differentiation, except in the realm of sex.²

The theory of "symbolic interactionism" finds in the use of language the distinctive basis of human personality and

¹ Sutherland and Woodward, IS, 172.
² Boisen, EIW, 151f.
human social organization. Language represents a system of symbols used in transmitting feelings or ideas to others. However, all transmission of ideas or feelings does not depend upon the use of language. Animals express themselves through cries, grunts or postures--something akin to certain forms of primitive or infantile expression. In the course of evolution other forms of communication come into being: manual gestures, facial expressions and motor activities. In man these symbolic gestures gradually give place or are subordinated to the use of language symbols. The use of language is first learned through imitation and mimicry and later by instruction and conscious effort.

Social interaction is the basic process through which human nature and society develop and are changed. The process can take place only when the contacts between people are social. Contacts are social only when ideas are communicated between persons by the use of symbols. Symbols constitute the medium for communication by virtue of the fact that they are social products. They are summaries of past experiences which provide the basis for a common understanding of present situations.  

Thus, by means of language human beings communicate with one another and respond to common social symbols, which connote meanings and feelings they share in common. There can be no

2. Sutherland and Woodward, 15, 636.
sharing of experience or communication of ideas unless members of human society employ gestures and symbols whose meaning they understand in common. The human personality is thus a product of social responses and symbolic interactionism. It is the internalization within the individual of the group organization by means of language symbols.¹

...When he converses with another, he converses also with himself. He also reflects and thus acts retrospectively. In this way he is able to build up within himself an inner organization, a conscience, by which his conduct may be determined not by outward compulsion but by inner self direction...In man there is no such physiological control. Instead we find among all known races of men certain mores and the internalization of these in the form of conscience.²

Thus according to Boisen's view (in which he follows the social psychologist, George Mead) personality represents an integration of self in terms of the internalization in the individual of the organized attitudes of others. It is then a reflection of the culture in which the individual lives and has his being. In the development of personality there is a constant interaction between social attitudes of organized society, which one himself accepts, and the particular role which he assumes as his own. In other words, self-attitudes develop from social attitudes. The child

¹ Boisen, RCG, 10.
begins with "taking the role of the other," first with his parents and then in the identifications of early childhood and adolescence. Finally, he takes the role of a "generalized other" which represents the organized social attitudes of the culture in which he lives. This view of Boisen's comes very close to Sullivan's concept of self as composed of the "reflected appraisals" of others.¹

In the development of personality, apart from the role of the internalized social attitudes or the "generalized other," the particular role that one has assumed for himself plays an important part. One's idea of one's self is the nucleus of personality. Everyone is interested in things which relate to himself and to the body of experience built around his concept of himself. The personality grows and enlarges through assimilation of new experiences. This process of assimilation is facilitated by the discovery of relationships between the already existing organized body of experience and the new experiences. Through the use of language these relationships are clearly recognized and understood. But, since language itself is a product of social interaction, any new experience has to be fitted into the fabric of social structure. This involves relationships to

1. Sullivan, MCP, 10.
the judgment of others, particularly of those whose authority we accept and upon whom we are dependent for love and protection.  

Conduct is thus determined by self-criticism which is at the same time social criticism and the system of values is dependent upon and a function of the social relationships.  

Growth is however not only a process of assimilation by the use of language and discovery of relationships between internalized experience and organized social attitudes. Beyond the realm of words and language symbols, lies the realm of feeling and intuition—the "subliminal region" of William James and "the unconscious" of Freud. This is the realm which is chiefly involved in mental illness. William James also regards this realm as one chiefly involved in religion.  

The best account of this realm, according to Boisen, comes from John Dewey:

Meanings do not come into being without language, and language implies two selves in a conjoint undertaking...Mind denotes the whole system of meanings...The field of mind is enormously wider than that of consciousness. Mind is contextual and persistent; consciousness is focal and transitory. Mind is a constant background and foreground; consciousness is a process, a series of heres and nows. Mind is a constant luminosity; consciousness is intermittent, a series of flashes of varying intensity...One great

1. Boisen, RCC, 11.
3. VRE, 431.
mistake in the orthodox psychological tradition is its exclusive preoccupation with sharp focalization to the neglect of the vague shading off from the foci into a field of increasing dimness...This larger system of meanings is present in every conscious experience...Consciousness is that phase of a system of meanings that at a given time is undergoing re-direction. It is the meaning of events in the course of remaking.¹

Dewey's concept of the "unconscious" differs from the Freudians in two respects: it recognizes the complexity of human mind and sees in consciousness an active and constant participant in experiences which Freudians assign to the "subconscious." This formulation further recognizes the importance of meanings in the organization of personality and we thus see the need of a psychology of mental illness which is based upon personal experience. Attempts to explain mental disorders in physiological or even psychosomatic terms have largely failed, and there are some who have even begun to speak of the "corporealization of the psyche."² Personality therefore represents a delicate and complex system of meanings whose organization is dependent on language, and consciousness is the discovery of new relationships and their assimilation into organized experience.

¹. Dewey, EN, 298-311
Attention is thus like a search-light playing over the vast field of experience and focusing on that which is in process of assimilation. Thus assimilated, or fitted into the organization of the self a new experience will sink gradually into the background, there to function automatically, or else to lie dormant until it is called forth by some appropriate stimulus.1

Personality disturbances set in when new experiences which are vital to one's standing in one's own eye are not socialized and assimilated. This inability to assimilate new experience and bring it into harmony with social standards and requirements, according to Boisen, is the primary factor in mental disorders of the functional type.2 This failure to measure up to the social expectations and standards which one has accepted as his own brings about a loss of self-respect and a sense of isolation and guilt.

The mentally disordered individual is one who, by standards which he has accepted as his own, stands condemned to such an extent that he is unable to bring himself before the inner bar of judgment. He cannot bear the thought that those whom he counts supremely worthy of love and honor should know him as he is. He thus becomes isolated from those with whom he is seeking identification and whose approval he wants. His battle is being fought out within.3

On the other hand, as Boisen points out, the delinquent or criminal confronts no such inner conflicts for, having

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1. Boisen, RCC, 287; See also EIW, 151.
2. Boisen, Art., (1928)1, 555-567.
rejected the authority of his parents and teachers, he finds his moral support and social approval in some gang with ideals and codes of its own. He therefore suffers neither from a sense of isolation and shame nor from any loss of self-respect. He finds the solution of his conflicts by socializing them with a lowered conscience threshold and comforting himself by the thought that he is no worse than his neighbor. On the contrary, the schizophrenic accepts for himself the primary loyalty to his early guides but he fails to achieve an integration on the basis of the role he has accepted for himself. There is a constant conflict between his level of achievement and his level of aspiration, as represented by the social requirements and standards of the group to which he belongs. There is likewise an intolerable sense of disharmony within, due usually to the pressure of certain instinctual tendencies which one is unable to control or acknowledge, for fear of condemnation.1 This fragmentation, Boisen says, is explained by the discouragement, withdrawal and loss of self-confidence which characterize the schizophrenic.

It is obvious that Boisen is more or less in agreement with Freudian psychology in seeing in the early experiences

of childhood the determinants of ego ideals and conscience of later life. The parents and early guides implant in the child ideals and standards "from which there is no escape except through growth into a larger loyalty and a more comprehensive understanding." He recognizes no distinction between the superego and conscience (as some psychoanalysts have tried to do) except in pathological conditions. He agrees with Hocking in regarding conscience as an awareness of success or failure in maintaining one's status and one's growth, and finds its origin in the organized system of meanings and moral judgments taken over from the group. The social structure of human society does not permit the evasion of primary loyalties, but it does allow their incorporation into a system of loyalties raised to the level of the cosmic and the universal. In psychoanalytic terminology this process would be described as the integration of the superego into the ego.

The schizophrenic disturbance can be explained not only in terms of a "divided self" but also by the altered concept of the "generalized other." Some alteration in

1. Boisen, Art., (1932) 1, 56.
2. Cf. Alexander, FP, 82-83.
the concept of self is implied in the very nature of the schizophrenic's problem.

It is that of his success or failure in the drama of life. At the beginning there is generally an overwhelming sense that something is wrong within. The consequent sense of personal failure may proceed in two directions. There may be a greatly exalted self-estimate...It is then an experience of the mystical variety. On the other hand, there may be marked self-depreciation. 1

Whatever may be the direction of the schizophrenic's thinking, any disruption of the accepted concept of one's role in life, Boisen argues, is a major factor in the causation of the disturbance. One's idea of one's self, as we have seen, is the most important part of one's personality; any sudden change in this concept of self is therefore bound to bring about a thoroughgoing reorganization of personality.

The enlarged concept of the self is one of the eternally valid insights of religion. So also is its recognition of the individual's insignificance. It is characteristic of religion that it extends the horizon in both directions. Religion rejoices both in the microscope and in the telescope. Our patient's fantastic idea of himself is thus not without an element of truth. 2

The religious concern, which is often associated with schizophrenic disturbances, explains the social origin of religion.

and can only be understood as an attempt on the part of mental sufferers to find social support and relief from the sense of isolation in elevating their individual selves to the level of that which is universal and abiding in human society. Thus we see that in Boisen's thinking, schizophrenia represents at once a break in interpersonal relationships and a desperate attempt to reorganize them in terms of larger loyalties and more abiding values in life. This is what we have called the sociodynamics of schizophrenia.

2. Causative Factors

We have briefly summarized some of the sociological concepts underlying Boisen's theory of schizophrenia. Boisen regards the acute schizophrenic reaction as a desperate attempt at reorganization in the face of an overwhelming sense of personal failure and guilt. The problem uppermost in the mind of the acutely disturbed patient is an intensely personal one, that of his own role in life. The basic evil in this disturbance is a sense of isolation. Having accepted the ideals and standards of his group as his own, he finds himself continually failing to measure up to them. This conflict is further intensified by the presence within him of certain disowned tendencies and cravings which he can neither control nor acknowledge for fear of condemnation. The extremes of elation and depression
to which he becomes subject, and the ideas of cosmic importance that invade his thinking are desperate attempts to find his meaning and place in life. Basically the problem represents a failure in social relationships. It is a failure to socialize and thus to assimilate new experiences and to bring them into harmony with the social standards and requirements which one has accepted as his own. In this section we propose to discuss some of the causative and situational factors that cause, or rather aggravate, this conflict between accepted ideals and instinctual cravings or natural limitations of self. What is Boisen's conception of the personality behind schizophrenia? Our study will of course be limited by the data that we can find in his writings.

1. The Psychogenic Approach

Boisen, as will be obvious, accepts the psychogenic interpretation of schizophrenia.1 This is based on his own personal experience and observation, as well as on the view of certain psychiatric experts and clinicians. In his own case, as he tells us, there was no organic basis for his mental illness. His difficulty was primarily rooted in a severe inner struggle.

I had just been trying to work out a difficult problem which involved intense and concentrated thought and a strong emotional tone when I suddenly found myself carried off into an abnormal mental condition in which I became terrified and bewildered. ¹

He was led to the same conclusion, as he observed his fellow patients. Excepting some cases of general paresis, post-encephalitis and cerebral arteriosclerosis he observed that most of them were physically well. ² While recognizing the organic basis of many mental troubles, he was thus led to accept, in the main, Freud's interpretation of personality disturbances. Richard C. Cabot rejected the psychogenic view of psychoses and strongly disagreed with the central thesis of Boisen's hypothesis. In a letter to Boisen he wrote:

> Whenever you can find a single psychiatrist of any standing who agrees with your views regarding the nature and causation of dementia praecox, I will be glad to argue the matter afresh.

However, in C. Macfie Campbell he found a psychiatrist who accepted the psychogenic interpretation of many mental disorders. Boisen tells us that in a seminar at the Harvard Medical School, Dr. Campbell was challenged by a member concerning his psychogenic interpretation. Thereupon he

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¹ Boisen, SLK, 121.
² Boisen, ETW, 4-5.
Not long ago an experiment was tried with some cats. A cat was brought into proximity to a dog of fierce mien and savage bark. The cat's blood was tested before and after the dog had barked at it and a distinct increase in blood was found. Here then is a physical effect from a mental cause. Suppose now that you make your test of the cat's blood only after the dog has got in his work. You find an excess of sugar. This means, you may say, diabetes, and you want to know what to do for the poor, sick pussy. How are you going to cure that cat if you leave the dog out of account? Pathological conditions may be the result of mental causes. If they are it is important to find the dog.1

Boisen strongly criticizes what he calls the extreme "organicism" of Cotton who convinced himself that focal infection was the basic cause of mental disorders.2 Of course Cotton is an extreme example who represents the out-moded "physical-basis" theory whose main tenet was "no cerebral pathology, no insanity." Boisen would, however, find support for his theory as far back as the latter part of the nineteenth century, when Jarvis and Brigham expressed the view that moral and emotional causes were far more operative than physical in the production of mental disease.3 But Boisen draws his inspiration from Freud, Jung and Meyer more than from anybody else. Freud recognized that neurotic illness is to

1. Quoted from Boisen, SLK, 49.
2. See Cotton, DDI.
be explained in terms of conflict that goes on in the region of dim awareness between the organized social self and unacceptable instinctual tendencies. He also emphasized the fact that successful psychotherapy depends upon effective rapport with the analyst. Jung pointed out the importance of a religious \textit{weltanschauung} in the process of recovery from mental disturbances. Meyer stressed the significance of the schizophrenic's ideation and disagreed with Kraepelin in the latter's view that the antecedents in the life of the patient are not at all worth considering.\footnote{1} He suggested a psychobiological approach to mental illness with emphasis on "the original endowment of the patient, the special traits of personality, the moulding influence of the home, the formation of habits, the stresses of the actual situation."\footnote{2} Boisen refers to Bentley and Cowdry who say that the physiological basis of even the simplest mental processes has not been ascertained with any amount of certainty.\footnote{3}

\textit{It is therefore not without significance that the recent advances in psychopathology have come with the attempt to build a psychology on the basis of personal experience, with special reference to the wishes, the fears, the frustrations and the dreams.}\footnote{4}

\begin{footnotes}
\item[3] Bentley and Cowdry, PMD, 379.
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ii. The Factor of Heredity

We do not find much reference in Boisen's writings to the problem of heredity in relation to schizophrenia. In the study of 173 patients at Worcester, to which we have already referred, 159 cases yielded information on this point. Out of these, 46 had some psychopathic inheritance; 18 had parents who were mentally ill; 7 had psychotic siblings; in 21 there was history of mental illness in remote relatives; and in 11 there was an alcoholic father. In 101 cases there was no previous record of mental or nervous disease. On the basis of these findings, Boisen concludes:

> It would be too much to assume that the absence of any mention of neurotic relatives meant freedom from psychopathic taint, but it does seem safe to say that while the group as a whole has more than its share of bad inheritance, the family history in the majority of cases was as good as average.

The group of 173 which Boisen studied were selected by Hoskins and his associates for neuro-endocrine research, and represented no cases of organic pathology. The findings of this research group are summarized in Hoskin's Biology of Schizophrenia, which presents an "immaturity concept" of schizophrenia. Boisen correctly represents the findings of this research project when he says:

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1. Boisen, EIW, 22.
while more endocrine dysfunction has been revealed than would be found among a group of normal persons, no single metabolic deviation has as yet been found to be characteristic either of dementia praecox as a group or of its several types. An inspection of our cases indicates moreover that in quite a number of patients the endocrine dysfunction was corrected without any appreciable effect upon mental condition and that in a few cases the mental condition cleared up without any alteration of the endocrine condition.¹

This does not mean, Boisen goes on to say, that physiological factors are not important; it merely shows us the complexity of the problem. In his own study of the control group he found that, while the percentage of physical disease was greater in schizophrenic cases than among normal persons, it was by no means characteristic. McFarland and Goldstein reached somewhat the same conclusions after an extensive survey of the psychiatric literature.²

iii. Early Influences

Boisen recognizes the importance of the early childhood influences in the development of personality. He sees their potency in the sphere of ideals and standards which implant themselves within the growing child. The influence of the parents and early guides is most significant in this process. The child begins with "taking the role of the other" with his parents, on whom he is dependent for love,

¹ Boisen, EIW, 23-24. See also Hoskins, Art., (1931), 682.
² McFarland and Goldstein, Art., (1938), 509-552.
security and satisfaction of his needs. Later on, in the play activities and cooperative undertakings, in which he participates with others, he incorporates within himself the organized social attitudes of his group and thus takes the role of "the generalized other." These ideals and standards, which he accepts as his own, become his primary loyalties from which there is no escape except through growth into a larger loyalty.¹ Conflicts arise when there is a clash between the accepted parental ideals and group loyalties and the disowned instinctual tendencies which are neither controlled nor acknowledged. Or the source of conflict may lie in the disparity between one's natural endowment and the accepted ideals which represent the ambitions of his parents and early guides.² In the face of such conflicts, one may lower his conscience threshold and find social approval for his infirmities through identification with groups of easy standards. Or one may suffer a severe inner struggle between his primary loyalties, which he continues to accept as his own, and his instinctual cravings. The result, in this case, is the crash of one's subjective world with resultant feelings of personal failure, isolation and guilt. Acute schizophrenic disorders, according to Boisen, are of

¹ Boisen, EIW, 174-175.
² Dunbar, MB, 136ff. Dunbar here discusses the case of a motorman whose psychosomatic disorders had an obvious connection with his strong attachment to his father and acceptance of his standards and ambitions.
this order. In both cases, however, there is a failure to integrate one's group loyalties and ideals into a more comprehensive loyalty; and the result is a "divided self," a bifurcated personality. Acute schizophrenic reactions, however, represent an honest attempt to reorganize one's personality around a new locus, an enlarged concept of self, and in many cases the results are constructive and fruitful. Evasive and concealment tactics, on the other hand, result in arrested development or progressive disintegration.

In his study of 173 cases at Worcester, Boisen found that unfavorable environmental influences were, on the whole, more general than was bad heredity. In 64 per cent of the cases environmental maladjustments were noted: divorce, separation, early death of one or both parents, quarreling and dissensions in the home, dominance or over-solicitousness of the mother. In 19 cases marginal economic status of the family was reported. Absence of positive maladjustments, says Boisen, did not mean that the home environment was necessarily good.

It follows therefore that unfavorable environmental influences were operative in a large number of our cases. At the same time we find not a few cases in which the environment influences seem considerably better than the average.1

1. Boisen, EIW, 22.
In a sociological survey of a small town parish in a Midwestern county, about the same results were obtained and the potency of home influences in shaping one’s ideals was demonstrated.  

iv. Sexual Etiology

In the 173 studied at Worcester, Boisen found a preponderance of sex maladjustments. Sixty-two unmarried male patients represented the shut-in type of personality and admitted no sex indulgence or sex interest in any form; thirty-four admitted masturbatory difficulties, ten admitted indulgence in erotic fantasies, while thirty gave evidence of both. Forty-three of the unmarried men admitted heterosexual experiences, including three cases of impotency; fifteen confessed or showed homosexual tendencies. Of the married men a large majority admitted difficulties in sex adjustments; there were a few cases which represented problems of sexual impotence, masturbation and erotic phantasy. In another group of thirty-nine patients studied at Worcester and Boston Psychopathic Hospital, the same problems, and more or less in the same proportion, were reflected. In the light of these studies Boisen concludes that sex maladjustment is primary in most cases of schizophrenia. Speaking of the Worcester group he says that on the whole

1. Boisen, EIW, 224-231.
There were none in the group who had arrived at healthy sexual development with wholesome expression of the sex drive. For all of them the realm of sex had apparently remained something at once terrifying and fascinating, un-assimilated in the organization of their experience and thus the source of much distress and discomfort.¹

How do we explain this preponderance of sexual maladjustments in schizophrenia? Boisen explains it in terms of a sociodynamic interpretation of sex.² The sex drive, he argues, is concerned with the perpetuation of the race, something for which the individual exists.³ In each individual there is a deep-seated but not always clear awareness of this fact, and there is usually an extreme sensitivity regarding maladjustments in this area.⁴ Neuroses and psychoses are often associated with the developmental stages in sexual maturation. Furthermore, sex drive is often surrounded with taboos and inhibitions, so that any maladjustments or anxieties connected with it are likely to be kept to one's self. This intensifies one's inner conflicts,

¹. Boisen, EIW, 26.
². Freud traces all mental disorders to sexual maladjustments ("Einfuhrung," Lectures, 20-22). Janet disagrees but finds seventy-five per cent of his cases having sexual maladjustments, MP, II, 236. English and Pearson find sexual components in a large number of neuroses, EPL, 323. Freud finds the trouble in repressed sexuality beginning with the Oedepal situation of childhood; Horney sees it in repressed hostility brought about by the same mechanisms, NPO, Chap. 4.
³. This is a fundamental point of departure between clergymen and psychiatrists. See Sullivan, Rev. (1939), 424-427.
brings a sense of personal failure and guilt, and engenders feelings of social isolation.

Absorbed in horror-stricken fascination for that of which he cannot bring himself to speak, he feels himself besmirched and unfit for the company of those whom he loves and honors, and he seems to himself different from his fellows. His very inability to utter those words gives him an exaggerated idea of their significance. He thus maintains his standards or ideals at the cost of dividing his own personality and of seeming to himself despicable in his own eyes and in the eyes of others.¹

v. Social Relationships

The primary evil in mental illness, according to Boisen, is a sense of personal failure and guilt. Unlike the delinquent who substitutes lesser loyalties for the primary loyalties and thus preserves his self-respect and morale, the schizophrenic refuses to lower or compromise his primary loyalties without being able to control or acknowledge his disowned cravings. He thus becomes a puppet in the hands of opposing loyalties and conflicting standards. This, in turn, brings a sense of utter failure and isolation. He judges himself by the standards which he has accepted as his own but has failed to measure up to. He takes this failure so seriously that he can neither acknowledge it to himself nor to anyone else; this serves to erect a wall of separation

¹. Boisen, Art., (1928)¹, 559.
between himself and his fellows. His sense of guilt is then due to something he is afraid to tell.

Its essence is not to be found in any mere infraction of a code but in a rupture of the interpersonal relationships as inwardly conceived... It carries with it the sense of isolation and estrangement for that which is supreme in our system of loyalties that which for the religious man is symbolized by his idea of God and which explicitly or implicitly is operative in the lives of all men.2

In his study of the 173 cases at Worcester, Boisen found a large majority of those who had never questioned the standards and ideals implanted in them by their parents and early guides, but had fallen far short in their performances. With the exception of a few cases who made attempts to get away from their primary loyalties, ninety-nine individuals were of the retiring sort with few friends and few social contacts; only eleven had some friends; eighty-four preferred solitary games and recreations; fifty-six enjoyed some respect or acceptance from their associates; eighteen felt humiliated and fifty-eight ignored. On the whole, social maladjustments were common in the group, and all with a few possible exceptions were those "who in the light of their accepted ideals were subject to a serious sense of inner disharmony and isolation."3

1. Boisen, ETW, 24-25.
Summary

In summarizing the causative factors in the study of his 173 patients, Boisen found nothing distinctive about them in terms of heredity, environment, intelligence and physical health. They were perhaps a little more handicapped in these matters than others. But, in a few cases heredity and intelligence were of average if not superior order. But the entire group was rather a seriously maladjusted lot of individuals. Maladjustments were most marked in the area of sex relationships; next in order were vocational and social maladjustments. But Boisen points out that there is no objective criterion of such maladjustments; the individual concerned is himself the criterion, and the important thing is how one looks at his situation.

We may therefore conclude that in this group we have individuals who are thwarted in their efforts to attain their major objectives in life in terms of their own picture of themselves. Anything which would contribute to such a sense of failure and thwarting whether it be poor intellectual or physical endowment, unfavorable influences, or maladjustments in the life situation would be a causative factor.  

1. Boisen, EIW, 27.
3. Developmental Aspects

The conflict theory of schizophrenia, as propounded by Boisen, has its antecedents in Freudian psychology with its dynamic conception of mind and its ailments. But unlike the orthodox school of psychoanalysis, Boisen's theory takes into account not only the intra-psychic basis of mental illness, but also its interpersonal components. In other words, Boisen takes a sociodynamic view of mental disorders. Perhaps he is more close to Adolf Meyer and his followers, who have stressed the importance of understanding mental disorders as reactions to life situations determined by internal and external factors related to the individual. We have already seen that the histories of schizophrenic patients are never free from problems of interpersonal adjustment. The onset of acute schizophrenic disturbance may be sudden or gradual; in both cases, however, certain developmental stages may be traced. What are the conditions, stresses and mental mechanisms that facilitate or hinder the outbreak of acute schizophrenic disorders? To such questions we now apply ourselves.

1. Cf. Fenichel, PTN. Fenichel is more oriented to the intra-than to the inter-personal. To him each person is an isolated problem, his lone source of authority being within himself. Boisen's view is interpersonal and intra-psychic both and it emphasizes the fact that "no man lives to himself alone."

1. The Basic Problem

The nucleus of schizophrenic disorders, according to Boisen, lies in a sense of personal failure and guilt, a sense of inner disharmony between the actual and the ideal. In itself, this feeling of disharmony is not an evil thing; it may be a "pre-condition of effort and of growth." It becomes malignant only when it is attended by a sense of isolation from those upon whom one depends for love and security and whose ideals and standards one accepts as his own. Man is essentially social and is born with impulses of a social nature. He grows and develops through interaction with his social environment. First, he begins with taking "the role of the other" with his parents and later on incorporates the organized social folkways and mores of his group in terms of "the generalized other." His concept of himself—which Boisen says is the nucleus of personality—thus grows and enlarges through assimilation of new experiences. Gestures and language symbols, themselves products of social interaction, become vehicles through which new experiences are understood, expressed and assimilated. This process of social action and interaction involves relationships to the judgment of others, particularly of those upon whom we depend for love and protection; and thus one's system of values becomes a function of the social relationships. In other words, the sense of isolation which follows feelings of personal
failure and guilt is rooted in one's inability to socialize and thus assimilate new experiences. To understand Boisen's reasoning, let us take a concrete example which he himself cites in his book. It concerns the cases of two brothers who came under Dr. William Healey's observation.

These two boys came under Dr. Healey's observation after one of them had been arraigned in the juvenile court for serious stealing. The parents' account of this boy revealed several neurotic traits such as restlessness, irritability, inability to eat at the table and occasional fits of nausea. The other was described as a "good boy"—happy, helpful and honest. During an interview the young malefactor told of an experience with a fellow who introduced him and his brother to vulgarity and pilfering. He said he detested these things; the very thought of them made him sick. But, whenever those hated thoughts did come to his mind, he could not resist the impulse to steal. He simply had to do something when thoughts of stealing and of that fellow came into his mind. This made him feel cross, impatient and fidgety. The meal times were particularly agonizing, for then his brother would purposely say those words to him, and thus enjoy his discomfiture. He himself never uttered those words, but his brother said them all the time.

1. Boisen, EIW, 147-149
2. Boisen, EIW, 142ff.
3. Cf. Healey, MCM.
These two brothers illustrate two common types and two contrasting ways of dealing with an inner conflict. Though brought up under exactly the same conditions with little difference in physique or intelligence, they react differently to a common situation. One of the brothers succeeds in assimilating the new experience. He meets the situation easily; he has no compunctions about it. By giving expression to those horrible thoughts, by talking, joking and laughing about them, he meets with the responses which indicate that he is not alone, but that others share with him the same desires and interests. He is thus able to socialize and thus assimilate the new experience, though, of course, at the cost of lowering his own standards.

The other boy, on the contrary, gets involved in a severe inner struggle by his inability to socialize the new experience. To him the new experience is a fascinating and yet terrible thing. He cannot bear the thought of it, neither can he give utterance to it in words. The only source of relief from this distressing situation is to give way to the associative impulses of stealing. The latter represents to him the lesser of the two evils, though it brings him only a temporary relief. The inner conflict goes on, and he feels a growing sense of isolation from those whose social standards he has accepted as his own.
This only serves to intensify his feelings of personal failure and guilt. Boisen writes concerning the young male-factor:

...he felt besmirched and unfit for the company of those whom he loved and honored. His very inability to utter these words gave him an exaggerated idea of their significance and increased their fascination for him. He thus felt himself in the grip of ideas and interests which he did not dare to acknowledge to those to whom he looked for approval. Judging himself by what he believed they would think of him if they knew him as he knew himself, he became despicable in his own eyes.1

Thus, according to Boisen, the schizophrenic's basic problem is a sense of personal failure which is rooted in an inability to socialize new experiences.2 A sense of personal failure which springs from the "divine discontent" within man is not an evil thing; it is a pre-condition to growth and effort.3 However, when it is associated with and followed by a sense of isolation from "that which makes life worth living to the individual," it definitely becomes an injurious thing. How this sense of failure is compensated

1. Boisen, EIW, 144.
2. Compare this view with Hoskins1 who conceives of schizophrenia as "an end result of a generalized failure of adaption that arises from defective evolution of the maturity process." He applies this failure to all vital processes, while Boisen confines it to the psychic life of man (Hoskins, BS, 165f.).
3. Cf. Adler, PTP. Adler sees a sense of inferiority at the basis of all normal and abnormal human behaviour and explains it in terms of a striving for superiority as a compensatory process. Whether Boisen's "personal failure" concept can be equated with Adler's view we shall consider later on.
for, or what defense mechanisms it may develop, we shall consider later on.

Whence arises this sense of personal failure? Is it something basic in human nature, something akin to Adler's inferiority complex? Or, the inability to socialize and assimilate new experiences—is it something akin to a failure in adaptive processes of which Hoskins speaks? In the case of the two boys, we would like to know something about their history prior to their initiation into vulgarities and the gentle art of pilfering. What was the attitude of the parents toward the two boys? Was it in any way discriminatory, over-indulgent, over-protective, or overly rejective? Was there much sibling rivalry in the family, in which the young malefactor, being apparently the younger, was the loser? Did he suffer from trauma at birth (Rank) or during the phallic phase of his development (Freud)? Boisen does not address himself to such questions, although they are important and might help to explain the intra-psychic conflict in the one brother and its absence in the other. Boisen does hint at the possibility of sex difficulties in one case, while the "good boy" was probably free from any such "fixation." Boisen also suggests that the latter's self-complacency "may have been derived from the sense of superiority which resulted from the discomfiture which he was able to produce in his brother." ¹

¹ Boisen, EIW, 145.
Some of these questions will receive our attention in the following pages. Here it is sufficient to say that Boisen sees the primary evil in schizophrenic disturbances as a sense of personal failure. In the next section we will discuss some of the protective mechanisms that are resorted to by the individual in an effort to ward off this sense of personal failure.

11. Constructs and Protective Devices

Boisen does not define the inner dynamics of the self-system which organizes itself around a sense of personal failure, although he does stress its interpersonal components. What are the consequences of this negative self-feeling? How does it affect one's growth and pattern of development? Since it represents a defect in assimilative processes and produces a sense of isolation, defensive measures are perforce brought into play. To the extent that these measures prove successful, one is enabled to achieve social integration and thus maintain one's self-respect and sense of belongingness. On the other hand, when these measures fail or prove partially successful in the face of severe inner conflicts, the result would probably be a general retraction of interests and a progressive withdrawal from interpersonal relationships. When these conflicts involve an honest attempt to deal with one's problems on a higher level of integration, they should not be looked upon as necessarily disintegrative.
How one deals with his problem—i.e. the sense of personal failure—is the all-important issue. But this, in Boisen's view, is determined by one's controlling desires and his degree of awareness. The controlling desires are said to consist of the desire for recognition, desire for response, and segmental or instinctual desires; the degree of awareness may be clear, confused or one of oblivion. It is not clear whether these controlling desires are mutually exclusive or can reside in the same individual. How these desires originate is also not explained. Are they physiological appetites turned into self-dynamic motives through adience? Or, are they due to the "functional autonomy" of human motives, some inherited energy system, an all-powerful libido or the Adlerian "will to power" concept?

Boisen does not deal with these questions, but is only content to observe that his findings indicate these controlling desires in his patients. We also find here some similarity to Thomas's concept of wishes and Sullivan's theory of human needs of security and satisfaction. In the case of the two brothers that we have cited, Boisen finds a preponderance of segmental tendencies (sex desire, in this

1. Boisen, EIW, 149-152.
2. Woodworth, PS, 36-43.
   Holt, ADL, 41.
3. Allport, PER, 190-207.
4. McDougall, EM.
5. Thomas, UG, 1-40.
case) in the young chief. The other boy is said to be characterized with "clear awareness" and perhaps with integrative tendencies (desire for recognition and response).\(^1\)

Integrative desires, combined with a high degree of awareness, characterize normal development. They are likewise marked with the traits of honesty and frankness in dealing with one's problem. Where the elements of honesty and frankness are lacking, socialization is sought in terms of certain psychological constructs and protective devices. The reaction of compromise which is very common among religious people, involves a substitution of minor for major virtues and loyalties. It is common among those who would cling to their primary loyalties without paying the price of the complete commitment essential to the attainment of higher levels of development.\(^2\)

Probably the two brothers would fit into this category. One compromised his primary loyalties with a gang by lowering his standards; the other found a solution of a severe sex conflict in the substitution of what in the boy's eyes was a lesser offense (stealing). Other protective devices are frequently used: bluffing, to cover up a sense of insecurity; diversion, to get rid of one's feeling of unworthiness; shifting responsibility on to other persons or things or to "an organic scape goat," as a device to make up for one's own failures and shortcomings.

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1. Cf. Kempf, PSY.  
2. Boisen, EIW, 154.
The method of withdrawal and surrender is a characteristic schizophrenic reaction pattern which may appear very early. Its origin lies in a basic inability to socialize new experiences, especially those that cluster around the area of sex. This brings feelings of personal failure and isolation from those whose standards one has failed to achieve. In the face of repeated failures the reaction of hopelessness sets in.

One escapes failure and pain by refusing to hope or to try. Such a reaction is likely to be accompanied by sulking and brooding, and by easy pleasure-taking. The latter is particularly apt to be the case where the primary evil lies in instinctual claims which the patient has neither been able to own or to control.1

It is surprising that Boisen does not discuss this schizophrenic withdrawal in terms of its manifestations in interpersonal relationships. How does this withdrawal show itself in the context of social relationships? White has an excellent discussion of this aspect. He points out that the mechanism of withdrawal and repression of interest in other people has a devastating effect on personality development, for it cuts one off from the educative effects of social participation and thus one retires from reality into the realm of phantasy.

The distinguishing feature of the preschizophrenic personality is that the fantasy life, at first perfectly normal, grows in a state of social isolation and is not corrected by the reactions and judgments of others... The peculiar feature of the preschizophrenic personality is thus not the presence of fantasy but rather the failure of fantasy to receive realistic correction.  

Boisen, however, does point out the fact that the schizophrenic's prepsychotic personality is characterized by a lack of interest in social surroundings. In the study of 173 cases already alluded to, he found a preponderance of social and sex maladjustments, "individuals of the retiring sort with few friends and few social contacts." This description fits in with what Meyer called the shut-in personality. Hinsie found this trait among his patients who as children were timid, shy and seclusive, and who clung "to the mother's apron strings." Boisen describes the case of a young man of twenty-seven years of age whom he studied at Elgin State Hospital.

H. C. came from a cultured home where the parents were devoted to each other and to the children. The patient had a younger brother who is said to have been "an open, friendly, likeable person" having many friends. As a child he was very jealous of his brother and would not let him have anything more than he had. He did well in his school work, but his social life was

1. White, AP, 529-530.  
2. Boisen, EIW, 25.  
4. Hinsie, TS, 45.
unsatisfactory. On entering college he continued to do well in his studies but remained shy and backward both with his own and with the opposite sex. He found no situation in which he felt at ease. Up to the time of commitment at the age of 25 he had never been away from home. He made some valiant efforts to overcome his difficulties, but these more or less sporadic attempts met with consistent failure and this led to progressive withdrawal from the outside world. His inability to succeed led him to fall back repeatedly upon the moral and emotional support of his family. He wanted to be independent, but always his incompetence brought him back to the one place where he felt safe. He became increasingly nervous and sensitive, irritable and angry with members of his family. The "spells" of anger became more frequent and more violent. He occasionally made threats against the lives of the family members. The final breakdown came when he learned that his brother had been married for some months. "He went into a most violent tantrum, threw a glass of milk, which he happened to have in his hands, at his father, ran upstairs and threw himself upon his bed." This condition gradually deteriorated and he was finally committed to the hospital.

In this case we have a gradual withdrawal from social contacts and relationships due to a basic sense of inferiority with repeated failures of attempts at compensation or readjustment. The protective devices outlined above lead to different types of personality development. Where integrative desires are prominent, a progressive unification of personality takes place. Valid types of religious experience,

according to Boisen, come under this category. When the socialization takes place on a contemporary and local basis, one reflects attitudes of confidence and self-reliance and finds satisfactory self-expression in social, vocational and sexual life. This represents the normal man. But socialization of the antisocial type involves rejection of primary loyalties and results in rebellious and cancer-like social formations. This represents the delinquent and the criminal. Where the type of solution is submergence, attitudes of dependence and fault-finding are in prominence. This is seen in the misanthrope, the partisan and the clinging vine. Where disintegrative tendencies set in, characterized by attitudes of anxiety, self-pity, seclusiveness, and hopelessness, the end result is a progressive pattern of schizophrenia.¹

4. Onset in Acute Schizophrenia

Schizophrenia has its primary nucleus in a sense of personal failure which arises from conflicting ideals and standards. It represents a failure in social capacity and interpersonal relationships. When the sense of failure is associated with feelings of isolation and segmental desires,

a pattern of withdrawal and apathy develops. Avoidance of people makes socialization progressively difficult; but protective devices only serve to transfer the locus of conflicts from the outer to the inner world and thus intensify the conflicts already present. In this state of intense inner turmoil the stage is set for a final showdown; any situational factor of sufficient strength may set this whole smouldering structure ablaze. Some traumatic experience—usually disappointment, loss of some loved one, or severe physical illness—may serve as a precipitating cause. Sometimes very minor causes, which somehow assume exaggerated importance for the individual, may precipitate the breakdown. Otto Fenichel describes a schizophrenic episode which began "with a patient's despair over the fact that a new hat did not fit." The choice of psychosis is, of course, determined by the character of the basic problem, the character and success of protective mechanisms, and the temperamental peculiarities of the individual. The acute schizophrenic disturbance begins, according to Boisen, with a tremendous stirring of profounder levels of mental life and the disruption of mental structure and norms of judgment. Such experiences, he argues, represent attempts to break up

1. Fenichel, OCP, 419.
sets and attitudes which impede growth, attempts which tend
either to make or break. Let us consider Boisen's view as
to how this acute disturbance develops. The various points
in our discussion will be clear if we begin with a concrete
case:

This patient was brought to the hospital
after he had made an unsuccessful attempt
to kill himself; the motive was said to be
self-sacrifice, for he "wanted to relieve
the world of its sins." The onset, which
was sudden and severe, began with a period
of intense self-absorption during which he was
unable to sleep. He was a native of Sweden
and was brought up in a good family environ-
ment. After serving seven years as a seaman
he returned and married at the age of 31. He
was often idle, for his trade was a highly
specialized one and the assignment of jobs
was determined by the union. The home life
was happy though somewhat "matriarchal."
Neither he nor his wife was active in church
life. In his political views he was inclined
toward Socialism. He related his experience
to Boisen after he emerged from the first
disturbance. He was at a Socialist meeting
one night and there he heard a man speak of
Jesus and of the need for giving one's life
for others. He returned from the meeting
with that thought deeply impressed on his mind.
In the night he woke up and heard a voice say
"You must be put to the test to see if you will
really give up your life." He felt as though
God was speaking to him and words from the
Bible came into his mind. He became very ner-
vous and agitated. That same night blood came
into his mouth and something told him that it
took almost two thousand years to produce a
man like him. A week later he was sent to the
hospital. He felt strange and "filled up."
He felt that "there were two sides" and that
he had to go "to one side or the other to
get salvation."
In the hospital he was put in a strait jacket and he had a dream that night. He dreamed that he was being crucified and was lying in the grave just as Jesus did; he also saw himself surrounded with devils. He was released from the hospital at the end of three weeks. He did not read his Bible or go to the church, for he was told that his trouble came from reading the Bible. The last attack came when something told him that he must go and read the Bible; then he started to pray, for, as he said, "Then it came to me that I had a second installment to pay. I had to finish paying my bet with God. I came then into a state of fear. Something said to me, 'Are you willing to commit suicide?' And it was just like I had to do it. I turned on the gas. That was for my wife. Then I slashed my wrists, one for one daughter and the other for the other daughter...I just felt that I had to do it to keep my promise."1

This case will serve to illustrate the points that will engage our attention in the following pages. We will describe the stages that are involved in the onset of acute schizophrenic disturbances.

1. Period of Preparation

This period of preparation includes the developmental stages prior to the actual onset of schizophrenic disturbances. The central problem of schizophrenia, according to Boisen, is centered around feelings of personal failure and guilt, of isolation and intolerable loss of self-respect. These represent severe inner conflicts which may grow in the

patient's mind for years, until finally an emotional explosion ensues, ending in a schizophrenic episode. However, the acute schizophrenic reaction is a desperate attempt on the part of the individual to find some solution to a problem which he has not been able to solve in a normal way.

In the case of Oscar, Boisen finds the problem in the area of his marital relationship, something which was "getting on his nerves." The schizophrenic reaction in his case represented "something in the nature of a 'transference' involving dependence upon a finite love object which needed now to be 'broken up,' or 'resolved.'" This interpretation is somewhat far-fetched as Boisen himself realizes, for the facts of the case, as we have them, do not justify it. What is more, the basic problem, which must go far back into the earlier years, is not clear, and the feelings of guilt and personal failure seem to be absent. But, as Boisen says, this case differs from others in that "the life situation did not involve the sense of personal failure and guilt, but rather a forward step in his development or maturity."1 It is, however, clear that Oscar's problem has some sort of relationship—real or symbolic—to the Socialist speaker's question, "Are there not many men who are willing to give

their lives for others?" His attempt at suicide in order to fulfill his bet with God in relation to the world and to his family does reveal the "personal" aspect of the problem, the problem of his own place in the scheme of things. In brief, schizophrenic reactions do not take place in a vacuum. Their outbreak may appear to be sudden and eruptive, but they all represent a history of antecedents that go back into early years, a long developmental period of incubation and intensification of basic conflicts. It is analogous to what Hutchinson calls the period of preparation that represents an initial stage in the process of insightful thinking. ¹

What are the precipitating causes of schizophrenic breakdown? As previously suggested, any traumatic or violent experience may bring this about. Any situation or event, real or imaginary, that tends to weaken one's psychological defenses, and thereby arouse anxiety, may result in a schizophrenic episode. In the case of Oscar, the preaching at the Socialist meeting concerning the need of self-sacrifice brought on the onset. Sullivan relates the case of a boy who went into an acute schizophrenic delirium when someone saw him indulging in homosexual fondling and told him that it was wrong. When a person who has sublimated

¹. Hutchinson, Art., (1939), 323-332.
all his lustful tendencies succumbs to a compromising situation and gets involved in an aftermath of self-reorimin-

ation and severe conflict, he is likely to break under the circumstance. Therefore Sullivan believes that the course of events which leads to schizophrenic reaction is "often initiated by a sudden failure of a sublimatory process."¹

White comes closer to Boisen's view and says that events, which challenge in some way one's already feeble self-esteem or inadequacy, may hasten the downward trend to schizophrenic reactions. "The sexual changes of puberty, and such major challenges as engagement, marriage, childbirth or heavy vocational responsibilities, often serve as precipitating events."²

11. Period of Narrowed Attention

Boisen compares schizophrenic reaction to anxiety states, though, as he says, in the latter condition contact with external reality is more or less maintained. Both represent attempts at reorganization characterized by concentrated attention and strong emotion; both are transitional states which may eventuate in successful or unsuccessful solutions. A period of intense absorption precedes the schizophrenic reaction, during which the patient has many

2. White, AP, 534.
sleepless nights and days. It begins with intense preoccu-
pation with one's personal situation and with emotion so intense that one is carried, as it were, into another world.¹ We found this true in the case of Oscar, whose breakdown was precip-
itated with a period of self-absorption and sleeplessness. Boisen reminds us that such a narrowing down of attention is common among Hindu holy men and others of the shaman type described by Max Weber, Coe and others.²

In our previous chapter we have referred to Storch's study of Strindberg and his patients. He points out that schizophrenic reaction begins with an indefinite abnormal mood or insane mood. The patient is aware that there is something wrong with him, but is unable to say what it is; things lose their usual appearance and everything appears in an uncanny light. Sullivan describes this "twilight state" as ecstatic absorption which follows ineffectual attempts to remedy one's interpersonal situation. He calls it

a rapid regression to a state in which dream-like revery processes pertaining to a God-like condition solve the acute abasement...His awareness is now that of a twilight state between waking and dreaming; his facial expression is that of absorption in ecstatic "inner" experiences, and his behavior is peculiar to the degree that he no longer eats or sleeps, or tends to any of the routines of life.³

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With the sudden failure of sublimatory processes a state of ecstatic absorption is reached. When a state bordering on panic supervenes, it results in "random activity, and finally incoordination of the skeletal muscle."\(^1\) Hutchinson, to whose studies we have already referred, would call this stage "the period of frustration."

### iii. An Upsetting Idea

The indefinite abnormal mood, characterized by intense preoccupation with one's self, soon gives place to a state of mind having a definite objective content. Ideas begin to come from all directions and the patient's mind becomes subject to "a flood of mental pictures as though an album within were unfolding itself."\(^2\) The deeper levels of the subconscious are profoundly stirred and erupt into consciousness. The experience is interpreted as a manifestation of the supernatural.

It is known as the "inspiration" or the "automatisms" and may be defined as the idea or thought which after a period of incubation darts suddenly into consciousness. In the case of the schizophrenic, because of the depth of the emotional stirring and the intensity of the concentration, such ideas come surging in with peculiar vividness...He assumes they must come from a superhuman source...he feels in the realm of the mysterious and uncanny.\(^3\)

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\(^1\) Sullivan, MCP, 67.  
\(^2\) Boisen, EIW, 30-31.  
\(^3\) Boisen, Art., (1942), 29.
In other words, some "big idea" seizes the patient and sweeps him off his feet. Oscar ran out into the street in his underwear, for, like Archimedes, the idea was so big that he simply could not contain himself. In his case the big idea was that God had spoken to him through the medium of a "voice." The voice was not something that he had heard with his ears; it represented a tremendous idea conveyed to him. As Boisen points out, the same thing is explained by patients in different ways—"funny ideas," "funny thoughts," "revelation," "inner pushes," "impulse," communications," etc. In a study of 75 cases at Elgin State Hospital, Boisen found that in 54 cases the schizophrenic episode began with some "upsetting idea."

Storch tells us that the insane mood is followed by "an uncanny belief in the demoniacal domination of things with all its irrational emotional force."¹ Sullivan includes under the term **automatism** the phenomena of tic, automatic writing and hallucinations—all characterizing the schizophrenic's initial reactions. The automatism is said to be "expressive of a dissociated tendency to integrate some particular interpersonal situation."² Boisen stresses the

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1. Storch, PAF, 62.
2. Sullivan, MCP, 68.
point that the importance of the "voices" and "visions" lies in what they say and reveal and in the fact that they are attributed to a supernatural source. He says that the mechanism behind these automatisms is not different from the "insights" or "inspirations" of normal persons.¹

iv. Period of Elaboration

The next period of schizophrenic disturbance is characterized by further extensions and elaborations of the "upsetting idea." The patient automatically follows the dictates of the "voices" and what they say becomes very important. In this stage

there is great enlargement of the field within which intuition is valid, and the critical faculties are in abeyance. They are, however, by no means absent. One sees it in the overwhelming perplexity which is so often present...He seeks communications from above not merely in the ideas which come into his head but also in all sorts of trivial happenings.²

We saw how true this was in the case of Clifford Beers who misinterpreted every slight incident as a part of an inquisitorial plan which, he thought, was being laid for him. Such ideas of reference we found missing in the initial phase of Boisen's own disturbance. He himself does not make any reference to such ideas being present at this stage.

However, both Storch and Sullivan point to a general feeling of persecution present in acute stages. For example, Sullivan says that after the panic has passed into terror, many patients believe they are being followed by people in automobiles.

This comes about rather simply. All the cars that are noticed are behind one. As a car passes, it ceases to have any relevance whatever. It is no longer perceived. Therefore, no car passes one, and so long as there are cars behind one, and they stay behind one, it must be that they are menacing.

Boisen finds a preponderance of ideas of death, of sacrificial renunciation and of cosmic identification in his patients. In 50 out of 75 cases previously alluded to, he found ideas of death; and when these are passively accepted, the result may be stupor or depression. Ideas of cosmic catastrophe appeared in 43 cases; others show concern with ideas of cosmic identification, of rebirth and of prophetic mission. When the idea of mission follows ideas of death, strange new ideas come surging in upon the patient and he believes himself possessed of cosmic significance. This was true of Oscar, for, after his unsuccessful attempt at suicide, he was led to believe himself "saviour" of the world. In Boisen's own case these ideas appeared a little

later. We will consider these ideas in greater detail in our next section. Here it is sufficient to say that this period is not only characterized by elation, exaltation, and a great profusion of new ideas but is also marked by bewilderment and perplexity, with the central problem pertaining usually to the patient's own role.¹

We may conclude this section with a reference to Storch. His classification differs from Boisen's in one or two respects. For instance, his studies show that the demoniacal phase is followed by a certain clarification,

a gradual penetration of the experiences with thought, the atmosphere of an infinite and inexhaustible significance, which at first embraced all things, grew narrower... And now the psychotic mood began to condense about certain delusional ideas, the supernatural sphere assuming more circumscribed limits. A wealth of mythological forms entered the scene.²

This mythological stage finally gives way to a religious or speculative one and extensive rationalizations appear.

5. Content of Schizophrenic Thinking

We have discussed the initial phases of schizophrenic reaction. A period of preparation or frustration precedes the actual onset of the disease. It represents a history of repeated failures in the sphere of interpersonal relationships and a progressive withdrawal from social interaction.

2. Storch, PAF, 48-63.
The schizophrenic reaction begins with intense preoccupation over one's personal situation, characterized by indiscriminate fear and anxiety, emotional imbalance and sleeplessness. Then there is a gradual narrowing down of attention and the psychotic mood condenses about a certain "upsetting idea" which is ascribed to a supernatural source. Further extensions and elaborations of the idea take place and a full-blown schizophrenic disturbance sets in. We now propose to consider the schizophrenic ideation and thinking in more specific terms. A representative case will serve as base line for our discussion.

It concerns James G., one of the 173 cases studied by Boisen at Worcester. He was a grocery clerk, 29 years old, of fair intelligence and good physique. He was born in the home of a Southern clergyman, who died when James was 12 years of age. As a boy he had certain difficulties in managing his sex drive. At the age of 16 he left home and after a period of aimless wandering he finally joined the army. Here he stayed nine years and found an outlet for his troublesome sex drive by going along with his mates to houses of prostitution. Thus, by lowering his conscience threshold and supported by group opinion, he was quite comfortable about his situation. On his discharge from the army, he married and settled down. However, his mental disturbance soon began with the arrival of a child in the family. His mind began "running and jumping" and he was in the grip of a spell of fear and indiscriminate anxiety. He felt himself weighed down with a great sense of responsibility, not for the new baby, but concerning human nature and its mechanisms. He wrote an article on human emotions and got great satisfaction when it was published in one of the local newspapers.
This disturbance soon cleared up, but another of a severer nature began with a setback in business. He lost his business and became involved in debt. A schizophrenic episode followed and landed him in the hospital. In an interview he gave the following story to Boisen: "How did it start? I hardly know. I think it was the smell of the fish. I had dreams of crawling along the bottom of the sea among the fish and the oysters and everything. I had to give up work and sit around and brood. Then ideas came to me. I didn't have to search for words. It was just as if I had been commanded to say certain words I had never heard of before. I had a vision and it seemed to me that I could see way back to the beginning of creation. I could see the evolution of man up to his present being. And it came to me that from the beginning of the world there have been two rulers over the peoples of the world, God and Satan...It seemed to me that a greater effort should be made so that both should become one...Of course this would take years and years. It was to be my job to start it and to get the spirit working... You see, I interpret it that there has always been a battle between the two for supremacy. I could see no earthly reason why such a conflict should be kept up. I didn't see why the Lord intended that people should be always and forever fighting each other. Thinking it was the true light of God, it seemed to me that in some way I might bring this to Satan's attention so that he could call his following into the light. I am the true spirit of God and the product of the earliest stages of man after it was evolved from the seas. When I was in rage, there was something telling me that I was the true spirit of Christ."

1. The Sense of the Mysterious

Each of the two disturbances of James began with the sense of the mysterious and involved concern with cosmic

1. See Boisen, Art., (1932), 51-60.
affairs. The first disturbance involved concern with human nature and its mechanisms, in which he felt a sense of cosmic responsibility; in the other, he took on a cosmic role, the role of a mediator between God and Satan. Both attacks began when he was challenged with parental or vocational responsibilities. Boisen, however, finds only a few cases where factors in immediate life situations account for the breakdown. "In practically all the cases the disturbance seemed explainable rather in terms of inner disharmony and conflict which had reached the stage in which a solution was inevitable."

In most cases, according to Boisen, there is a common concern with cosmic affairs and a tendency to personalize the forces which the patient conceives to be in control. Strange, uncanny ideas and influences from apparently mysterious sources invade his consciousness. He enters a strange new world in which previous experience and accepted standards become irrelevant. He seems to be utterly at the mercy of mysterious "voices" and "visions" whose commands he must follow or perish. It is as if his conscious self sinks to the nethermost regions where it is at the mercy of the primitive and terrifying ideas and imagery which

1. Boisen, ETW, 33.
To the individual concerned the effect is overwhelming. It shatters the foundations of his entire mental structure. It sweeps him away from his moorings out into the uncharted seas to the unknown lands of the inner world. He is no longer concerned about the merely individual but about the cosmic and the universal.  

In general, Boisen points out, acute schizophrenic reaction is associated with a sense of the mysterious and with "archaic symbolism, bizarre ideation and also by much religious concern and by a relatively good recovery rate."  

Storch finds such ideas characteristic of primitive thinking and views schizophrenic thinking as regression to "numinous primordial feelings," which involve awe of what is mysterious and cannot be understood.  

In short, it is the tendency of this emotional attitude toward what is mysterious to place everything which does not belong to the sphere of what is immediately known or familiar, in a separate sphere of mystery and to elevate all these things to the realm of the "supernatural."  

Boisen describes these feelings as sudden eruption into consciousness of elements from the subconscious, so that the meaning outstrips symbol and the conventional language.

2. Boisen, EIW, 32.
3. Storch, PAF, 63.
in rendered utterly inadequate to express the profusion of ideas that dart into the mind as automatisms. To the patient only one thing is certain: "things are not what they seem; in everything that happens he sees hidden meanings."1

This sense of the mysterious comes also as a result of the patient's efforts to reorganize his values in terms of what he conceives to be the universal and the cosmic.

11. The Sense of Peril

With the sense of the mysterious is found associated, in many cases, an acute sense of peril and fear of death. James saw the world involved in a terrific struggle between God and Satan, and in the spirit of a melioristic philosopher he took it upon himself to bring about a reconciliation between the warring parties. Oscar, whose case we have previously cited, heard the voice of God, calling upon him to save the world from destruction. Beers found himself threatened with inimical powers which were in league to hasten the day of his "cosmic" trial. Boisen's delusions centered around the idea of a cosmic catastrophe, in which he was to play the role of a "saviour." In the case of Albert, one of the patients Boisen studied at Worcester, there was an acute sense of peril and fear of death.2

He thought he was going to die. Then things took on a new light; everything became different and he believed that "the dawn of creation" had come. Ideas of cosmic identification soon followed and he was led to believe that in previous incarnations he had been Jonah, Augustine and Christ. Storch describes the case of a young schizophrenic patient who constantly strove to "increase her dimensions" through identifications with Christ and other individuals of higher standing. In our own experience at Boston State Hospital we have found various forms of the same idea. One schizophrenic patient, for example, who died recently, thought she was going to die, for her "enemies have decided to have it so." She further said that "there was only one way of escape (pointing to her genitals) but it is blocked now. I have had no movement and the doctors don't do anything about...But, now, it's no use. The opening has been closed and I have to die!" Another patient that we saw was so panic-stricken that he would not budge from his place, for any movement of the body meant death. Another young patient identified herself with all the important figures that she knew of—Gandhi, Ali Khan, the emperor of Japan, President Truman, Christ and so on. It is interesting to note that

she never identified herself with any female figures.

Ideas of world catastrophe loom very large in the ideation of schizophrenic patients. Boisen finds this true especially of the profounder disturbances. In 57 out of the 173 cases studied at Worcester, ideas of impending world change were commonly present. In 53 cases there were exalted ideas about one's role in the cosmos. One patient thought that the world was about to go to pieces and he identified himself with the world. Three patients thought that they were called upon to stop or stay the on-coming catastrophe. Three others believed that Christ would soon reappear and that they would be called upon to have "a central role in this great event." Sullivan cites the case of a young man who was deeply attached to his mother and was strictly disciplined by his father. His father suddenly died and he developed mental disorder before the funeral began. During the course of an interview he stated that he was "the worst scoundrel." He believed that he had "brought crime on the world" and he felt himself responsible for the people who died "everyday on my account." Sullivan categorizes such delusions under world-disaster psychosis which he believes is "the outcome of a career of interpersonal frustration through the instrumentality of a rigid moral system acquired in the early years but energized in adolescence by the coming of lust." Storch explains cosmic delusions in terms of regression to primitive archaic age levels. The schizophrenic's delusions of cosmic catastrophe represent only images of the revolution that is taking place in his inner world. This agrees with Freud's view that the idea of a coming end of the world is the projection of the inner catastrophe, the subjective world which has gone to pieces.

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"The individual is first one and then another personage and
sometime nothing at all. At one moment he may be a zero
quantity and the next moment the Almighty." In 23 patients
he found such ideas; in 24, ideas of mission; and ideas of
rebirth in 23. Ideas of death, self-inflicted or accepted
as inevitable, appear in 61 cases. All these ideas, Boisen
remarks, frequently occur together with ideas of cosmic
catastrophe and cosmic identification. When these ideas
occur in conjunction with feelings of self-blame and personal
responsibility, they tend toward favorable results. When
ideas of death and self-importance are limited to earthly
power and influence and do not go to assume cosmic or relig-
ious significance, "they lead to concealment reactions and
are bad for prognosis." Hoch and MacCurdy point out that

5. Boisen, EIW, 34.
ideas of death (not associated with cosmic concern) in depressed or stuporous states show unfavorable outcomes. In a few cases, Boisen finds ideas concerning change of sex, which Storch explains as due to the destruction of "the perfect unity of sexual instinct." In brief, according to Boisen, in panic reaction of the profounder type there is a common constellation of ideas centering around cosmic identification, cosmic catastrophe and nihilistic delusions. When these occur in conjunction with feelings of guilt, self-blame and personal responsibility, the outlook for recovery is very promising. When ideas of death and self-exaltation have no cosmic reference, the prognosis in such cases is rather poor.

iii. Sense of Personal Responsibility

As we have already indicated, according to Boisen's findings, favorable prognosis in schizophrenia includes a desire to face the facts and to accept responsibility. He finds this true in the case of Albert and other patients he has studied. Ideas of reference that may occur in such cases are merely incidental and should not be taken seriously. Albert was quite frank about his problems and showed

1. BS, 191f.
2. Storch, PAF, 64-68.
3. Boisen, EIW, 35.
"remarkable frankness, telling apparently everything, even that which was degrading to his pride."¹ Boisen describes the case of another patient who finally recovered. He was brought to the hospital in an extremely agitated condition. He was afraid something was going to happen to his wife and he believed that he was going to die. He read mysterious meanings into the most trivial happenings. While in the hospital his social attitude was co-operative and frank. He was eager to talk over his difficulties and went regularly of his own accord to the chaplain's office. He represents the type of man who never thought seriously about his life and experience. But his mental illness involves a thorough re-organization of his personality.²

In 130 out of the 173 patients studied at Worcester, Boisen finds concealment reactions. He finds four types of such reactions.³ In most of these cases there is an externalization of conscience. The patient has extreme delusions of persecution; he hears voices which censure him; he believes his mind is being read or that his food is poisoned. These ideas, says Boisen, may all be regarded as indications of an uneasy conscience. In other words,

1. Boisen, EIW, 35.
2. Boisen, TPI, I, 11.
the patient instead of accepting blame and guilt externalizes them and thus evades his own responsibility. **Transfer of blame** is shown in 70 cases and represents an attempt to substitute acceptable explanations in place of unacceptable, instinctual cravings. This is seen in delusions concerning electric currents, hypnotic influences and hostile human agencies. **Fictitious self-importance** is shown in a large number of cases, but when it is associated with religious concern, the factors of externalization of conscience and of transfer of blame are usually lacking. The **incapacitation reaction** represents a spurious solution in terms of physical illness, of a failure to accept personal responsibility. In 19 cases, Boisen finds acceptance of responsibility associated with the reaction of self-blame. These reactions, he believes, are good prognostic signs. Three of these cases made complete recovery; three were sufficiently improved; while five showed a temporary recovery. No studies are available in this connection, but psychiatric opinion in general would probably support the view that the patients who are frank and cooperative and accept responsibility for their condition stand a much better chance of recovery than those who show the opposite reactions and are thus not easily accessible to psychotherapeutic efforts. But, whether any therapeutic formulations can be based on
merely ideational considerations will probably be disputed by psychiatrists and clinicians.

iv. Erotic Involvement

The sex factor looms large in the cases studied by Boisen. Of the 173 patients studied at Worcester, 36 patients indulged openly in erotic practices. 56 patients acknowledged sex difficulties, although they displayed no overt erotic behaviour. In the remaining group, there was no direct evidence and the patients themselves were reticent about these matters. These showed much better prognostic results than the group who openly indulged in erotic behaviour. From these findings Boisen concludes:

These figures support the view that the primary evil in a large proportion of the cases is the short-circuiting of the urge for self-realization and the dissolution of the personality under the influence of instinctual cravings which have got beyond control, and that this occurs most surely in those cases in which the individual makes no resistance. They show furthermore that the preservation of the appearance of decency through the seclusive, evasive, reticent attitudes tends to prevent the more extreme forms of the disintegration and that such individuals may even get better and go out.¹

Boisen goes on to say that his findings indicate that self-blame, even in its morbid states, is not necessarily evil:

¹ Boisen, EIW, 37-38.
it may be "an attempt at cure which makes or breaks the sufferer." In other words, attitudes of frankness and self-blame are good prognostic signs. It seems that in Boisen's view erotic contents and behaviour can be associated with favorable outlook only when they are appraised by the patient as sinful, unworthy or evil.

On the other hand, Boisen believes that open eroticism is generally to be viewed as advanced deterioration of self-respect. Patients who indulge in overt sexual behaviour have, as a rule, never "arrived at healthy adult sexual development with wholesome expression of sex drive." He cites the case of a stoutly-built boy of twenty-three whose condition progressively deteriorated. He indulged in erotic phantasies and practices. He masturbated openly, exposed himself before the nurses, and talked freely of his early sex-play with girls. Another patient believed that women were in love with him and controlled his sex functions, and he insisted on living with them.

It would appear that Boisen regards open eroticism as a poor prognostic indication. Symbolic sexual behaviour, in his opinion, would be a good prognostic sign. In the case of Albert, there was little sex concern (though sex

2. Boisen, TMI, I, 27.
problem figured in his illness), but he did indulge in "obscene drawings" which led to his discharge from an occupational therapy class.\textsuperscript{1} Another woman patient who finally recovered, refused all food and regurgitated everything that was given her. She became mute, untidy, and would retain large quantities of saliva in her mouth for long periods. According to Storch, much of this behaviour is symbolic of sexual activity or resistance to it. Refusal of food or retention of urine represents resistance to sexual activity. On the other hand, as in the case of a schizophrenic teacher who urinated in bed, urination was a substitute for sexual act.\textsuperscript{2} Sullivan considers nihilistic delusions, associated with continuing preoccupation with sex functions, as a deeply regressive phase of schizophrenic, the outlook for recovery being very poor.\textsuperscript{3} He does not however agree with Boisen that 'overt' sexual behaviour shows poorer prognostic indices than 'accepted' sexual problems.\textsuperscript{4} He points out certain inconsistencies in Boisen's reasoning. Speaking of erotic behaviour Boisen stresses the point that great caution must be exercised in passing judgment on the basis of objective behaviour alone. What we need to know is the meaning of

\begin{thebibliography}{9}
\bibitem{1} Boisen, EIW, 36.
\bibitem{2} Storch, PAF, 16.
\bibitem{3} Sullivan, MCP, 85.
\bibitem{4} Sullivan, Rev., (1939), 424-427.
\end{thebibliography}
this particular behaviour to the patient. Two patients may do equally disgusting things; for one it may mean self-punishment or degradation of the ego, while in the case of the other, it may be just an expression of baser human nature. From a prognostic standpoint, "the significance of such behaviour is vastly different in the two cases."¹ Now, how does this emphasis on the meaningfulness of a particular behaviour, square with Boisen's view that open indulgence in sexual behaviour is always to be viewed as advanced deterioration of self-respect?

6. Dynamics of Schizophrenia

In the preceding pages we have discussed Boisen's studies concerning the onset and ideation in acute schizophrenic reactions. How is the schizophrenic reaction precipitated? What are the developmental stages preceding the appearance of the fully psychotic behaviour? What are the characteristic ideas and beliefs of acutely disturbed schizophrenic patients? What prognostic indices do these suggest? These questions have engaged our attention so far. In this section we propose to discuss the schizophrenic disturbance not from a merely phenomenological standpoint but from a dynamic point

¹ Boisen, EIW, 57.
of view. How can we account for the different forms of schizophrenia? This is a hotly debated question and different theories have been offered to account for these. But we are here primarily interested in Boisen's point of view and in his hypothesis that certain protective devices that the patient brings to bear on his basic problem are partly responsible for different types of schizophrenia.

1. Reaction Patterns

Schizophrenia, according to Boisen, represents a failure in the realm of interpersonal relationships. It is a defect in adjusitive processes, an inability to socialize and assimilate new experiences. It is a clash between "the generalized other" and instinctual tendencies which are neither controlled nor acknowledged. It is likewise a conflict between the 'accepted' ideals and ambitions and one's natural endowment. Repeated failures of attempts at reorganization of personality, combined with unfavorable situational factors, result in a growing sense of isolation and feelings of personal failure, inferiority and guilt. From this arises an intolerable loss of self-respect which, according to Hoskins, is "an imperative biological necessity." Progressive withdrawal from society then becomes a habitual pattern, a method of dealing with one's personal situation and of reducing one's feelings of inferiority and shame by avoiding painful social contacts. This method of avoidance makes socialization
progressively difficult, increases the sense of isolation, and intensifies one's conflicts by internalizing them. How one deals with one's sense of personal failure and intolerable loss of self-respect, then becomes an important question. Various defensive or adjustive methods are used to cope with this problem.

(1). Drifting

This method of dealing with one's problem is an acknowledgment of defeat and surrender. Boisen's findings show that many patients, instead of making a determined effort to combat their psychosis, simply give up the struggle and drift down toward destruction. They lose all ambition and become discouraged and apathetic. Unable or unwilling to view their problems realistically, they find solutions to their problems in the world of fantasy, day-dreaming and hallucination, where nothing is beyond one's reach. Klein remarks:

The apathy of the schizophrenic of this type may consequently be a defense mechanism. At all events through the years the apathy may become more and more pronounced and its effects more noticeable. It is commonly held

1. Boisen, EIW, 28-41, 153-162. For a detailed discussion of Boisen's point of view, see Hoskins, BS, 83-91; Klein, MH, 161-170; White, AP, 537-538. These psychiatrists accept Boisen's view of the dynamics of schizophrenia.
that many chronic drifters, ne'er-do-wells, prostitutes, hermits, and hoboes are really victims of schizophrenia of the simple type. 1

(2). Delusional Misinterpretation

A large number of schizophrenic patients, according to Boisen's findings, resort to the protective mechanisms of denial, projection or compensation. Unlike the drifters who give way to apathy and demoralization, they refuse to acknowledge defeat by denying it and find in their delusional world convenient face-saving devices to bolster up their egos and conceal their failures and shortcomings. They misinterpret reality (which they may correctly perceive) to suit their purposes and build delusional systems in which they imagine themselves kings and rulers or hapless victims of aggressive designs. They find themselves surrounded with enemies and hear voices that threaten them with sexual or physical aggression. Boisen terms this device as "externalization of conscience"--a projection of inner conflicts and cravings on to the outside world. In actuality, this is not different from the common tendency among normal humans to project their own defects and failures into their environment. Thus the psychotic distortions of belief are but an exaggeration of the tendency to deny one's defects by seeing them in others, or to disparage those gifts

and talents in others which one lacks in himself. Extreme delusional misinterpretations isolate the individual from the group; but "even though they estrange an individual from his group, they serve to keep him from going to pieces and enable him to maintain a certain degree of integration and poise."¹ A large part of the population of mental hospitals is composed of just such individuals. They have achieved a measure of integration on the basis of their delusional beliefs, and within the sheltering walls of the mental institution they act as useful members of the hospital community. But they present a sorry spectacle and have apparently lost all incentive to growth, self-realization and to abundant living.

(3). Reactions of Panic

In the cases studied by Boisen reactions of panic often occur. Even the patients who drift or are deluded sometime or another become aware of their danger. Drifting down the path of destruction and disintegration they may suddenly become acutely aware of the danger that threatens them. The result in such cases is likely to be a profound emotional disturbance. The patient may become extremely discouraged and hopeless about his situation; he may completely withdraw from reality and believe himself

¹. Boisen, EIW, 29.
dead or may actually attempt suicide. Or, as Klein puts it, "he may react to this with the emotional excitement of a person trapped in a burning building or with the hopeless despair of a condemned criminal whose last appeal has been denied."¹ On the basis of his own experience and that of his patients, Boisen draws a line between these panic reactions and the end results of personality disintegration or delusional malformation. Such panic reactions, in both their agitated and stuporous forms, "are not evil in themselves, but are analogous to fever or inflammation in the body. They are attempts at cure...which are closely related to certain recognized types of religious experience."²

Boisen distinguishes two types of panic reactions. The simple types of panic reactions are relatively free from concealment devices. These patients do not make use of "face-saving" devices, but accept responsibility for their condition. Feelings of self-blame and guilt are predominant in such disturbances which as a rule begin with sudden onset. Concealment reactions, if at all present, are only temporary. Mixed types of panic reaction take "place in a personality already somewhat warped through its attempts to interpret

¹ Klein, MH, 163.
² Boisen, EIW, 29-30.
the life situation in terms that will enable it to go on functioning as a unit. They are like those who admit defeat or error by denying it.

According to Boisen's findings, the profounder panic reactions are commonly associated with a constellation of ideas including cosmic catastrophe, cosmic identification, rebirth, previous existence, mission, and so on. Nihilistic delusions, "when accepted and not resisted as due to enemies," also occur in the same constellation. The concealment reactions, on the other hand, represent ideas of fictitious self-importance, incapacitation, and transfer of blame. While in the drifting type none of these ideas occur to any large extent, they are also characterized by "the lack of the fighting spirit in the face of difficulties." Concerning the patients who show panic reactions and acceptance of self-blame and responsibility, Hoskins writes:

It is perhaps this very persisting honesty and willingness to fight it out that accounts for the relatively good prognosis in such cases. They are likely to fight through to more or less satisfying victory, but failing this, are likely to reach a state of unresolvable despair.

ii. Clinical Types

We have considered the dynamics of schizophrenia in terms of the reaction patterns as they develop during the

1. Boisen, EIW, 41-42.
2. BS, 85.
acute phases of disturbance. We have seen that the subsequent course and end-result of schizophrenic reaction depend to a large extent upon the adjustive techniques that the patient brings to bear upon his particular problem. We will now briefly consider the dynamics of the different forms of schizophrenia in terms of clinical classifications.

(1). Simple

The simple type of schizophrenia is more or less the drifting type which represents a way of life. Lacking adequate resources and ambition in his personality, the patient "drifts into a world of fantasy and easy pleasure-taking without putting up any determined resistance." Withdrawal is a major reaction pattern in this variety and may be present from very early years. Repeated failures at readjustment bring the reaction of hopelessness and despair, and one escapes from the sense of failure by "refusing to hope or to try." With the progressive shrinkage of interest and initiative, the patient sinks deeper and deeper into a world of fantasy to the point where the dream-world becomes the real world. In brief, simple schizophrenia represents the picture of one who loaf, dreams and drifts according to the impulse of the moment.  

(2). Paranoid

The "self-deceiving" type of patients, who take refuge in their delusional misrepresentations, may be included under paranoid schizophrenic states. The patient refuses to accept defeat or error and uses various face-saving devices to conceal his failures and inferiorities. He may build for himself a paranoid construction to preserve his ego, or he may devise a persecutory scheme which serves the same purpose by transferring blame on others. The resulting attitudes are either of fictitious self-importance or of bitterness and hatred. The person who has suffered nothing but pain and unpleasantness in his interpersonal relationships finds in paranoid constructions a haven of rest and security. Sullivan considers the paranoid development in a schizophrenic state as bad omen, and shows the difficulty of therapeutic approaches by stating:

A paranoid systematization is...markedly beneficial to the peace of mind of the person chiefly concerned, and its achievement in the course of a schizophrenic episode is so great an improvement in security that it is seldom relinquished.

(3). Hebephrenic

The hebephrenic type, according to Boisen, represents

2. Sullivan, MCP, 77.
the terminal stages of the demoralization which may follow upon an unsuccessful attempt at reorganization. The unfortunate sufferer not only loses hopes but self-respect and drifts down to progressive disintegration. In him the instinctual tendencies go wild, and he is extremely indifferent or oblivious to the opinions of others. He gives up his struggle and becomes what Klein calls "the shuttlecock of impulse."

The hebephrenic patient represents a complete "fragmentation of personality," and his speech affects—neologisms, word salads, and ideational distortions—can only be understood in this light.1 Hoskins accepts Boisen's characterization of hebephrenic ideation, but believes that no impressive evidence for its psychogenic basis can be secured.2

(4). Catatonic

In discussing catatonia, Klein remarks, "Boisen is on home ground," for, as we have already shown, he spent many of his days in the hospital in catatonic stupor. From him, therefore, we get an insider's view of catatonic inner dynamics. "From the outside," writes White, "it was impossible to say more than that he (stuporous catatonic) seemed to resist being disturbed and to be alertly registering what went on

2. Hoskins, BS, 90.
around him."¹ Boisen views catatonia as a desperate attempt at reorganization in the face of an overwhelming sense of personal failure and an awareness of danger.

The panic reactions associated with catatonia arise from an acute awareness of danger. Drifting down the path of destruction he suddenly becomes aware of the destructive nature of this downward trend and of the loss of love, hope and security that it implies. This sudden realization may seize him with panic and throw him into a violent emotional upheaval. Then follow desperate attempts at reorganization in the face of threatened danger. But the issue may be victory or shattering defeat. The attempt may fail if the sufferer lacks adequate personality resources, or if he is unable to own or control his instinctual cravings. The panic, in that case, will paralyze further efforts and a quick regression to hebephrenic states will follow.

But constructive results may issue as a result of these desperate attempts, especially when they are free from malignant trends. The purposive aspects of acute disturbances are recognized by Sullivan.² The patient recognizes the danger and faces the issue squarely and frankly without

¹ White, AP, 537-538.
² Sullivan, Art. (1924), 77-91.
resorting to projective or other concealment tactics. Boisen finds the largest proportion of recoveries in the panic group. Even in warped personalities, panic "may serve to break up the shell of delusional misinterpretation and set the victim free."¹ Hoskins agrees with Boisen that in such cases "the individual is most obviously overwhelmed by failure of his own sense of self-esteem and most determined to regain it."²

Acute schizophrenic reactions are analogous to certain "eruptive" types of religious conversion experiences, for in the latter, too, a sense of personal failure and guilt is present. The individual may become extremely panicky and terror-stricken, as the realization of his "sinful" or "lost" condition suddenly dawns on him. There may be alternating moods of elation and depression, of hope and despair, of morbid conscientiousness and obsessive guilt. The individual may believe that he has committed the "unpardonable sin" and feel himself threatened with "hell fire" and the oncoming "day of judgment." Feelings of utter worthlessness and deep self-depreciation may possess him, and he may believe himself sunk into the slough of sin and shame.

¹ Boisen, EIW, 43.
² Hoskins, BS, 90.
from which only the "abounding grace of God" can rescue him. Usually the same constellation of ideas as we find in acute schizophrenic state is present. The individual goes on to concern himself with cosmic affairs and believes himself as "in the central role in the cosmic drama." Personal issues and problems are raised to the level of the cosmic and the universal. Such profound emotional upheavals may result in an eruptive breaking up of evil habits and the turning of vital forces along new channels. In acute schizophrenic upheavals similar results may accrue, for they often serve "to purge out accumulated poisons and break up malignant concealment devices which have been blocking development."¹

The panic reactions in catatonia may take the form of excitement or stupor or of both. The dynamics of these conditions are viewed as "attempts, by regression to genetically older thought processes, to reintegrate masses of life experience which had failed of structuralization into a functional unity."² Here Boisen is "obviously using Sullivan's characterization of catatonic regression as "intra-uterine mind." The basic dynamism involved in the

1. Boisen, EIW, 159.
2. Boisen, EIW, 111.
catatonic state is, according to Sullivan, a profound preoccupation with "regaining a feeling of security." The appearance in this state of "ancient myths of redemption and rebirth" and of "the remnants of religious teachings" is not due to any unfolding of some racial unconscious but is merely a regression to primitive level of thinking. Boisen, however, differs from Sullivan at this point. He regards catatonic stupor and mutism, not merely as regression to primitive thinking or an expression of acute despair, but as representing desperate attempts at reorganization of personality in the face of danger. The mutisms, stupors, postural attitudes and the autistic shutting out of reality by catatonics are akin to mystic ecstatic brooding and the complete self-absorption of creative thinkers. They are attempts to attain vital solutions to vital problems by "shunting out extraneous disturbances." Unlike Sullivan, Boisen sees meanings and values in the cosmic concern of the catatonic; they represent personal values and loyalties raised to the level of the universal and the abiding. What appear to an outsider as meaningless gestures and movements may represent intense mental activity and vital emotional vibrations. The patient is not lost in a world of fantasy and make-believe; he is honestly and valiantly coping with vital personal issues.²

1. Sullivan, MCP, 74-75
This concludes our discussion of the dynamics of schizophrenia. The primary evil in schizophrenia is a sense of personal failure and guilt, and the acute schizophrenic reaction is a desperate attempt at reaching a solution of this basic problem. The result, however, may be unsuccessful and the chronic schizophrenic states represent arrested or progressive disintegration of personality. Defensive mechanisms of projection, denial and withdrawal lead to drifting, delusional misinterpretation and progressive dissolution. Happy outcomes of schizophrenic reaction are marked by frankness, self-blame and acceptance of responsibility. Religious concern in such cases is a particularly good prognostic indication.

7. Therapeutic Formulations

We have thus far been concerned with the different aspects of Boisen's studies with schizophrenia. We have discussed them objectively and in relation to other studies that bear on them. In the following pages we propose to consider the therapeutic implications of his theory with some concluding observations and remarks.

1. Prognostic Indices

The end results of acute schizophrenic reactions may lead to progressive or arrested disintegration, or to com-
plete or partial social recovery. The patient may recover from his mental illness without any particular change in his attitudes or personality. In such cases there may be repeated recurrences, since the basic problem remains unsolved. In other cases there is either a progressive degeneration or an integration based on delusional misinterpretation. There are, however, patients who do recover from their temporary disorders with very favourable results.

Are there any objective indications which can help us to determine the course of a particular schizophrenic psychosis? Boisen says that any such forecast must be based upon "moral stock-taking". We must go back from outward symptoms to "inner forces and motivations which make either for life or death, for renewal or destruction."¹ What a particular behaviour means to the patient, and how it is related to his scale of values, is more important than any judgment passed on his objective behaviour alone. On the basis of his studies Boisen makes some important suggestions.

(1). Reaction Patterns

The character of reaction patterns in acute schizophrenic states furnishes important prognostic indices. Acute disturbances involving acceptance of responsibility

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¹. Boisen, Art (1933), 577-578.
Also see Boisen, EIW, 38-57, 159-162
and self-blame, in Boisen's opinion, represent a favourable outlook. Where the patient takes to projective devices and transfers blame to others, the outlook for recovery is definitely poor. Of the 173 patients studied by Boisen at Worcester, 69 showed these concealment reactions and never made a complete social recovery; the remaining number include patients who made complete, partial or temporary recovery. In their pre-psychotic personalities these patients reflect traits of emotional instability, sensitivity and self-consciousness; they are also free from concealment reactions and are frank and open about their problems. Sullivan, as we have pointed out, finds a large incidence of recoveries in such cases. Hoskins says that such patients are accessible to psychotherapy.

(2). Ideation

Associated with panic reactions are a set of ideas that are peculiarly characteristic of the patients who are more or less free from malignant involvements. It represents a constellation of ideas, including ideas of cosmic catastrophe, cosmic identification, rebirth, previous existence, mission, etc. It is the cosmic character of such ideas that chiefly distinguishes these patients from the drifters and the self-deceivers. The latter may occasionally have such ideas, but in most cases their ideas have reference to earthly
influences and forces. Paranoiac constructions in panic reactions are also at their minimum, or merely incidental and transitory. In 99 of his cases Boisen finds panic reactions associated with ideas of death, cosmic catastrophe or cosmic identification. Among these he finds a large number of social recoveries. Boisen is probably alone in suggesting ideational content as a significant prognostic index.

(3). Personal Attitudes

Attitudes of frankness, honesty and self-blame suggest a favourable outlook for the patient. Chances of recovery are much better in the case of one who accepts blame and responsibility for his condition and voluntarily seeks help from those who are competent to offer it. Boisen's findings, in which he is a pioneer, show that the sense of guilt and shame is not necessarily an evil thing. The incidence of recovery he finds proportionately larger in such cases. Unless there are complicating factors, "those who commit 'the unpardonable sin' are likely to get well." Psychiatrists in general recognize the presence of such negative self feelings in catatonic and depressive states, but few

1. Boisen, EIW, 40.
would accept them as "constructive," especially in their morbid states. But more statistical studies need to be made before one can challenge Boisen's point of view.

(4). Sudden and Acute Onset

Sudden and acute schizophrenic disturbances stand a much better chance of recovery.

"The more sudden the onset and the more acute the disturbance, the more likely the patient is to recover, provided he can be protected from self-injury and from physical infection and exhaustion." \(^1\)

There is a general agreement among psychiatric investigators on this point. For instance, Strecker reports that the incidence of spontaneous recovery is much greater in cases of acute and stormy schizophrenic onset. \(^2\) The acute reactions may even occur in advanced schizophrenic states and may help to break up malignant formations and bring the sufferer back to reality. But the acute disturbance is like a two-edged sword; it may make or break. Where it fails the patient degenerates rapidly; successful outcomes, however, result in reintegration of personality around higher goals.

(5). Life Situation

The chances of recovery are much better if the life

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1. Boisen, EIW, 56.
2. Strecker and Ebaugh, PCP, 423f.
situation allows a satisfactory adjustment. If the patient lacks adequate personality resources, favourable environmental factors, or fails to achieve some solution of his instinctual cravings the chances of recovery are rather slim. The prognosis is hopeful if the patient is acceptable to his social group and has necessary personality resources. Where the schizophrenic reaction involves a strong element of struggle against external circumstances, the case is particularly hopeful. This is often true of catatonic patients who, unlike the drifters, put up a strong fight against their psychosis; and it is generally agreed that the incidence of cures is better in catatonia than in other forms of schizophrenia.\(^1\)

(6). Religious Concern

Boisen's findings further indicate that religious concern in acute reactions is a good omen. Boisen uses the term religion to include concern with cosmic affairs or values, besides prayer, Bible reading or other religious activities.\(^2\) He points out that religious concern or quickening is often associated with crisis periods. In acute panic reactions, therefore, it often makes its

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2. Boisen, EIW, 49
appearance even in those who have not previously been religiously trained. We find a striking illustration in the case of Clifford Beers who once found himself writing a religious poetry during one of his psychotic hours. The explanation for this is found in the social nature of religion, as Boisen suggests.

Religion is thus social in origin and it seeks to meet the need for social response and security in the attempt to identify the individual self with that which is felt to be universal and abiding in human society. The personalization of this conception in the idea of God is a consequence not merely of the social origin of religion but also of the need of the struggling individual for social support and for relief from the sense of isolation.

Cosmic concern and the tendency to personalize cosmic forces are usually associated with panic reactions when the patient becomes acutely aware of danger and makes desperate attempts at reorganization. In drifters and self-deceivers such cosmic concern is usually lacking or merely passing; they are more concerned with mundane affairs and mundane forces.

11. Constructive Aspects of Acute Disturbances

Boisen emphasizes the essentially constructive character of acute schizophrenic reactions. They are desperate attempts of the sufferer to reorganize his personality in the face of

acute danger. They represent problem-solving experiences, involving vital personal issues or decisions in life situations. They are akin to the creative processes involved in the production of human insight. The patient may emerge from "the wilderness of the lost" as a creative artist, converting his liabilities into assets. Various others writers including William James and Sullivan, have emphasized this constructive aspect of acute mental disturbances. French and Kasanin have report two cases of schizophrenic patients and arrive at the conclusion that acute psychoses may be regarded as temporary episodes leading from lower or older levels to higher or newer levels of adjustment.

In the light of his findings Boisen concludes that acute reactions may result in happy or unhappy solutions, and as such they are not to be considered as evils. They are essentially curative and like fever or inflammation represent nature's power to heal. Just as one's temperature in typhoid fever is a sign that enemies in the blood are being destroyed by phagocytes, so in acute reactions curative forces are making a desperate attempt to save the patient's life. Mental disorders, therefore, especially in their acute forms, are manifestations of nature's healing power.

They are attempts by regression to the lower levels of mental life to assimilate certain hitherto unassimilated masses of life experience. They represent the delinquescence of the old sets and attitudes which make possible new formations. They are essentially purposive; in this group we even found individuals whose lives had been changed for the better.1

But, as in fever or inflammation in the body, so here, the curative forces of nature may succeed or fail in healing the ailments of the mind. Where they fail the outcome is progressive degeneration and destruction. This shows itself in the formation of malignant growths and concealment reactions. But, where the sufferer cooperates with the power of nature and brings his own inner resources to bear on his problem, the results are definitely constructive and salutary. In other words, Boisen looks upon suffering as definitely remedial. When the patient recognizes this purposive element in his suffering, appreciates the seriousness of his condition, and faces his ordeal with courage and frankness the outlook for recovery is very favourable indeed. Religious concern, as we have indicated, is also a very good prognostic sign in acute schizophrenic reactions. It is a great synthesizing force in human personality. It helps the sufferer to raise personal issues or personal loyalties to the level of the

1. Boisen, EIW, 54.
universal and the cosmic; it provides emotional undergirding and support; it reduces fears and anxieties, feelings of guilt and isolation; it sensitizes one to the infinite possibilities of his being. Religion, therefore, whether in health or in illness, is a unifying and constructive force in life. Crisis periods are especially associated with religious quickening and religious concern. It is therefore not surprising that severe emotional and mental crises, such as acute schizophrenic disturbances, turn one's thoughts to the realm of unattained possibilities symbolized by religion and the idea of God. We again come back to Jung's point of view that a weltanschauung, or a philosophy of life, is a positive factor in maintaining mental health.

iii. Principles of Psychotherapy

Boisen recognizes the problem of creating a therapeutic relationship with schizophrenic patients. This is especially true in severe psychotic disturbances. Such patients are impervious to therapeutic approaches, and it is difficult to establish rapport with them while their fears, their suspicions, their self-blame generally become so irrational and obsessive as to yield little to treatment. For such patients, Boisen seems to imply, radical procedures may be indicated. Acute disturbances, however, are like the "breaking open of an abscess. The poison is already out and no lancing is
necessary.¹ Such acute reactions would, in Boisen's view, be free from protective devices and malignant involvements. What principles and procedures of psychotherapy are therefore applicable in the case of such acutely disturbed schizophrenic patients?

Boisen calls our attention to certain principles of psychotherapy which are applicable in the treatment of schizophrenia. These are based upon his findings and upon his own counseling experience with acutely disturbed mental patients.

(1) In the ailments of the mind, as of the body, Nature's curative forces are at work. "Man's power to help is very limited, and nature itself is the chief actor in most of the cures that are actually affected."² The physician or counselor is a kind of chemical catalyst or obstetrician, and merely assists nature in removing obstacles that block or hinder "the free flow of life-giving forces." This assumption has important corollaries.

(2) It follows therefore that man has within himself resources for growth and mental health. This is, of course the basic assumption of non-directive psychotherapy.³

¹ Boisen, EIW, 267.
² Boisen, EIW, 54.
³ Rogers, CP, Chapter VII.
Sullivan states this point very clearly in these words:

Personality tends towards the state that we call mental health or interpersonal adjusting processes, handicaps by way of acculturation notwithstanding. The basic direction of the organism is forward.¹

The primary task of a wise counselor is therefore to bring into light the inner resources and inner conflicts of personality,² to facilitate "the accession to awareness of information which will clarify for the patient the more troublesome aspects of his life."³ Very often, says Boisen, the mere bringing to light of the patient's difficulty is sufficient to resolve the conflict.

(3) Interpersonal communication provides catharsis for repressed conflicts, reduces the sense of isolation, and concretizes and clarifies one's generalized fears, anxieties and worries. In the inability to communicate and thus socialize new experiences lies the failure of the schizophrenic. That which one is unable to communicate to others lies unformulated in the subconscious, only to manifest itself in psychotic revery and autistic processes. This is perhaps the reason Boisen considers the use of language as "the key to the understanding of schizophrenic

¹ Sullivan, MCP, 48.
² Boisen, Art, (1928), 563-564.
³ Sullivan, MCP, 91.
⁴ Sullivan, MCP, 91.
thinking. ¹ This brings out the need to encourage the patient to talk over his problem with a wise and sympathetic physician.

(4) The real evil in mental illness lies not in the conflict but in the sense of isolation and estrangement which it entails. It is therefore not necessary "to lower the conscience threshold in order to get rid of the conflict." What the patient needs is "forgiveness and restoration to the fellowship of that social something which we call God." The patient must be set free from his fears and his feelings of isolation. Higher social standards and ideals must be implanted or reinforced and the patient must be helped to identify himself with the group of those who are moving to become better. Rigid and static moralities must be replaced by the dynamic type. ²

(5) How the patient looks at his own situation is more important than what the physician thinks about it.

No judgment should be passed on the basis of objective behaviour alone. What inner meanings and motivations underlie a particular behaviour, in terms of the patient's own scale of values, is most important and must be taken into account. What the patient thinks, what the "voices" say

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2. Boisen, REP, 8.
to him, in fact all his ideas and beliefs may furnish important clues for psychiatric approach. To use Meyer's phrase, "to make sense out of nonsense" is the psychiatrist's job. Favorable prognosis is indicated in acute panic reactions characterized with ideas of cosmic catastrophe, cosmic identification, rebirth, previous existence, mission, and so forth. These cues are especially promising if religious concern is associated with them, and attitudes of self-blame, honesty and frankness are present.

(6) Psychotherapy is a matter of personal relationship between the patient and the physician, and techniques and methods are of secondary importance.

Wherever the patient has come to trust the physician enough to unburden himself of his problems and wherever the physician is ready to listen with intelligent sympathy, good results are likely to follow regardless of correctness of the physician's particular theories or procedures.1 This does not mean that techniques are not important. We always learn from the experiences, insights and skills of successful practitioners. But one is not required to understand all the factors involved in order to do good psychotherapy, just as a driver does not need to be a mechanic in order to drive his automobile.2 What is necessary is a genuine interest in the patient and a readiness to listen to him. "The essence of

1. Boisen, EIW, 240.
2. Boisen, EIW, 239. See also Campbell, Art. (1925), 31; Cabot and Dicks, AMS, 189-203.
psychotherapy is thinking with the patient about his problems.¹ We must respect his personality and not impose our own opinions and formulations upon him. We must be able to see through the symbols he uses to express his problems and to interpret them to him; we must sense things that are left unsaid. The assertion that one should be non-judgmental is not true in all cases. A good counselor must be a good diagnostician and recognize the cases that are more or less hopeless. He must judge, but judge kindly. "He must really be able to see some possibilities of usefulness amid the wreckage of apparent failure and some possibilities of beauty in what seems commonplace and unlovely."² There are two methods of psychotherapy in current practice: one relies on personal influence alone and uses the techniques of suggestion and persuasion. The "faith-healing" groups employ such methods. The other way is to discover and solve the patient's actual difficulties. This latter method gives hope of genuine progress.³

(7) The importance of group therapy must be recognized. The primary evil in mental illness is a sense of isolation from those whose ideals and standards one has accepted and upon whom he depends for love and security. For the sake of

¹ Boisen, Art. (1948)², 21.
² Scotford, Art. (1944), 6.
³ Boisen, EIW, 245f.
mental health one must belong to some group. The delinquent does this by associating himself with a gang who have easy standards and, thus, preserving his mental health at the cost of lowering his conscience threshold. "It seems safe to say that no man will have a psychosis so long as he can belong to some group whose standards he can accept as final.\textsuperscript{1}

The minister of religion challenges one to integrate his primary loyalties into a more comprehensive and abiding loyalty; he is an outstanding exemplification of the group therey. He may disturb a man's conscience but he and his group have also the power to heal.\textsuperscript{2} When the patient attempts reorganization of his personality in the context of interpersonal relationships, especially under the influence of a religious group or a psychotherapist, the attempt is more likely to be successful. Attempted reorganization fails in most cases where the experience is solitary.\textsuperscript{3}

(8) There are great therapeutic values in religion and in worship. Apart from providing emotional and social support which the schizophrenic patient sorely lacks, religion raises personal issues and values to the level of the cosmic. There is therapy in the very idea of God. In his concern with cosmic affairs the patient is simply struggling to reduce his sense

\textsuperscript{1} Boisen, Art. (1932)\textsuperscript{1}, 58. See also Boisen, EIW, 288-290.
\textsuperscript{2} Boisen, Art. (1948)\textsuperscript{2}, 19.
\textsuperscript{3} Boisen, EIW, 160.
of isolation and attain a sense of belongingness with what he conceives to be supreme in his system of loyalties. Very often this is personalized and expressed in the idea of God. "This idea of God thus has a unifying effect not only upon the individual but upon the group in that it provides all with a common object of loyalty and makes for an organized universe." In common worship and fellowship we find a further exemplification of this integrating influence of religion.

8. A Critical Appraisal

Boisen's psychiatry of schizophrenia presents a remarkable synthesis of the fields of sociology, psychopathology and religion. Perhaps very few investigators have attempted such a difficult task, especially in an area which is so beset with obscurities and contradictory views and findings. Boisen has turned schizophrenia inside out and traced its inner processes and dynamisms with remarkable acuteness. Starting from his own schizophrenic episode as a point of departure, he has found the same dynamisms at work in a large majority of cases that come to mental hospitals labeled as "schizophrenic." He has drawn data from his wide field without succumbing to any particular point of view except his own. Let us briefly summarize and appraise the main points of our discussion so far.

(1) In his *sociodynamic approach* to schizophrenia, Boisen follows the viewpoint of George Mead and the Chicago School of Social Psychology. Personality is a product of interpersonal relationships. It represents an integration of self in terms of the internalization in the individual of the "generalized other," which includes primary loyalties and organized social mores. These integrative processes take place through socialization and assimilation of new experiences, in which language symbols and gestures play a prominent part. Personality disturbances set in when new experiences, which seemingly conflict with one’s "accepted" standards, are not socialized and assimilated. This at once separates one from his own group and creates a sense of personal failure and guilt. In schizophrenia these adjustive difficulties combine with a strict moral upbringing and a marked sexual sensitivity to produce acute intra-psychic conflicts. Thus schizophrenia represents a failure in interpersonal relationships and its primary evil lies in a sense of personal failure and social isolation.

(2) Boisen’s hypotheses are based upon a *psychogenic* view of schizophrenia. In this he is largely influenced by the dynamic interpretations of Freud, Jung, Meyer, Sullivan, Campbell, and others. In his view, genogenesis or somatogenesis play a relatively minor role in the etiology of schizophrenia. The importance of early influences is however
recognized. He accepts Freud's view that sex is an important etiological factor in mental illness, more specifically schizophrenia; but like Freud he does not regard schizophrenia as a "narcissistic" disorder inaccessible to psychotherapy. The idea of "the generalized other" in Boisen's conception is somewhat similar to the Freudian "super-ego"; but instead of regarding it as something rigid and static, he stresses its constructive and dynamic aspects. Primary loyalties and group folkways play a constructive and unifying role in the development of personality; they grow and expand as does the individual and their true significance is seen in terms of their integration into a larger and more comprehensive system of loyalties and values. It is only when the primary loyalties or ideals lose their dynamic character and become "fixated" that they block progress or act as "ego-alien" forces.

(3) The basic problem of schizophrenia lies in a sense of personal failure and social isolation, a sense of disharmony between one's accepted ideals and his own instinctual cravings which he can neither acknowledge or control. Boisen does not throw into bold relief the inner dynamic structures of these feelings but explains them more in the context of interpersonal relationships. The sense of failure and isolation arises from some basic inability to socialize and thus assimilate new experiences. This separates one from his group
and creates in him feelings of guilt and shame because of his failure to measure up to the standards he has accepted as his own. In contrast to the schizophrenic, the delinquent substitutes lesser loyalties in place of his primary loyalties (one wonders if the delinquent has often much of a choice between the two!), and thus by lowering his conscience threshold finds social approval and identification in gangs with easy standards. But how are we to account for these differences among the individuals? Are they something innate, acquired, or genetically determined? These questions Boisen leaves unanswered.

(4) How one deals with the sense of personal failure is an important question. This brings into play various protective devices. Compromise, diversion, bluffing, shifting of responsibility, and withdrawal are some of the common devices to ward off the feelings of inferiority, failure, guilt and isolation. In the schizophrenic there is a general retraction of interest and a progressive withdrawal from the external world. But how is this method of withdrawal at the same time a method of dealing with one's sense of isolation? Perhaps Boisen would retort that although this withdrawal further intensifies the sense of isolation, nevertheless it helps the patient get some relief from the sense of failure and guilt. All these protective devices are merely defenses against the basic sense of personal failure.
But, then, what accounts for the differing manifestations of basically the same problem? Boisen does not explain this, nor does he as before attempt to interpret the dynamics behind these protective mechanisms except in terms of a sense of personal failure. In attempting to reduce all abnormal mental phenomena to a single principle derived from a study of schizophrenics alone and in using it as a dynamic explanation for behaviour patterns which belong to totally different chains of cause and effect, Boisen, in our opinion, repeats the fundamental error of Freudian and Adlerian theories. The sense of failure which is fundamental in Boisen’s conception of mental illness seems to be rather close to Adlerian principle of inferiority. This is certainly not an adequate explanation for the entire ramifications of a mental illness.

(5) In Boisen’s view schizophrenia is a developmental disorder. A history of interpersonal maladjustments, especially in the realm of sex, precedes the actual onset of the disease. Schizoid trends begin to appear early in life, but the full-blown psychosis does not, as a rule, occur before adolescence. The precipitating causes of the acute disturbance, in Boisen’s opinion, are merely incidental and have no bearing on the disease itself. Psychiatrists would probably disagree with Boisen. Why should a particular cause and no other serve as the precipitating cause of schizophrenic
breakdown? It must have some relationship to the chain of developmental causes preceding the onset. Fenichel suggests that the precipitating cause represents or symbolizes childhood threats or anxiety-linked strivings. Any situation involving major decisions or major responsibilities—the areas of peculiar difficulties for the schizophrenic—may precipitate such a disorder. From the therapeutic angle, it may be suggested that the cause that brings about an actual mental breakdown may, in some cases, foreshadow the means whereby the patient may be brought back to reality.

The onset of acute schizophrenia begins with a period of preparation or frustration. It is a period of intensification of basic conflicts in which situational stresses play an important part. This is followed by a period of intense preoccupation and sleeplessness; the patient becomes extremely restless, nervous and highly suggestible. Then an upsetting idea, an automatism darts into the mind and with that the patient finally enters "the wilderness of the lost." Further elaborations of the idea occur in mythological or religious forms. The whole process is analogous to the phenomenon of insight in human beings. It can also be compared

1. Fenichel, PTN, 454-457. William Malamud describes the case of a young man, in which the importance of precipitating causes is clearly seen. See Art. (1944), 833-860.
2. Hutchinson, Art. (1941), 347-357.
to ecstatic mystical experiences, and Boisen makes frequent references in this connection to the writings of Max Weber, Coe, William James, and others. What impresses us is the fact that he makes no mention of Storch and Sullivan in this connection. These men describe the very processes which Boisen describes and there are striking points of contact. The only reference to Storch we can find in his writings is contained in a recent paper, and that in a somewhat different context. But we are inclined to believe that Boisen's description is more authentic, coming as it does from one who has himself been through the schizophrenic experience. Viewed in the light of his own illness, it becomes very illuminating.

(6) Boisen discusses "schizophrenic thinking" from the ideational standpoint. In acute disturbances there is a deep sense of the mysterious. Strange uncanny influences are personalized in terms of the cosmic. A certain constellation of ideas occurs in panic reactions: cosmic catastrophe, cosmic identification, ideas of rebirth, previous existence, mission, etc. Nihilistic delusions are also present, while ideas of reference do not as a rule occur in such acute reactions. In concealment reactions the delusions do not

have a cosmic reference. In panic cases which are free from projective tendencies there is self-blame, acceptance of responsibility and attitudes of frankness and honesty. Such patients give no evidence of open eroticism, and they are usually shy and reserved in discussing their sex problems, while this is not the case with drifters and self-deceivers. Such are, in the main, the findings upon which Boisen bases his therapeutic formulations.

Boisen is perhaps one of the few investigators, as Hoskins points out, who had made such a comprehensive study of the subjective aspects of schizophrenia. Several others before him have, of course, concerned themselves with this problem. Among them may be included Freud, Jung, Bleuler, Storch, and Mayer. Their dynamic interpretation of the meaning of symptomatic manifestations have done much to advance the psychiatric understanding of schizophrenia. But Boisen has been more concerned with the inner meanings and motivations that lie behind symptomatic behaviour and brings to bear on his interpretation a point of view and a personal experience not shared by any of his predecessors. When Boisen proposes the ideational differences as a basis for prognosis and for therapeutic endeavor, not only does he break new ground, but he finds himself almost alone. That schizophrenia, at least certain forms of it, may be functionally constructive, has been generally conceded by Sullivan, Fromm-Reichmann,
French, and others. That it involves concern with cosmic affairs and is comparable to certain eruptive types of religious and mystical experiences is also acceptable to many psychiatric writers. But there are questions which raise violent disagreement: How can we go behind objective behaviour to the inner meanings and motivations that prompt it and propose a theory of schizophrenic ideation that will be applicable in all cases? Boisen's conclusions may be right in certain cases but do we grant his premise? Attitudes of frankness and acceptance of responsibility are helpful and make the patient accessible to psychotherapy, but are morbid guilt feelings and nihilistic attitudes healthy signs? Do they not in so many cases lead to suicidal or self-destructive attempts? How do we account for recoveries in cases involving obviously no religious or cosmic concern? Clifford Beers is one instance and there are several others. Should we give up those whom we consider as hopeless cases on the basis of the hypothesis that they are "drifters" and "self-deceivers"? Do not Sullivan and Kempf cite instances of "spontaneous" recovery, who, on the basis of Boisen's theory, would have been given up as hopeless? If these cases represent "flight from reality," are not all psychoses, like all neuroses, a similar escape? Is "marked religious concern" in the patients always a good
prognostic sign? In our own hospital experience we have come across a large number of such patients who seem to be pretty well institutionalized! Boisen's own findings support these propositions, but they lack corroboration from other sources. Yet these findings open up a fascinating and maybe a very promising field of inquiry for psychiatry and religion alike. Boisen has done a great service in pointing out the teleological, problem-solving and ethical character of schizophrenia. He has seen meaning and rationality in what used to be regarded as explicitly meaningless and irrational.

(7) Boisen has not studied the structural aspect of schizophrenic thinking. Indeed in a recent article he makes mention of Storch's studies in this connection and seems to agree with his view that schizophrenic thinking resembles primitive thinking. He, however, finds the explanation in the fact that the schizophrenic, as well as the primitive man is much closer to nature and more receptive and attentive to extra-mental influences. The tendency toward concreteness and directness of perception, in the case of the schizophrenic, is explained as due to the fact that the latter "finds himself face to face with what for him is ultimate reality. He is profoundly stirred emotionally and quickened
mentally. For him meanings are outstripping symbols. 1 The normal man and the primitive have a similar tendency toward concreteness, but for a very different reason: they do their thinking in "an accepted currency of ideas" and very often indulge in mere verbalization without any emotional participation. We find it hard to follow Boisen's reasoning here. How he can see the same tendency toward concreteness in the primitive, the schizophrenic and the normal man is something difficult to understand. It is also to be noticed that Boisen follows Storch, Sullivan and others in viewing schizophrenia as regression to infantile and primitive thought processes "to reintegrate masses of life experience which had failed of structuralization into a functional unity." 2

Now, the question that we would like to propose is this: If the schizophrenic really regresses to primitive or infantile ways of thinking, how is he able to carry on such abstract and conceptual activities which Boisen's theory makes him capable of? Furthermore, Arieti's investigations suggest that the schizophrenic follows the "Von Domarius" principle as opposed to Aristotelian logic. He accepts identity based upon identical predicates; he confuses a symbol with the object it symbolizes; he is incapable of

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2. Boisen, EIW, 111.
figurative language and is more concerned with the mere verbalization of words than their connotation and denotation; he confuses the physical world with the psychological, and lives in a world of perception rather than a world of conception.¹ What we are trying to suggest is how these findings affect Boisen's view that schizophrenia represents a superior order of cosmic and rational values. In our opinion he has weakened his position by accepting the theory of schizophrenic mental regression.

(8) The subject of erotic involvement also requires comment. According to Boisen's findings, patients who display no open eroticism but acknowledge frankly their difficulties in managing their sex drive showed a larger incidence of recovery than those who indulged in open or overt eroticism. Sullivan does not agree with Boisen's view and points out a fallacy in his reasoning. At one place Boisen remarks that "great caution must be exercised in passing judgment on the basis of objective behavior alone,"² and he lays greater emphasis on inner meanings and motivations. Now, if this is true, says Sullivan, then "it is clear that we are violating this wise dictum if we assume that open indulgence in sexual behaviour is always or

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¹ Arieti, Art. (1948), 325-338.
² Boisen, EIW, 57.
generally to be viewed as advanced deterioration of self-respect. We have also pointed out that eroticism may not be expressed overtly, but it may find expression in terms of fantasies, drawings (as in the case of Albert), or other forms of expressive behaviour. What would Boisen's prognostic indices suggest in such cases? But he is probably right and finds agreement with Sullivan and others when he says the schizophrenics usually show sexual maladjustments in their pre-psychotic personalities.

(9) Boisen describes certain reaction patterns in schizophrenic disorders: drifting, delusional misinterpretation and panic reactions. Hoskins, Klein and White follow, in general, Boisen's interpretation in describing the subjective aspects of schizophrenia. In fact, Klein accepts his theory of schizophrenia in toto, for its obvious implications for prophylaxis and for mental hygiene movement. We again feel that Boisen does not sufficiently account for the dynamics of these reaction patterns. The drifter is an ambitionless loafer and the self-deceiver has more ambition than endowment; one meets frustration by demoralization, the other meets it by misinterpreting it in his favor; one accepts defeat as inevitable while the other accepts it by denying

it. All these reactions are explained, as before, in terms of a basic sense of personal failure. Panic reactions manifest themselves when one somehow becomes suddenly aware of danger. The danger consists in the fact that one suddenly comes to realize that he is drifting down the road to destruction. How are these panic reactions motivated—by a sudden eruption of the subconscious or by some "supernatural" agency? Boisen would probably accept the latter position, although he is not quite emphatic on this point.

(10) Boisen's reaction patterns parallel more or less the psychiatric classification of schizophrenia into simple, paranoid, hebephrenic, and catatonic. The first three types represent ways of life and include drifters and self-deceivers. They are regarded as more or less hopeless cases, although, as we have pointed out, cases of actual recoveries among just such patients have been reported. Elsewhere Boisen regards this psychiatric classification as unsatisfactory. "What it represents is types not disease entities. The types thus distinguished must be regarded as dynamic action systems and interpreted in terms of meanings."¹ Sullivan makes the same point.² But, in our opinion, this Kraepelinian

2. Sullivan, MCP, 74.
classification is almost vital to Boisen's theory of schizophrenia. It is also to be noticed that while Sullivan and other writers are careful to make a distinction between dementia praecox or "process" schizophrenia and schizophreniform functional disorders, nowhere in his writings does Boisen observe this important distinction. To him there are just two main types of psychosis: functional and organic. He seems to regard all forms of schizophrenia as purely functional. Modern psychiatric opinion is divided at this point, but there seems to be certain measure of agreement in regarding only catatonia as probably functional. Other forms of schizophrenia may have some somatic factors associated with them. We also notice in Boisen's writings a tendency to generalize too much. He seems to use schizophrenia and mental illness as synonymous terms. His studies are strictly confined to schizophrenic cases, but he regards the principles derived from these studies as equally applicable to all cases of mental illness. This generalizing tendency is more obvious when he deals with the relationship between mental illness and religious experience.

(11) Boisen's therapeutie formulations evolve from his psychiatry of schizophrenia. He would regard simple, hebephrenic and paranoid schizophrenics as unsuitable for any intensive psychotherapy; in such cases shock therapies may

be indicated. Psychotherapeutic endeavors are strongly suggested when prognostic indices include a certain constellation of ideas, panic reactions associated with attitudes of frankness, self-blame and acceptance of responsibility. Religious concern is regarded as indicating a very favorable outlook for recovery. In psychotherapy special attention is given to the patient's ideas and their meaning to him. The importance of listening, rapport and empathy is recognized. The patient must be given insight into his condition and helped to get over his internal conflicts and problems. Techniques are of secondary importance, and psychotherapy is a matter of personal relationship between the psychiatrist and the patient. What the patient needs is emotional support and group approval. This must be provided through group therapy. The psychotherapist must be permissive, understanding and non-condemnatory, but this does not mean that he has to be non-judgmental. He has to be a good diagnostician and must recognize the cases that are hopeful and those that are not. These are some of the therapeutic principles that Boisen enunciates. What do they imply?

In the first place, we notice that Boisen lays emphasis on catharsis, rapport and permissiveness. So far he follows the same techniques as exemplified in non-directive psychotherapy. But Boisen is no Rogerian and insists that all
these principles can be traced to Freud, Jung and others. The implications of Boisen's theory, however, require a most directive approach to the patient. If the latter does not fit in the procrustean bed of his theory, then of course he is to be rejected as more or less a hopeless case. A patient who does not have cosmic delusions or one who indulges in open eroticisms, stands already condemned. With this sort of pre-conceived theory in one's mind, how one can approach a patient with empathy and with an open mind is rather difficult to understand. We have to recognize the uniqueness of every individual patient with ideas, attitudes and behaviour which may not be categorized within any set theory, no matter how sound and valid. When therapeutic approaches are made with a set theory, all diagnoses of schizophrenia are apt to be thrown into a single category, and individual differences among the patients may be overlooked. A theory which may be a good working hypothesis must never be regarded as an established fact. Moreover, "if the conflict theory is sound, its advocates have no record of prophylactic accomplishment by means of which to confirm its soundness."1

(12) Boisen's approach to schizophrenia, however, is very constructive. His theory is based upon expert scientific

inquiry and merits serious consideration and further investigation. Let us enumerate some of the important points of our discussion:

(a) Boisen's story makes fascinating reading when studied in the light of his own schizophrenic episode and subsequent recovery.

(b) For the psychiatrist Boisen's study has much interest and significance. It helps him to understand the ideational content of schizophrenic thinking and to exploit its therapeutic possibilities. It is also a convincing argument in favor of the psychogenic view of mental illness.¹

(c) It goes behind external behaviour to its inner meanings and motivations, and stresses their importance to an understanding of schizophrenia. In emphasizing the constructive and remedial nature of schizophrenia, Boisen gives ground for hope to many an unfortunate soul, while at the same time helping the society to look upon mental illness, and in fact all suffering, in a new light.

(d) Boisen's views have important prophylactic implications for mental hygiene. If the conflict theory is sound,

¹. Hoskins, Klein and White have relied on his findings, in describing the subjective aspects of schizophrenia. See Hoskins, BS, 83-91; Klein, MH, 161-170; White, AP, 537-538. Sullivan recognizes the importance of his studies, MCP, 73, footnote, 52; Rev. (1939), 424-427.
then schizophrenia can be prevented. The primary evil in this disorder is a sense of personal failure and social isolation; it is essentially a failure in interpersonal relationships. This social evil then can be prevented by improving interpersonal relationships and building positive mental health.

(e) Boisen's theory emphasizes the importance of religious ministry to the mentally ill. In fact, Boisen has had an important part in the evolution of the pastoral clinical movement and in the introduction of psychiatrically trained Protestant ministry in the mental hospital.
CHAPTER VI

THE PROBLEM FOR RELIGION

In this concluding chapter we propose to consider critically some of the prophylactic aspects of schizophrenia, especially in relation to the work of religion in general and of the Protestant Church in particular. The inquiry will concern itself with the question: What are the religious implications of Boisen's studies of schizophrenia? The question will be considered under five sub-heads: 1. Is the schizophrenic reaction comparable to religious experience? 2. If so, what are its implications for religion? 3. Is there any religious therapy for schizophrenia? 4. What role can the church play in the field of preventive psychiatry? 5. What organized efforts are being made to create a psychiatrically oriented ministry in the service of the mentally ill?

1. Schizophrenic Reaction and Religious Conversion

In the preceding chapter references have been made to the frequent appearance of religious ideas in schizophrenic patients, and in many cases this happens
irrespective of previous religious training. This religious concern is characterized by ideas of cosmic catastrophe, cosmic identification, ideas of death, rebirth, previous existence, mission, and so on. These ideas are also characteristic of certain types of religious experience. This fact has been noted not only by Boisen but also by a number of writers before him.

1. Mysticism

We have previously alluded to the writings of William James, Delacroix, Pratt, Leuba, and others. These writers have noted the presence of pathological features in certain types of mystical experience. Some of the common features include ecstatic visions, auditions, automatisms, alternating feelings of extreme exaltation and morbid depression, and archaic symbolisms. These mystical experiences are also characterized by a peculiar set of ideas that have much in common with schizophrenic thinking. Storch, Schou and Campbell have studied the ideation of schizophrenics and have shown how frequently religious and mystical ideas colour their thinking.

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1. Cf. Beers, MTF, 184. Beers, who evidently had little in terms of previous religious training or background, was surprised to find himself composing religious poetry in his psychotic hours.
The process by which the mystical experience is induced has also something analogous to the onset of schizophrenic reaction. Like the preparatory stages in insightful thinking or in schizophrenic onset there is a gradual narrowing down of attention. Various devices are used to bring it about—drugs, auto-hypnosis, or other psychological or spiritual techniques. There is an abundance of feeling and passive suggestibility. Then, like an automatism, the mind becomes strangely awakened to spiritual perception, and some new idea or truth darts into consciousness, which is interpreted as something "given" or "inspired." "Voices" are heard which command the individual to renounce his present way of life and act in conformity with the revelation given. This experience may result in nothing more than an ecstatic absorption in or union with deity, or it may have some important social implications. As we study these experiences in the light of Boisen's views what do we find?

In the first place, Boisen has contributed nothing new to our knowledge by pointing out the pathological features of mysticism or the religious elements in schizo-

2. Coe, PR, 139, 267.
phrenic thinking. That has been done before. But when he suggests that mystical experience and schizophrenic reaction are dynamically the same, he is saying something at once new and intriguing. Just because there are some common features involved, do they by that token belong to the same order of experience? Do we establish identity on the basis of similarity? How are we to determine that ideas and values have the same meaning for the mystic who is in conscious control of his mental faculties and the schizophrenic who has, at least temporarily, lost control of himself? These are pertinent questions which Boisen has not sufficiently considered. There is also the danger that in interpreting the religious experience of the mystical variety in pathological terms we may miss the finer values and realities which these experiences do represent and see in the mystical visions, intuitions and aspirations nothing beyond the delusions and hallucinations of the schizophrenic.

Boisen believes that the common features involved in schizophrenic reactions and certain types of mystical experience can be explained on the basis of common causative factors. Now, according to Boisen's view, the primary causative factor in schizophrenia is a sense of personal failure and this arises, in most cases, from an inner conflict between instinctual cravings and accepted ideals.
and standards. We are not prepared to believe that this is the primary factor in all mystical experiences. There may be deeper and more consciously motivated reasons that urge men toward mysticism.

There may be dissatisfaction with human conditions, inner restlessness and conflict, hunger for a better state, vision of the splendour of a larger life, or a foretaste of ecstatic joy. It is also to be noted that mystical experiences, as a rule, do not begin with the emotional explosion that precipitates schizophreniform reactions. In mysticism there is a gradual progression from the state of awakening to the state of divine union or fellowship which is the mystic's destination. No such clear awareness of goals is discernible in the case of the schizophrenic. In spite of his aberrations the mystic has always and everywhere challenged men to the higher obligations of their faith and message. The schizophrenic is an object of pity and only challenges the society to do something to rescue him from his plight or at least to take measures that will prevent this distressing disease. One does not have to go mentally insane in order to solve the problems which can be solved in a normal and socially acceptable manner.

1. Johnson, PR, 117.
11. Sanity of Jesus

Boisen's interpretation of Jesus is also something new and challenging. Many psychiatric writers have charged Jesus with insanity on the basis of his claim to messiah-ship and his "grandiose" ideas concerning his role and mission. He has been called in turn "paranoiac theo- manique," "paranoiac," "epileptic" and "ecstatic." Boisen compares him with the schizophrenic! But this has to be understood in the light of his viewpoint. He believes that a true understanding of his personality cannot be achieved except as we recognize "as a fact that he did have the set of ideas which we have found to be characteristic of our acutely disturbed patients." Boisen accepts Schweitzer's view of Jesus' messianic consciousness but explains it, not in terms of current theology or tradition of Jesus' time but in terms of experiences that "arise spontaneously within individuals who are passing through searching inner struggles which make either for life or for death." Thus, he finds in the prophets, not in the apocalyptists, the best clue to the understanding of Jesus' messianic consciousness. He takes an accurate view of

1. Binet-Sangle, FJ. Schweitzer, PBJ. Bundy, PHJ.
2. Boisen, EIW, 141
3. Boisen, EIW, 75.
the sources and collects his data by carefully sifting the evidence of Mark and Q. That Jesus had an exalted idea of himself and of his mission, argues Boisen, is shown by the fact that he believed in an impending world catastrophe and in his death and message a means to usher in the Kingdom of God. His experiences at his baptism, in the wilderness and on the Mount of Transfiguration were of an unusual nature. All these things, taken together with the fact that his own relatives thought him insane, conclusively prove that his religious experience was not that of the "normal" man. What are the implications of such a view?

Boisen believes that there is no essential difference between Jesus' exalted idea of himself and the catatonic's delusion that he is Christ. Both represent crisis experiences in which there is a tendency to raise personal values and loyalties to the level of the cosmic and problems of one's role and place in the scheme of things become of the greatest import. From this arise ideas of personal responsibility and personal mission. But such ideas must be harmonized and corrected by social experience, for only thus can one achieve harmonization within and communion without. That is exactly where many a schizophrenic reaction, which can be potentially constructive,
falls short. On the other hand

the significance of Jesus would then lie precisely in the fact that with a true sense of the social responsibility which rested upon him he achieved also the highest degree of harmony, not only inwardly but also in his social perspective. This we explain by the view that here was a man who brought to the crisis experience no mere concern about his personal destiny. Like the great Hebrew prophets his concern was for his people and their fate.¹

To understand the full significance of Jesus' personality, Boisen argues, one must admit that Jesus thought himself as the Messiah and had the set of ideas that characterize the acutely disturbed patients. This admission does not detract from his personality; it entitles him to "the highest rank among men of religious genius." He represents the realities after which mental sufferers are groping and shares with them the experience of the "nethermost world."

In the light of this discussion what do we make of Aubrey's charge that Boisen is seeking to establish the messianic consciousness of Jesus at the expense of his sanity?² We believe this charge is not entirely justified and seems to be based upon a superficial understanding of Boisen's position. That Jesus regarded himself as the

1. Boisen, ETW, 139.
Messiah of the Jews seems to be a well-established fact of modern New Testament scholarship. How we interpret this fact seems to be a crucial question. Schweitzer interprets it in terms of the apocalypticism and theology of Jesus' time; Boisen explains as a species of experiences that arise spontaneously whenever men are seeking vital solutions to vital problems. Thus Boisen links Jesus to the prophets and the saints as well as to the mental sufferer who is likewise seeking solution of his severe inner conflicts. Cosmic ideas of personal significance and mission arise because these men are face to face with issues of life and death. The misunderstanding with regard to Boisen's approach arises because: (a) Boisen's view is wrongly associated with the various pathographies of Jesus which are clearly based upon uncritical use of New Testament sources and are coloured by personal prejudice and antagonism to Christian religion; (b) there is tremendous ignorance and unfounded fear in popular mind about mental illness; (c) the person of Jesus is held in such an exalted cloister that any suggestion relative to his sanity throws people into a panic of emotion and renders an objective weighing

Kepler, CTJ, 355-360.
of facts and arguments very difficult;¹ and (d) finally, it
must be said that Boisen has consistently failed to de-
marcate between mental disease as such and its schizo-
phreniform reactions. He has gathered his principles from
his study with schizophrenics and has fallen into the
error of extreme generalization. Moreover, as we have
previously pointed out, there is the constant danger that
in the effort to subordinate unique insights and crucial
experiences into fixed categories of classification de-
duced from study of exclusively psychiatric material, one
may fail to "reckon adequately with the delicate laws of
the spiritual life which stand revealed to the analyst
who has religious appreciation."²

iii. Normal Religious Experience

Boisen finds experiences of the "cataclysmic" var-
iety in the lives of great religious geniuses and saints.
The constellation of ideas - cosmic catastrophe, cosmic
identification, archaic symbolism, ideas of mission and so
on - is said to be present in the experiences of prophets
and saints. Like the psychotic patient, Jeremiah finds
hidden meanings in almond tree, boiling cauldron, and
broken vessel and "accepts implicitly the promptings which

¹. Bundy, _PHU_, 268.
come into his mind as of supernatural origin and divine authority."¹ He believes himself a passive instrument in the hands of God and is entrusted with a message of doom. Ezekiel is commanded to act out the visions and is likewise entrusted with a message of doom and wrath. In the authoritative "Thus saith the Lord" the psychotic delusion of cosmic identification is said to be present. From the prophets and apocalyptists a host of instances can be cited to demonstrate the recurrence of these characteristic ideas. But Boisen finds two distinguishing features in prophetic experience: (a) The prophets were men of moral integrity and spiritual insight, and (b) their primary concern was not with their own personal salvation but with that of their people. They completely identified themselves with their people and "went down into the depths... in their sufferings." Perhaps part of their severe disturbance was due to this group identification rather than their own personal conflicts.

Paul's disturbance is however explained as primarily rooted in some severe inner conflict between the "flesh" (instinctual cravings) and his accepted pharasaic morality. His religious fanaticism represented a protective mech-

¹. Boisen, ETW, 74.
anism to shelve in this sense of inner disharmony and failure. The Damascus experience was an end result of these accumulated intra-psychic problems. Paul's conversion experience is regarded as "definitely hallucinatory in character." The light he saw, the voice he heard and the message he received would then be thought of as audiovisual hallucinations of the schizophrenic. This "period of confusion and disorder" was followed by a "period of elaboration" during which he withdrew to Arabia. Psychotic ideas of birth, death and rebirth are seen in such Pauline expressions as "dying with Christ," "being raised up again," "Christ liveth in me," being "in the third heaven," etc. The experiences of George Fox, John Bunyan and Swedenborg are similarly interpreted. Certain common features in their experiences are noted: a sense of being possessed and led by the Spirit; a deep sense of failure and guilt; alternating periods of extreme elation and morbid depression; visions, revelations, auditions; ideas of impending cosmic catastrophe, new birth and mission. Some of these men, so says Boisen, would be institutionalized if they were living today. But in their own day these men were accepted not only as perfectly normal but they became fountainheads of great religious movements in history.
Such experiences are by no means uncommon today, especially in fundamentalist churches who derive their authority from tradition and are primarily concerned with the problem of sin and salvation. ¹ We recently came across the case of a "converted" Baptist whose religious experience dramatizes some of the ideas we have been discussing. For him it was a perfectly normal experience and resulted in reorganization of life. He related his experience in these words:

.......

And there was a black man who came at me from out of the darkness, and as he came toward me he was swinging his fist, trying to hit me. But he never hit me... Then I looked up to the ceiling and there was God's face. There was his face! It was beautiful with long flowing golden hair and big gold eyes...

And the Lord told me that Jesus had died for me and that he had sent Jesus to save me... Then I saw Jesus standing there... and I was beside him and an angel was above us. Then Jesus said to me, "I shall send you someone to fight your battles for you."...

Then there was standing beside me a little yellow man with a red sash and a long silver cord.

He had come to fight my battles for me. From this time on I felt comfortable for I knew I had someone to protect me. (After some time) One night I was sleeping on the bench in front of the fire, when the Holy Ghost came to me and said, "Get up, get up! I have something for you to read." I jumped

¹ Boisen, RCC, 261-302. In these pages Boisen discusses the evolution of the revivalist movement in American history and argues that these sects arise in social crises and represent values which the liberal churches have lost. The latter have surrendered the authority of tradition without freeing themselves from the traditional point of view. They seem to be neglecting the problem of the "sick soul" entirely. See also Boisen, EIW, 83-88.
up and looked up there into the west. There were big golden letters written across the sky. It read JUDGMENT! It was God's judgment on me. He told me that although I had been converted I had not been saying my prayers enough. He told me to read and pray. From that time on I began to read and to pray and my Lord came to me and I knew him.... But the real nearness came to me when I was sanctified... When one becomes sanctified through the truth you freeze in the presence of God and cannot move. How long one stays this way depends upon how much one believes. For me it was twenty minutes. Hallelujah! Glory to His name!

Now this represents the experience of a normal man and can well be compared with some of the experiences of George Fox and others. Despite its undoubted pathological features, it was for this man a constructive experience and gave him a sense of inner calm and poise which he had perhaps never enjoyed before. Boisen does not suggest that such experiences are to be encouraged or desired. He stresses the point, however, that such experiences are not necessarily evil; they serve to dramatize one's inner struggles and conflicts and bring them out into the open. The final test of validity of these experiences is not in how they happen but in

1. Excerpt from two pastoral interviews made by E. Randolph Stone, a theological student, on November 14th and 21st, 1949 respectively. Available at the Department of Psychology of Religion, Boston University School of Theology.
what is attained. The purposive element in cataclysmic ex-
periences has been generally recognized by students of re-
ligion and psychiatry alike. But how far this analogy can
be carried is a debatable point. Do schizophrenic reaction
and "eruptive" conversion experience represent merely two
different ways of looking upon exactly the same problem?
That they do show some common features and in some cases
common causative factors is more or less generally conceded.
But, as we have previously argued, it seems difficult to put
them together in the same category or order of relationships.
Then there seem to be some important differences between the
two: (1) Psychotic reactions represent a regression, a re-
treat from reality in the face of mounting difficulties.
Religious experience - eruptive or normal - is a progression
from lower to higher level of integration. (2) Schizophrenia
represents a failure in social relationships but religious
experience involves an attempt to integrate them on a higher
level. (3) The schizophrenic is primarily involved in his
own internal conflicts. This is not always true in religious
conversion experience. (4) The schizophrenic loses the
control of his mental faculties, at least temporarily; most
cases of conversion do not show such disruption; on the other
hand, their mental faculties are quickened and illuminated.
(5) The schizophrenic loses control of his emotions and his consciousness becomes clouded; in valid religious experience this is not the case. (6) In most cases, the mentally ill patient gives up his psychotic interest in cosmic affairs after recovery; in religious experience this interest is maintained throughout life. These are some of the important differences that have to be considered before one can reasonably equate schizophrenic state with religious experience.

iv. Religion in Crisis

Schizophrenic reactions and cataclysmic religious experiences have some common characteristics. This fact cannot be denied, irrespective of what differences one may hold with Boisen. How can these common characteristics be accounted for? Various explanations have been given. William James believes that insanity and religious mysticism both have to do with the "subliminal regions" in which states the mind becomes strangely receptive to spiritual perception. Otto believes that all religions originate in "numinous primordial feelings." Since schizophrenia is said to represent a regression to primitive thinking, Storch concludes that the common features of both schizophrenia and religion can be explained in terms of this regression. Schou takes a somewhat similar view and holds that both can be explained in terms of the deeply imbedded "primitive character of
religious life." The question does not arise for those who put religion and insanity in the same category and regard them merely bits of superstition and nonsense.

Boisen's view of this inter-relationship is at once different and refreshing. The common characteristics are due to common causative factors and the study of the one throws light on the other.

Both arise out of a common situation, that of conflict between the ideal and actual self. In both there is acute awareness of unattained possibilities, with the sense of estrangement and guilt as the primary evil. In mental disorder as well as in religious experience we may see manifestations of nature's power to heal. In religious experience as well as in mental disorder we may find pathological features. The difference lies in the outcome. Where the outcome is destructive or inconclusive, we think of it as mental disorder. Where on the other hand, it results in progressive unification and social adaptation we may think of it as religious experience.

As we have said before, Boisen holds the progressive, unbroken development of personality as the ideal thing. But this cannot be always attained. When inner tensions are allowed to accumulate, a cataclysmic experience may serve to break up evil habits and turn vital energies into new channels. Understood in this light, Boisen's view has

1. Schou, RMM, 132.
2. Boisen, RCC, 112.
important religious and social implications.

Crisis experiences - whether physical, mental, or social - tend to be associated with religious quickening. In normal times people do not, as a rule, feel or strive so intensely for personal and social issues as they do when crises come upon them. Even so few people pass through life without at one time or another becoming aware of the inner urge for higher possibilities within them. Crises occur in the course of normal development and are associated with the critical epochs of life - birth, puberty, marriage, illness, bereavement, death, disappointment in love or in business. Maladjustments in any of these areas of interpersonal relationships may create severe intra-psychic conflicts. "When interpersonal relations are insecure, hostile, and predatory the society declines and its members suffer nervous and physical disorders."¹ Intra-psychic conflicts always arise in the context of interpersonal relationships and they may result from other causes besides "a sense of personal failure and guilt" which Boisen thinks of as basic. When these tensions and conflicts are allowed to accumulate and are carried into life unresolved, they may make an emotional

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explosion almost inevitable, often resulting in serious personal or interpersonal tragedies. Granted that in some cases the outcome may be constructive and may result in reorganization of life around higher values and nobler aspirations, nevertheless the cost in human sorrow and suffering far exceeds the negligible, perhaps very doubtful, gains that may be said to accrue from such human tragedies. The goal of religious education and mental hygiene, as Boisen himself realizes, is to prevent the accumulation of intra-psychic and interpersonal conflicts and help the individual to achieve a progressive unification of personality.

Religious quickening in crisis situations is associated not only with individuals but also with groups. Boisen made an extensive survey of religious conditions in rural churches during the economic depression of 1930's and discovered that there was a considerable growth of mystical sects during that period. This association of economic distress and religious revival is explained by the fact that suffering together through no fault of their own, people are forced to think and feel together intensely regarding the ultimate issues of life.... Under such conditions many persons become deeply stirred emotionally and ideas come surging into their minds. The psychological process is the same as that which occurs so frequently in mental illness.
When, however, the experience is induced within a social matrix and follows accepted patterns, the danger of personality disorder is at minimum.\(^1\)

This perhaps explains the fact why such general calamities as economic depression do not result in any considerable increase of mental illness. The sense of isolation, which, according to Boisen, is the primary evil in mental illness, is lessened by group cohesion and identification and thus conditions become favorable for the revival of religious interest. This is an effective answer to Landis and Page who have tried to refute the conflict theory of mental illness on the basis of their findings that the economic depression did not result in any increase of mental illness.\(^2\)

But did the war result in any increase of religious sects or religious experience? Boisen finds that no religious movement of any importance has arisen out of a war situation, even though it is a social crisis of the greatest magnitude. This is explained by the fact that

\begin{quote}
in time of war the reaction is of the malignant rather than of the benign type. The tendency is to hate and blame the enemy. This is a faulty diagnosis and the real evils, which are not confined to the enemy, remain uncorrected. The broad perspective and the comprehensive loyalty essential to
\end{quote}

\(^1\) Boisen, RCC, lllf.

true religion are therefore not achieved. A further explanation is to be found in the dominance of the military mind."

This seems to be a very novel explanation of exceptions that do not fit one's hypothesis. We know from the history of Hebrew-Christian religion that national calamities including wars have been seasons of great spiritual quickening. Any social or national crisis - whether depression or war - seems to affect the common people in the same way. Nevertheless we agree with Boisen's view that crisis situations may be periods of religious renewal for the individual as well as for the society. The primary cause of mental illness is, however, in the realm of interpersonal relationships. This does not mean that we rule out other causative factors of mental illness including the functional type. But, given a healthy and wholesome interpersonal environment, one can grow into a full-orbed personality despite many a handicap. Although we are not prepared to put religious experience and schizophrenic reaction in the same category as Boisen evidently does, we accept the indirect implications of his views, i.e., religion is a strong bulwark against schizophrenia. Schizophrenia finds breeding ground in an environment which is infested with the

1. Boisen, RCC, 66.
poison of hate and bitterness, of fear and insecurity, of repression and hostility. Religion changes and recreates the environment and provides conditions for growth and creative living. "The goal of religion is identical with the goal of healing - to make men whole."  

2. A Psychiatric Approach to Religion

In the previous section we have discussed the implications of the view that acute schizophrenic reactions and certain eruptive types of religious experience involve common constructs and common causative factors. We have seen the pros and cons of this view. We have further conceded that certain types of cataclysmic experience manifest themselves with tremendous emotional upheaval, especially where there has been an accumulation of unresolved intra-psychic or inter-personal problems. They represent nature's attempt at cure and healing. These attempts may issue in happy or unhappy solutions, depending upon the assets and liabilities of the individual concerned. Religious concern is usually associated with these crisis experiences and represents the individual's need for social response and personal security. What are further implications of Boisen's view, from the standpoint of psychology of religion?

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1. Normal versus Pathological

According to Boisen's views, no hard and fast line can be drawn between the normal and the pathological.¹ Psychologically speaking, it is largely true that abnormality is a matter of degree; it is merely an exaggeration of the normal. Our view of what is normal depends upon our point of view. Psychiatrists often use the term "normal" statistically in the sense of the average, but this norm is not reliable when we are measuring human personalities. The legal norm is likewise arbitrary and is very much inclined to follow the social norm.² Boisen defines it as "conformity to some accepted standard" and conceives this standard in terms of ideals and objectives, for he says that as participant observers in an enterprise our objective becomes the normative.³ Although Boisen does not tell us in specific terms as to what this objective should include, he points in the right direction.⁴

Boisen criticizes the common tendency on the part of religious thinkers to delimit valid religious experience to a narrow category they term "normal," thereby assuming that

1. Boisen, EIW, 164-166.
2. Pennington & Berg, CP, 17-45. These pages contain a very excellent discussion of this question from different points of view.
4. Johnson, PR, 222-226. Here is included a very good discussion of the subject from the point of view of religious psychology.
religion functions only in the "normal" human personality. For example, Wieman defines religion as "man's acute awareness of the realm of unattained possibilities and the behaviour that results from this awareness," but when he comes to deal with religion in relation to mental illness he limits its valid expression to normal human experience and excludes its pathological manifestations from religion.\(^1\) Starbuck, Coe and Pratt have likewise tried to draw a line between the normal and the pathological and have been exclusively concerned with the former. All these tendencies, Boisen points out, have led to ignoring "the significance of the pathological for the understanding of the laws of the spiritual life."\(^2\) On the other hand, Boisen finds that the medical profession, instead of shying off at the problem of the pathological, have found in the study of diseased conditions one of their best approaches to the understanding of normal human physiology.\(^3\)

It will be recognized that Boisen is partly right in his criticisms. There has been a tendency in the past to make arbitrary distinctions between the normal and the abnormal. Pratt, for instance, seems to make an artificial

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2. Boisen, EIW, 152.
distinction between the mild and the extreme types of mysticism. The same tendency to compartmentalize personality is seen, for instance, in attempts to differentiate between Jesus' sense of divine commission and his messianic consciousness or between his divine and human personality. While the students of religion, in our view, rightly exclude the pathological from valid religious experience, they often fail to see the religious needs and longings of the mentally ill. Religion represents great resources for health and healing which can be effectively used in the service of these sufferers. It must also be admitted that the student of religion can learn much about human nature by a study of the pathological, for in personality disorders we are dealing with "the great forces of love and hate and fear and anger." Boisen's pioneering efforts have contributed much in turning our attention to these important problems. There are however a few things that have to be borne in mind: (1) Some sort of dividing line between the normal and the pathological is almost inevitable. A great deal of confusion is bound to follow when we attempt to use these terms interchangeably. In many places in his writings Boisen seems to imply

that schizophrenic disturbances are structurally different from their psychotic manifestations. This distinction is untenable and is not recognized by any psychiatrist of note. Normal experiences even in their most acute or cataclysmic form are distinct from the psychosis of schizophrenia. This distinction must be clearly recognized if we are not to confuse religion with psychiatry and vice versa. (2) Unlike Boisen, the student of religion does not ordinarily have the background or experience to understand the psychiatric problems of the mentally ill. He must be content to use the insights gained by the experts in this field. Like the student of philosophy he relies on the data offered by this and other sciences and interprets their religious implications for the individual and for the society.¹ If Boisen's argument is pressed to its logical conclusions, the student of religion will have to be an expert not only in psychiatry but in all branches of knowledge that deal with abnormal phenomena. (3) We must avoid the danger of a morbid approach to the problems of human personality. Boisen, perhaps unwittingly, tends to interpret everything in terms of the pathological. (4) Finally, the issue of the normal versus the pathological is largely a false one. How one

¹ Cf. Brightman, PR, vii.
interprets these things is most important. There is "little to be gained by pursuing the relative merits of approach through the pathological or the normal... a student could learn much from each, and that if well taught, he would learn very similar things."¹

11. Empirical Approach to Religion

In our discussion of the sociodynamics of schizophrenia we pointed out that Boisen largely follows the Chicago School of Social Psychology in his emphasis on the social nature of man. Religion, the idea of God and the laws of the spiritual life are all looked upon as "derivatives of the social nature of man." RELIGION is a social phenomenon and seeks to meet the need for social response and security; it may or may not include the idea of God. GOD is the symbol of that which is supreme in one's system of loyalties and it represents the need of the struggling individual for social support and for relief from the sense of isolation. The problems of SIN and SALVATION are nothing but the problems of mental illness and its cure. GUILT implies a sense of isolation from the fellowship of those whom one loves and whose ideals one accepts for himself. CONSCIENCE is an internalization of these ideals and standards and is something

¹ Hiltner (ed), CPT, 42.
that keeps growing. FORGIVENESS is a matter of restoration to mental health (salvation). These are some of the main concepts underlying Boisen's social psychology. What are their implications?

1. Provided the limitations of the empirical approach to religion are clearly recognized, it provides one of the best methods to deal with personality problems. Students of religion are increasingly making use of the empirical method in the study of religious experience in its normal and abnormal aspects. Boisen has consistently followed this approach in his sociological and psychiatric investigations of religious phenomena. A recent statement of the implications of this approach for religion and theology is embodied in Johnson's interpersonal psychology. The importance of scientific tools in the study of religion can hardly be over-emphasized. Furthermore, these methods bring us into direct contact with human personalities in health or illness and thus provide us with a first hand knowledge of their problems and possibilities.

2. There are however some dangers against which we must guard ourselves, especially when we attempt to interpret religious concepts and beliefs in terms of the principles

derived from study in a narrow field. Although Boisen does stress the elements of spontaneity and freedom in religious experience, one gets the impression that religious realities have no more than a mere regulative value in human life and that religious experiences are determined under social compulsion. To use psychiatric terminology to explain religious concepts also causes a great deal of confusion in our thinking and misunderstanding in our relationships with the psychiatrists. Then there is the question: Are the goals of religion in "saving souls" and the goals of psychiatry in integrating personalities the same? Boisen seems to think so. From the psychological point of view this may be alright, but to reduce Christian theology to the level of mere preventive psychiatry sours too much of humanism and hedonism. Again, there is danger in over-emphasizing the therapeutic aspects of religion. Do religion and health always go together? Are mentally and physically healthy people always religious?

To emphasize the therapeutic role of religion is likely to lead us into Christian Science and eventually to the back waters of agnosticism which first plagued the Church in the second century.¹

The interpretations of Boisen are exposed to this danger. Religion has undoubtedly great therapeutic resources but

it is not exhausted by them. Religious values have something to do with social approval and social response but they also have a constitutive reference that transcends them both. Religious experience begins in the context of interpersonal relationships but it is not produced by them.

3. We must not, however, fail to recognize the constructive aspects of Boisen's position. He emphasizes the social aspects and implications of religious beliefs and ideas. Indeed we cannot fully understand the nature or power of religion except as it manifests itself in the context of social relationships. Religion is the greatest integrative force in life and knits individuals, groups and nations together in terms of loyalties and values and goals which have cosmic and universal significance. Religion is an antidote to fears, anxieties and insecurities that block individual growth and distort interpersonal relationships. Conscience or the primary loyalties that it represents are not to be discarded and blamed for all neuroses and psychoses; they have a legitimate and necessary function in life; their true meaning can be realized only when they are comprehended in a larger loyalty that has cosmic and universal reference. The sense of guilt is not something that must be gotten rid of; it represents a sense of failure and isolation and can only be tackled when the individual is reintegrated into interpersonal relationships.
iii. Therapeutic Resources of Religion

There is a growing interest in the Protestant churches today in the problems of physical and mental illness. What are the reasons for this health consciousness? We may state six reasons: (1) A growing recognition of the fact that religion is concerned with the whole man; (2) better appreciation of the health resources of religion; (3) renewed emphasis on pastoral ministration to individuals rather than masses; (4) the developing concepts of psychosomatics; (5) the vastness of the problems in the field of health and mental hygiene; (6) the exigencies of the present day demanding a closer cooperation among all professions interested in the welfare of human society.

The clergyman stands before a vast horizon, but it would seem that no one had noticed it. It also looks as if the Protestant clergyman of today is insufficiently equipped to cope with the urgent psychic needs of our age. It is indeed high time for the clergyman and the psychotherapist to join forces to meet this great spiritual task.2

These are the words of Jung who further stated that most of his patients were not able to solve their problems or find healing until they had regained a religious outlook or achieved an adequate religious experience. The significance

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1. Hiltner, IRH, 3-6.
of these words becomes clear when we remind ourselves of Boisen's findings with schizophrenic patients. He has demonstrated that religious concern in mental illness is a very favorable prognostic indication. Religion is not an escape from reality; it represents a serious attempt on the part of the patient to reorganize his life in terms of values and loyalties that are cosmic and abiding. Religious concern arises spontaneously in times of crisis, when one is facing issues of life and death, of one's role and place in the scheme of things. Not only this, to one who is passing "through the valley of the shadow" of mental illness, religion is a stay and a staff; it meets the needs for social support and companionship and thus takes away the pang of isolation and loneliness which inflict the mental patient and not infrequently the acutely ill or dying person. Religion reduces the feelings of failure and guilt (which are common in mental patients), not by lowering the conscience threshold, but by providing "forgiveness and restoration to the fellowship of that social something which we call God."

Johnson well epitomizes the great health resources of religion: (1) the sense of personal worth; (2) trust in the ultimate victory of good over evil; (3) membership in a

1. Boisen, EIW, 268.
communal fellowship; (4) the support of invisible yet constant companionship; (5) confession and forgiveness; (6) the urging and guiding of growth; (7) the aspiration and dedication of worship; and (8) the discipline or way of life.⁴ As we relate these to the needs of the schizophrenic patient we can well appreciate the great importance of religion in mental illness. We are of the opinion that Boisen has clearly demonstrated the importance of religion in the ideation of schizophrenic patients. Whether religious concern has any prognostic signification he has not conclusively proved; but, recognizing the integrative power of religion in health or in illness, we are in agreement with Jung that a "religious outlook" on life is always a healing influence. Furthermore, if religious concern is involved in acute schizophrenic reactions, a minister of religion, properly trained and equipped, has a definite place in the therapy of schizophrenia. When minister and psychiatrist join hands in treating mental ills, the question does not arise whether a person in trouble should go to the psychiatrist who has no interest in religion, or to a minister who has no knowledge of psychiatry?

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¹ Johnson, Art. (1947), 565.
3. Religious Therapy for Schizophrenia

We have so far discussed the theoretical implications of our present inquiry. In the following pages we propose to gather together some of the practical suggestions that bear on the therapy of schizophrenia. One or two points however, call for some elucidation.

1. Some Basic Assumptions

At the outset it must be made clear that the primary responsibility for the care and treatment of the schizophrenic patient, once he enters into a mental institution, rests with the psychiatrist. We are well aware of the danger of clerical psychotherapy which is often based upon uncritical acceptance and use of psychiatric theories and formulations. Neither are we in favour of basing our religious approach to the mental patient on Boisen's therapeutic formulations. Whether these formulations have any merit or therapeutic significance it is for the psychiatrist to decide and evaluate. This present study has merely attempted to gather together the results of Boisen's researches and has given a critical appraisal of the same from the standpoint of religious psychology. We are, however, inclined to accept the view that psychotherapy "is not a profession, but a helping activity carried on by various professions at different levels"
and from different assumptions. What are some of the assumptions behind our approach to the schizophrenic patient?

(1) A religious approach involves certain contextual differences with other psychotherapeutic approaches. It presupposes a certain conception of the universe in which an operational understanding of human personality can be placed. This implies belief in a Creator and Sustainer of values and in the potentialities of the spiritual realm. Man bears the divine impress upon himself; he is free and responsible and can attain to his full stature in cooperative living with his fellowmen. Religious resources of love, hope and faith are available to anyone who strives for them. Spiritual realities can be mediated through prayer, meditation, worship, or any worthful interpersonal activity.

(2) The significance of religious values for the schizophrenic patient can be seen in the light of Boisen's findings. The primary evil in this psychosis, according to Boisen, lies in a sense of isolation and personal failure. The schizophrenic is indeed a lonely person. Despite his apparent indifference to the outside world he

2. Hiltner, PC, 32.
"has some dim notion of the unreality and loneliness of his substitute delusional world." Boisen has demonstrated that the acutely ill patient stands in desperate need of religious resources. The spontaneous religious concern that is associated with acute schizophrenic reactions represents an attempt on the part of the sufferer to find social support and response, an attempt to find relief from his sense of isolation. Religious ministrations to such patients, therefore, cannot be denied and a minister who is psychiatrically oriented can be of great help.

It follows therefore that our religious ministry should be extended not only to the chronic patients, but also to the acutely disturbed schizophrenic patients, especially in those cases where religious concern is predominant. The minister can bring to the aid of such patients resources and understanding which the psychiatrist does not, as a rule, possess.

(3) Alexander has pointed out that the schizophrenic does not need insight so much as supportive therapy. Very often he has a considerable insight into his own condition. We believe with Hiltner that the primary task of the counse-

lor is to "help the patient to help himself." This implies a non-directive or rather "responsive" approach which lacks the elements of moralization, generalization, condemnation, coercion or advice. We do not agree with Boisen that the counselor has to be judgmental and approach the patient with some preconceived idea or diagnostic impression of his troubles. We believe that as ministers or chaplains we should not be committed to any particular psychiatric theory or formulation. As soon as we do this we are in danger of taking the role of the psychiatrist.

We approach the patient as friends and religious counselors, representing in our personalities the health resources of our religion. These resources can be communicated through the psychological channels of empathy and example, fellowship and sharing, learning by doing together, faithful practice of ideal principles, and prayer of gratitude and trust to heal anxiety and guilt.¹

(4) The minister can carry on his work more effectively in a mental hospital if he works in close cooperation with the psychiatrist. In fact, it has been our experience that the psychiatrists are generally aware of the therapeutic possibilities of religion. An understanding

¹ Johnson, Art. (1947), 566.
psychiatrist will always refer cases of religious difficulties to the chaplain. Boisen has clearly demonstrated the fact that religion and psychiatry can and must supplement each other, especially in a field where the problems are so vast and complex.1

11. Pastoral Counseling

The mental institution furnishes unique opportunities to the Protestant minister for service and counseling. There are various ways in which he can make himself useful to mental patients: counseling and visitation; worship and singing; group projects and directed activities; counseling in referrals and follow-up interviews; community relationships and education.2 The aim of such religious activities is fourfold; (1) to help the patient reintegrate himself into society in terms of more comprehensive loyalties and more abiding values; (2) to help him utilize the resources of religion for making a Christian adjustment to life; (3) to help him solve his religious and moral conflicts; and (4) to bring the community resources to his aid. In counseling mental patients, especially the schizophrenic, certain essential points have to be borne in mind.

(1) Prerequisites

In dealing with the mental patients the minister must first solve his own personal problems. A minister who carries his own worries, problems, frictions, tensions and crises into the mental hospital cannot help those who are themselves victims of these unhappy experiences. Positive emotions of love, joy and peace dispel fears, anxieties and guilt feelings. Spiritual remedies are communicated by contagion more than by talking or sermonizing. And schizophrenic patients are strangely responsive to spiritual perception! Other requirements for counseling include discipline and integrity of character, training in the methods of pastoral counseling and certain amount of clinical experience in working with mental patients. In working with schizophrenic patients a knowledge of the etiology and dynamics of schizophrenia is essential.

(2) Flexibility

Alexander has pointed out that in dealing with the schizophrenic patient the principle of flexibility is of utmost importance. Not only the methods but the goals of psychotherapy may have to be changed, depending upon the patient and the nature of the therapeutic relationship. This presents no problem for the pastoral counselor who
is non-directive in his approach to the patient. The essence of non-directive psychotherapy consists in:
(a) the recognition of the significance and worth of each person; (b) the implicit faith in his inner resources and capacity for growth; (c) the ability of the counselor to achieve the internal frame of reference of the patient.¹
This philosophy of human relationships is in accord with the basic assumptions of Protestant faith. The schizophrenic patient, according to Boisen, is capable of dealing with his problems provided the counselor helps him bring them into his conscious awareness.

(3) Empathy

Empathy seems to be the keynote of psychotherapy with schizophrenia. Its importance has been well emphasized by Hoskins in these words:

A knowledge of the laws of empathy and skill in applying them constitute the chief if not the sole, stock in trade of the psychotherapist in his dealings with the schizophrenic patient.²

The essence of empathy consists in "thinking with the patient about his problems,"³ an ability to achieve his internal frame of reference and perceive "the hates and

¹. Rogers, Art. (1949), 82-84.
². Hoskins, BS, 57.
³. Boisen, Art. (1948)², 22.
hopes and fears of the client through immersion in an empathic process."¹ Much of the behaviour and mannerism of the acutely disturbed patient becomes intelligible and meaningful as soon as one is able to identify one's self with him in an empathic emotional relationship.

(4) Rapport.

The schizophrenic patient, especially in the catatonic states, is often inaccessible to psychotherapy. The crux of the whole problem consists in establishing rapport. Once this is achieved and the patient is able to relate himself to at least one person in his environment, he is already on his way toward socialization so that other techniques and methods can be used as desired. Such a patient is particularly suspicious to those who approach him "with the intention of intruding into his isolated world and personal life."² The minister who approaches him as an understanding friend often meets with much success. We have seen even catatonic patients, who usually make no response to any stimulus, open up to one who is genuinely and truly interested in them. The catatonic is one of the most sensitive persons on earth and intuitively detects any lack of genuine interest on the part

of the counselor.

(5) Permissiveness

The pastoral counselor must learn to accept the patient in spite of his bizarre mannerisms, queer thinking and seemingly rude behaviour. After all he is in the mental hospital just because of these peculiarities. And these are not always meaningless; they represent cravings, desires and longings which the counselor must attempt to understand and interpret to himself. The expression of negative feelings becomes especially strong and often violent when the patient has come to have some regard for the counselor. The importance of pastoral relationship depends on how these negative feelings are handled.

(6) Transference.

The problem of transference relationship is an especially difficult one. Many therapeutic efforts come to grief on these difficulties of transference. Once the patient has come to accept the counselor, he rapidly forms a strong emotional attachment with the counselor. This transference wisely handled can bring the patient back from his psychosis. But, it is equally fraught with danger; any element of real or seeming rejection on the part of the counselor may throw him into a deeper psychosis. The minister should be particularly careful at this point,
for he has in most cases, neither the training nor experi-
ience in dealing with this problem. Where he is involved
in these transference relationships he must constantly
seek the advice and guidance of the psychiatrist.

(7) Guilt

Feelings of guilt and shame characterize many schizo-
phrenic patients. Indeed, according to Boisen's findings,
the primary evil in schizophrenia lies not in the conflict
but in the sense of guilt. The psychiatrist attempts to
remove the conflict by reducing guilt feelings. We tend
to accept Boisen's view that guilt feelings arise from
the sense of isolation and failure in interpersonal
relationships and the religious therapy consists in re-
storing the patient back to the fellowship and communion
with God and man. Boisen places great emphasis on confess-
ton and socialization as means to help the patient to
socialize and thus assimilate his disowned cravings and
desires. Boisen also finds that patients who have deep
guilt feelings combined with attitudes of frankness and
acceptance of responsibility actually show a greater
incidence of remissions than those who resort to conceal-
ment reactions. The significance of these findings must
be recognized by the pastoral counselor.
(8) Religious Concern

The pastoral counselor has a special opportunity with patients who are involved in religious conflicts and difficulties. We have already considered in some detail how and why religious concern arises spontaneously in men facing issues of life and death, for then the question of one's place and role in the scheme of things becomes vitally important.1 Crisis experiences, whether personal or social, tend to be associated with religious concern. This is often the case with acutely disturbed patients who first come to the mental hospital. These initial contacts with the patient are of much significance, as providing unique opportunities for real service and learning. A psychiatrically oriented minister can render effective religious therapy to mental patients involved in religious or spiritual conflicts.

4. Religious Services

The importance of religious services for mental patients is being increasingly recognized. It is refreshing to note the vigour and scientific skill with which trained Protestant chaplains are endeavouring to make these services helpful and satisfying, adapted to the discovered

1. See pages 348-354.
needs of patients. In the light of our inquiry the significance of worship for the schizophrenic patient becomes obvious. Of all the mental patients it is he who most needs the services of religion for social support and emotional re-enforcement. In this section we will discuss the therapeutic implications of group worship, concluding with a few comments of a practical nature.

1. Values in Group Worship

One of the most significant studies, in this connection, has been made by Leslie. His investigations demonstrate the fact that group therapy lends itself remarkably well to a religious approach. The psychological processes involved in group therapy—interstimulation, interaction, transference and identification—provide avenues for enlarged confidence, socialization, re-education and a laboratory in social living. These values can be communicated through verbal or non-verbal means including psychodrama and role-taking (Moreno), activity groups (Slavson), participation techniques (Rosen), and release therapy (Levy). Among other values we may include emotional support, catharsis, reduction of guilt and anxiety, increase of self-esteem, development of insight, and spiritual

1. Leslie, GTM, 251-274.
undergirding. Religious gatherings and worship services include and enhance these values by raising them to the level of the cosmic. They give meaning and reality to these interpersonal activities by providing mutually shared goals and aspirations. However, when the religious leader is not consciously aware of these values and of the processes whereby they accrue, religious worship tends to lose its therapeutic significance and becomes a matter of mere routinism for some and escapism for others. To attain its therapeutic goals a religious service designed for mental patients must involve: (a) a conscious awareness of the goals to be attained; (b) understanding and exploiting of the psychological processes inherent in groups; (c) adaptation of methods and materials to the discovered needs of the patients; and (d) maximal patient participation.

11. Social Significance

The importance of group worship for schizophrenic patients becomes obvious in the light of our studies. Religious concern spontaneously arises in crisis experiences. One who is struggling for life is likely to be seriously concerned with the ultimate question of his role and place in the scheme of things. It is not surprising therefore that the acutely disturbed schizophrenic patient often
shows deep interest in religion. It becomes for him an oasis of hope in "the wilderness of the lost." Not only this, in his lonely and private world religion reduces his intense feelings of isolation by providing emotional support and a sense of divine comradeship. The religious assemblage helps him to focus his attention upon that which he conceives to be supreme in his hierarchy of loyalties. How does this assemblage differ from ordinary church congregations? Chiefly in two respects: (a) there are ordinarily no social or familial ties binding the patients, and (b) for them religion is not a matter of choice or convenience; it is an intensely personal and vital affair. Of course there are among these unfortunate sufferers a large number of those who are characterized by concealment reactions and seem to have largely given up their will to fight and their desire for more abundant living. But even in these cases the minister of religion can with faith and hope and skill achieve "miracles of grace." If Sullivan and others have demonstrated successes with such cases, there is more reason for the minister to be hopeful and optimistic. We therefore do not agree with Boisen that "the ministry of religion in a mental hospital should chiefly concern itself with .... those for whom there is still hope for rehabilitation."¹

¹ Boisen, Art. (1948)¹, 121.
The psychiatrist usually concerns himself with the acutely disturbed patients and leaves the rest to their fate. But the minister dare not follow his example! Christian faith sees in even the most hopeless of cases possibilities for growth and rejuvenation.

iii. Worship Service

The aim of religious worship for the mental patients is not merely to awaken faith and arouse religious emotion but to redirect them along constructive channels of socialized living. Religion must not become a substitute for psychosis or a means of strengthening it. Wholesome, healthful religion must take the place of one which may have been responsible for the patient's difficulties. Boisen has made some very constructive suggestions regarding the planning and conduct of worship for mental patients, especially the acutely disturbed patients. The following analysis includes part of his suggestions: (a) **Positive emphasis.** All available resources of religion should be used, with main emphasis on the positive emotions of love, faith and hope. We must avoid the tendency, often reflected in Boisen's approach, to overlook the fact that in a divine service of worship we are dealing with "worshippers" and not with mental patients as such. (b) **Group participation** constitutes an important feature of institutional service and
this must be provided for not only in song but also in prayers and responses. The schizophrenic patient has withdrawn from interpersonal relationships; the end of psychotherapy is to reintegrate him into society through a process of socialization. Religion achieves this end by relating the individual to the cosmic and the universal. (c) The principle of flexibility is as important in group worship as in psychotherapy with schizophrenic patients. By this we only mean that the leader of worship must allow for spontaneity and handle interruptions and disturbances during the worship without any show of emotion or annoyance. Permissiveness and Christian love should radiate from his personality. (d) Informality is desired especially in small worshipping groups. In larger groups, however, orderliness and decorum will increase the effectiveness of the service. On certain occasions interferences do creep in and the minister must be prepared for them. (e) A regular order of worship seems to be desirable and makes patient participation easy. We have seen its value in Sunday worship services at the Boston State Hospital. A fine worship order has been worked out by the chaplain, which allows for maximum participation by the group. Careful attention should be given to the selection of prayers and passages of scripture. Imprecatory and judgmental references should
be avoided. (f) Sermons have an important place but they should be short, concrete and illustrative. We do not agree with Boisen that sermons should always deal with the problems of the patient. Worship offers the patient a chance to transcend his immediate mental situation and set his hospital experience in a perspective that has reference to values that are eternal and abiding. The sermon should not be problem-centered but goal-centered. Problems have their place but their treatment must always be related to goal-achieving ends. (g) Music has a therapeutic value of its own and musical therapy has come to have an important place in many mental hospitals. Music is a regular feature of most of the Protestant services and therefore no detailed comment is here necessary. There is often much musical talent represented among the mental patients. This must be capitalized upon, for it offers another chance for active patient participation. There is the possibility of developing choirs which foster the elements of spontaneity and interest in worship services. (h) Hymns. Boisen has done the most original work in compiling hymnals that are well adapted to the needs of mental patients. Ordinary hymnals contain much material which is inapplicable and in some cases disturbing to patients. Boisen has brought together a compact collection of hymns designed to give suggestions

1. Babbitt, PMH, 18.
2. Boisen, HHC.
of positive value to the patient. The hymnals avoids doctrinal conflicts and "gospel hymns" (although in his latest edition he makes a concession by including some of the old favorites) yet makes maximum patient participation possible. The best and most singable tunes are used and they are pitched low enough for unison singing.

iv. Group Therapy Classes

In passing may we make reference to the group therapy classes which characterize Boisen's work with schizophrenic patients. They are somewhat analogous to the "Classes in Human Relations." The method consists of starting with cases of mental patients from other hospitals, especially those that feature emotional problems. The patients, to whom these cases are presented, take the role of the psychiatrist and analyze these cases. The leader encourages them to discuss freely the problems presented, give their appraisal of the solutions effected and then to indicate from their own experiences situations parallel to those presented in the cases. In the retelling of emotional experiences the patients often bring into the open their own suppressed emotions and gain a better understanding of their own problems. They also gain insight by listening to their fellow-patients. These group sessions pro-

1. See Bullis and O'Malley, HRC.
vide opportunities for emotional catharsis and their problems are thus subjected to a process of intellectualization and objectification. These class sessions provoke more active participation and interpersonal activity than the participation type of group therapy which is used in Boston State Hospital. There are however a few points which call for some comment; (a) Boisen selects the patients for these classes on the basis of his prognostic formulations. Only the patients who show religious concern and are more accessible, are taken into these classes. It is true that all therapy groups are chosen with some bias in mind, but, as we have pointed out, this is in many cases an arbitrary classification and precludes other patients from participating in these classes; (b) in the actual class sessions, special attention is given to those who seem to fit into Boisen's formulations. Others who show no particular interest in religious discussions are more or less brushed aside; (c) as a consequence of approaching the patients' problems with these preconceived diagnostic impressions, the leader naturally tends to be directive and judgmental. There are, however, many practical suggestions in this method for our religious work with mental patients. In Boston State Hospital there is provision for weekly group meetings for the patients.
The meetings are religious but they are conducted in a very informa1 manner and achieve somewhat the same purpose. However, there is room for development and growth and Boisen's approach contains several helpful suggestions.

5. Community Relationships

We have briefly considered some of the important aspects of Protestant ministry to mental patients - worship, visitation, counseling and group activity. These have been discussed with special emphasis on the needs and problems of schizophrenic patients. We have also pointed out that much of the success of the minister's work depends upon his ability (1) to maintain his own role as a minister of religion, (2) to collaborate with the psychiatric staff and thus enlist their support for his work, (3) to interpret the nature and significance of his work to other departments of the mental institution, and (4) to establish liaison between the patient and the community. It is this last aspect that will engage our attention in the following section.

The mental hospital is not a place of social sequestration; it is a school where through a process of re-education and socialization the patient is enabled to reintegrate himself back into society. This point is of
very great importance, especially in dealing with the
schizophrenic patient whose trouble, in most cases, is
functional and results from some severe disturbance in
his interpersonal relationships. He withdraws from society
as a result of his internal conflicts. The task is there-
fore to reintegrate him back into society. The minister
achieves this reintegration by relating the patient to
a fellowship which is more comprehensive and abiding.
This need not involve any conflict between the goals of
psychiatry and religion. Indeed there is essentially
no conflict when we conceive of this fellowship as compre-
hending both contemporary and supra-personal relation-
ships.

One of the important tasks of the minister is in
terms of liaison action and community extension. This
can be done in various ways. A few suggestions may here
be included:

1. Social Visits

There is a crying need for the public to take more
interest in the inmates of mental institutions. Friendly
visitation from friends and relatives bring cheer and
emotional support to the mental sufferer and help to keep
him in contact with the outside world. Boisen and Beers
attribute their recovery from mental illness to the regular visits of their friends and relatives. The schizophrenic is one of the most lonely persons; despite his apparent indifference he longs for social companionship. Even a catatonic who makes no response to any stimulus appreciates the kindness and attention of those who visit him. The minister can do many things to ameliorate the lot of these unfortunate sufferers: encouraging individuals and groups to call on them on visiting days; letters of cheer and comfort and small gifts on special occasions mean a lot; group projects may be undertaken to provide the patients with scriptures and devotional materials; interpreting the needs and problems of the patients to their relatives.

ii. Community Interpretation

There is a great deal of ignorance about mental illness among the people. Mental illness is regarded as a disgrace or some mysterious affliction that cannot be prevented and cured. These undesirable social attitudes make the lot of mental sufferers more difficult. Often there are untruthful reports about mental hospitals circulated in the community by unstable discharged patients, insecure relatives and dissatisfied members of hospital staff. The minister can do a real service by presenting the function and work of the hospital to groups of persons
outside the institution, interpreting to them simple facts about mental illness, and enlisting their support on behalf of the patients. He is in an advantageous position of inviting visitors, church groups and students, and conducting them through the institution. A resourceful minister can thus become an indispensable part of the mental institution.

iii. Rehabilitation

The return of the mental patient to the community is a task beset with problems and difficulties for both, more especially the former. The patient enters the community as a child who has to begin life from bottom up and it is only after a period of reeducation and readjustment that he can become a full-fledged member of society. Many patients are themselves aware that their return to society is going to be difficult not only socially but economically. Often they meet with rejection and rebuff from their relatives who look upon them with suspicion and doubt their sanity even when the psychiatrist has declared them symptom-free. Many employers are most apprehensive about an ex-patient from a mental hospital. One has only to read the life of Beers or Boisen to realize the plight of recovered mental patients. The problems of rehabilitation center around five areas: (1) vocational counseling; (2) vocational training; (3) job finding and placement;
(4) interpersonal adjustment; and (5) personal counseling. It is in the last two areas that the minister has his chief responsibility, although he may indirectly help the individual to contact community resources. The fellowship of the Christian Church offers a unique opportunity for such a person; in it he can find acceptance, permissiveness, emotional support and spiritual re-enforcement. But, before this can be achieved the people need to be educated: (1) unfortunate social attitudes and the stigma that attaches to mental illness must be removed; (2) the psychological processes affecting the adjustment of the returned patient must be appreciated and understood; (3) the families concerned need to treat the patient with respect and consideration; (4) provision must be made for his increased participation in religious and social activities; and (5) personal counseling and contacts with the patient should be continued. The Christian fellowship thus offers to the patient an opportunity to organize his life around new values and new loyalties.

6. Prevention of Schizophrenia

Boisen's formulations lead us to believe that schizophrenia can be prevented. Indeed only such a view inspires optimism and gives rationale and impetus to prophylactic efforts. Klein calls schizophrenia "a disease of civiliza-
tion" and argues that the failure to find the disease among animals gives support to the conflict theory.¹ That the disease, at least in its schizophreniform reactions, is primarily rooted in emotional causes, is generally agreed by psychiatric investigators. Even so, every psychosis—organic or functional—has emotional components which are always preventable. We have previously considered this question at some length. Here we propose to discuss the role of the Church in this field of prevention. It is our view that the task of prevention is not confined to psychiatrists or mental hygienists alone. It goes deeper into social and religious life and as such the minister of religion is intensely interested in the problem. Our discussion will necessarily be of a general nature, for the causative factors in schizophrenia are not specific to it. All functional psychoses have, in general, common causative factors.

1. Recapitulation

Schizophrenia represents a failure in interpersonal relationships. The primary evil in this psychosis is a sense of failure and an intolerable loss of self-respect.

¹ Klein, MH, 172-173.
Sociodynamically, the inability to socialize and assimilate new experiences is the crux of the schizophrenic's adjustment problem. The individual gets involved in a severe conflict between accepted ideals and disowned instinctual cravings which are neither controlled nor acknowledged; in some cases the conflict is between one's accepted ideals and his limited endowment. The distinguishing features of a schizoid personality, which is vulnerable to schizophrenia, include introversion, cerebrotonic traits, defective sex adaptation, over-conscientiousness, marked feelings of inferiority, ambitiousness, repressed hostility, and daydreaming. The familial environment of the schizophrenic is usually characterized by frictions, unwholesome or repressive sex codes, overprotection or rejection, rigid and inconsistent religious ideals. This gives us a picture of the personality and environment of one who is vulnerable to schizophrenia. It also reveals some of the areas of conflict in which religion can offer its resources and thus change the situation. The whole problem seems to center around the spirit, method and ideals of one's early environment. What are the resources that religion can bring to bear on this problem?

11. Health Resources of Religion

Religious resources can help one to face life's problems in a way that nothing else does. Religion provides suppor-
tive companionship to meet crises in life—a support of invisible yet constant companionship and a membership in a communal fellowship. It satisfies the need to love and to be loved and gives a sense of personal significance. It gives incentive to socialized living and impresses upon us the fact that loving is indispensable to living. It provides guidance toward maturity and interpersonal relationships. Religious faith involves control over emotions; prayer opens one’s eyes to limitless resources for growth within and without; confession provides catharsis and forgiveness implies acceptance; corporate worship provides contagion through which spiritual values are communicated and shared. Wholesome, healthful religion helps one grow into a life which is emotionally mature and interpersonally satisfying. If schizophrenia can be prevented, then religion seems to be one of the best agencies through which its tendencies may be corrected. The problems of the schizophrenic patient, as we have studied them, are of an interpersonal nature. They can be effectively dealt with if religious resources are available.

iii. Aims and Objectives

Clarity of aims and objectives in health education should characterize our efforts in the task of prevention. The following aims may be included in our approach to the problem:
(1) We must teach our people that religion can prevent mental illness. People do not realize the fact that religion has tremendous resources for health.¹ Many fail to realize this positive aspect of religion and see in it nothing but authoritarianism, rigid morality and repressive psychology.

(2) We must develop in our people increased appreciation for the dynamic quality of family living and its significance for growth and maturity.² Among the major contributions of good family life Slavson includes satisfying affective (love) relations, ego satisfactions, giving expression to creative-dynamic drives, and engendering emotions and attitudes that dispose toward social usefulness and group participation.³ These aims, however, cannot be realized unless members of a family are bound together in terms of common loyalties and common ideals.

(3) We must help create in our people healthy and wholesome attitudes with regard to sex. Schizophrenia and other mental illnesses largely arise from wrong personal and parental attitudes toward sex—wrong attitudes with regard to masturbation, menstruation and facts of sex. It is also true that the attitude of the Church in the past has been repressive as is reflected in the teaching concerning

¹. Federal Council, RHL, 35-43.
original sin, virgin birth, and superiority of celibate life over married life. Repression in matters of sex has naturally led to an exaggerated interest in it.

(4) We must acquaint our people with the community health resources and with the potential contributions to health that can be made by the physician, psychiatrist, psychologist, social worker, teacher, and other professional workers. So much of unnecessary trouble and worry would be avoided if people knew where and how to find help in case of need.

(5) We must help people cultivate habits of prayer, meditation and group worship. There are great resources for health and happiness in religious exercises. They quicken spiritual life, promote interpersonal communion, and release vital energies for constructive social action.

iv. Methods and Approach

(1). The Assets of the Pastor

In the field of mental hygiene, as Rennie and Woodward point out, the pastor has certain advantages over other professional workers: the people have an attitude of trust towards him; he has a sound philosophy of life; he represents a dynamic faith; he deals with people as individuals in a total situation and is concerned with all phases of human experience; he has close associations with the family as a
A pastor who combines with these assets a warm, understanding and permissive personality can do a great deal in preventing mental ills. His task in the field of preventive psychiatry is indeed strategic.

(2). Pastoral Counseling

Pastoral counseling has an important place in preventive work. To counsel and help those who have emotional problems the pastor needs to know the basic principles of the science and dynamics of human behaviour. With this must be combined genuine understanding, ability to listen responsively and a dynamic faith. He must use all available sources at his disposal including prayer, scripture, sacraments, quietness, faith, friendship, purpose and dedication to Christian service. But these must always be related to the needs and requirements of the individual. Pastoral visits and other contacts put the pastor in a peculiarly favorable position to discuss and deal constructively with problems while they are in a formative stage. He stands in a unique place to help with the problems of family relationships, dating, courtship, pre-marital and post-marital counseling. There are problems of emotional instability as men and women reach

2. English & Pearson, EPL, 323f.
toward the inevitable life changes. He needs to give special attention to the needs and problems of the aged and provide ways and means by which their talents and abilities can be constructively used.

(3). Group Activities

Pastoral counseling and other services must be supplemented with methods of group work. Through planned and goal-aimed group activities opportunities for social satisfactions can be provided. Group activities develop appreciation for others, satisfy gregarious impulses and foster a spirit of friendly rivalry.¹ Boisen's plan of group therapy classes can well be used with children and young people of the church. In all group work special attention should be given to those who have difficulty in group relationships or are otherwise withdrawn, exclusive and shy, for it is out of these individuals that most of our schizophrenics come. The church should be "a laboratory in socialized living."

(4). Worship

Worship is the center around which the life of the community should be organized. To be helpful worship and preaching must be adapted to the needs of the worshipping congregation. Positive aspects of worship experience

¹ Leslie, Art., (1949), 1-5.
should receive more emphasis. There is no essential contradiction between preaching and a non-directive approach; in so far as they show the same basic approach they supplement each other. When religious preaching is purged of its negative features and is related to the discovered needs of the people, it can perform a vital function in the educative ministry for mental health. The practice of religious assemblage is a unique feature of Hebrew Christian religion; its therapeutic and socializing possibilities must be realized and maximally exploited. Protestant churches often suffer from a considerable poverty of symbolism and good music and the length of the sermon is often out of all proportion to its value. These take away from worship some of the important values that may otherwise accrue from it.

v. Some Suggestions for Programs

The seriousness of the mental health situation makes it necessary that we give increasingly larger attention to problems of mental health. Mental health programs must become a regular feature of our Protestant churches. Some practical suggestions may here be offered:2 (1) Special seminars on religion and mental health, which are likely to arouse interest and make for understanding. (2) Weekly

meetings emphasizing values in personal religion. (3) Courses in religion and mental health can be introduced within the framework of teacher training curricula. (4) Group projects organized around the subject of religion and mental health. Youth activities and study groups can use discussions, debates, contests, audio-visual aids to understand and appreciate the health resources of religion. Parents' groups can study the dynamic factors in family living, causes of family conflicts, frictions, etc. Teachers' associations may be interested in studying the dynamics of growth and mental health, or some problems of abnormal psychology. Projects can be undertaken which include visits to mental institutions. Young peoples' groups can be brought together to discuss their mutual problems. Opportunities for the aged must be created so that they may feel a real part of the church community. (5) There is need for church clinics and guidance centers where young and old can come for help, guidance and inspiration; but they should keep in close touch with the health resources of the community for referrals and expert advice. (6) Churches should organize classes in human relations for their children and youth. Bullis and O'Malley's books may be used as a beginning. Some of

the main features of this method are: Children are told some story from the Bible or from everyday life--stories which feature some emotional problems. The children are then asked to analyze the story, isolate the emotional problem of each figure in the story and find parallel situations from their own experiences. This will give them experience in dealing with actual problems of interpersonal relationships. It will also help them to realize that their own problems are not unique and will provide channels for catharsis and self-expression. These classes will be of particular help to those children who are shy, withdrawn or aggressive--from among whom most of our mental cases come. The leader can make these classes more constructive and therapeutic if he can use sociometric measurements to have an objective basis for his therapeutic endeavors.

7. Clinical Pastoral Movement

Our present inquiry would be incomplete without some reference to the clinical pastoral movement in the founding of which Boisen was a pioneer. Historically, its antecedents can be traced back to several streams of influences coming from different directions.

1. Historical Antecedents

Flanders Dunbar compares the movement to the evolution of the clinical movement in medicine about twenty years
A great deal of controversy raged around the subject before clinical training came to be recognized as an essential part of the curricula of medical schools in Europe and America. It became increasingly clear that in order to understand the complexity of incipient diseases the medical student must have a first-hand knowledge of their late and terminal stages. Researches in endocrinology led to renewed interest in the clinical aspects of medicine, and psychiatry itself sprang up as a borderline field between religion and medicine. Thus interest in the psychogenic aspects of personality disorders has gradually increased and today we are in the era of what is called psychosomatic medicine. Nor should we forget the important contributions of the mental hygiene movement and social work in the field of preventive psychiatry.

Wood traces the beginnings of the clinical pastoral movement to the work of Dr. Ellwood, Worcester, minister of the Emmanuel Church in Boston. In 1906 Dr. Worcester, in cooperation with some physicians, admitted nervous sufferers for treatment at his church. That was the beginning of what became known as the "Emmanuel Movement." Dr. Richard C.

2. Alexander, FP, 13-21. These pages include a discussion of how the psychological point of view progressively won its way into medicine.
3. Wood, CRC, 143-146.
Cabot of the Harvard Medical School was deeply interested in the movement and wrote concerning it:

> Association of minister and physician for the alleviation or cure of nervous disorders should be favored, provided the clergyman had the proper training in psychology and psychotherapeutics and provided he will adopt a strict system of record-keeping under the direction of his medical co-adjuter.

Strictly speaking, the idea of clinical approach to the problems of religion goes back to 1913 when the Reverend William Palmer Ladd first made the plea for the practical training of ministers before the General Convention of the Protestant Episcopal Church. In 1923 Dr. William S. Keller of Cincinnati implemented this approach by starting what became known as the "Bexley Hall Plan." This plan made it possible for seminarians to work during summer vacations in public institutions and social agencies under expert supervision. In 1935 it was decided to expand the plan into a year-round program known as "The Graduate School of Applied Religion." But the school from the first was denominational and institution-centered and confined its activities to the Cincinnati area. It can therefore hardly be called a movement.

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The idea of a clinical year for theological students was first introduced by a medical man, Dr. Richard C. Cabot. His first article in the Survey Graphic of 1925 created general interest in the question among seminarians and physicians alike. It would appear that Cabot sent this article for publication at Boisen's instance who wanted support for his isolated efforts at Worcester State Hospital.
The idea of a clinical year for theological students was first introduced by a medical man, Dr. Richard C. Cabot. His first article in the *Survey Graphic* of 1925 created general interest in the question among seminarians and physicians alike.\(^1\) It would appear that Cabot sent this article for publication at Boisen's instance who wanted support for his isolated efforts at Worcester State Hospital. In the article Cabot pointed out the similarity between the medical and ministerial training and stressed the need for clinically trained religious workers in mental hospitals. It was his belief that the work in a mental hospital was of such a thankless, monotonous and discouraging nature that

the only persons who can be relied upon to face such terrible work continually and yet to retain their best human qualities are persons of a dedicated life, persons who feel the call to serve their fellows as the first thing in life...even though there were not enough men to take the entire care of these poor souls, the presence in the wards of an asylum of even a few students and teachers of Christian ideals and steady compassion would be of greatest value.\(^2\)

Thus we see that during the early twenties there were influences both from outside and from inside the Church, influences that served to bring out into the open the urgency of a clinically trained ministry in the service of the physically and mentally ill.

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ii. Boisen's Pioneer Work

Although the Council for Clinical Training came into being as a legal entity in 1930, its beginnings go back to the hospital days of Boisen when as a mental patient he became seriously interested in the problem of mental illness and its religious implications. Soon after his remission from the hospital he began to translate his idea into a definite plan of action. First at Boston Psychopathic Hospital and later at Worcester he laid the foundations of what became a churchwide movement in clinical pastoral education. The problems and difficulties he met with in his pioneering efforts are described in his book.¹ When in 1925 Flanders Dunbar went to Worcester State Hospital, the only trace of the new project in theological education she could find was three theological students, one working in the Social Service Department and two working on the wards. But she observes:

That the presence here of these students represented in itself not an inconsiderable achievement one would have scarcely imagined, but Mr. Boisen had already spent no little time and energy among hospital superintendents before he found anyone with sufficient daring and vision to permit anything so startling as the advent of theological students into the hospital domain.²

¹. Boisen, EIW, 5-11.
Beginning in 1924 Boisen's eight years' service as Chaplain of the Worcester State Hospital not only laid the groundwork for later developments but also constituted a unique demonstration of a trained religious ministry to the mentally ill. That at one time or another Flanders Dunbar, Carroll Wise and Philip Guiles have been associated with him as students or colleagues shows the importance these persons attached to his pioneer efforts.¹

From the very beginning Boisen's approach to clinical pastoral work has had its own distinguishing features. He brought to his task many and varied assets and insights. His own schizophrenic episode and his grasp of psychiatric concepts gave to his approach certain elements of freshness and originality which others lacked. It would perhaps be not incorrect to say that he had a better understanding of the psychiatric aspects of religion than of the religious aspects of psychiatry. The main emphases of his work wherein he differed from others are: (1) he approached his work committed to a particular psychiatric view of mental illness—the psychogenic theory; (2) he believed that the best approach to the problems of religion and life was through the pathological rather than the normal and he has therefore

¹ Cf. Wood, CRC, 154-159.
always been interested in mental hospitals; (3) his main emphasis in clinical work has been on knowledge and understanding rather than skill and ability.

I have been far less concerned with the study of techniques and skills than in the effort to discover the forces involved in the spiritual life and the laws by which they operate.¹

These one-sided emphases naturally led to sharp differences of opinion and division of efforts. For example, Cabot strongly disagreed with Boisen's assumptions. To him the primary objective of clinical pastoral training was not understanding but service to the sick in body and in mind. To this end he stressed the importance of skills and abilities in dealing with people in trouble. The emphasis on research work with a view to understand the profundities of spiritual life was secondary. We believe that while Boisen has been extreme in his one-sided approach, his emphasis on research and understanding was essentially correct. The issue between the pathological versus the normal or skill versus understanding is largely a false one. That all these emphases should be combined in a synoptic approach to the problems of religion and life is today the goal of clinical pastoral training. However, Boisen's insistence on the fact that the primary sources for the understanding of human nature are to be found not in books but in living human documents has done

¹ Boisen, Art., (1945), 17.
much to bring the theological student out of his sacred cloister into the valleys of human sorrow and suffering.

iii. Council for Clinical Training

After eight years of experimentation Boisen's pioneer efforts resulted in the founding of the Council for Clinical Training in 1930 at the home of Cabot in Cambridge, Massachusetts. The aims and objectives of the Council included the following:

(1) to enable students to gain a clear understanding of the sick and distressed, their emotional and spiritual conflicts, their infirmities and strengths;
(2) to help the student develop adequate methods of working with troubled people, and a working concept of his limitations as a clergyman with regard to all conditions of men; and
(3) to help the student to learn how to work cooperatively with the representatives of other professional groups and community agencies toward the prevention and alleviation of human ills.

The content of the training programs included items such as growth and development of the individual, his relationship to society, sources of conflict, meaning of illness, techniques of individual and group counseling, the church and its relationships to other groups, and correlation of religious beliefs and practices with secular concepts. With

the inauguration of the Council new centers of clinical training besides Worcester began to develop. The plan called for intensive training of theological students in summer months or other suitable times in well-established institutions where the services of trained supervising chaplains and professional staff would be available.

Institutions were favored not as a preparation for a specialized pastoral work but rather because of their controlled environment in which to pursue this study of the nature and variety of human problems.¹

The program of service included ward duty as an opportunity to serve and observe, friendly contacts with patients through recreational programs, religious services as the focal point of all activities, patients' choirs, etc.

Since 1930 the work of the Council has gradually expanded and there have been continuous programs in general and mental hospitals, as well as in certain penal institutions. Training centers operated under the auspices of the Council include ten mental hospitals, four general hospitals and five correctional institutions. Up to the present, over one thousand students and clergymen have been received by the Council for training, these representing seventy-seven theological schools in the United States,

¹ Hiltner (ed.), CPT, 9.
twelve in Canada and eleven in other countries. Clinical Pastoral Work is the official journal of the Council, published four times during the year. The journal aims to bring together descriptive accounts of pastoral work, to clarify specific pastoral situations, to use the insights of other professions, and to consider the principles and methods of clinical pastoral training of theological students.

The clinical pastoral movement has undergone further development and extension since the days of its inception at Worcester. We have already referred to the work of Dr. Keller in Cincinnati and the founding of the Graduate School of Applied Religion in 1935. After the beginning of the war it was brought to Cambridge as a department of the Episcopal Theological School. In contrast to the Council for Clinical Training, with its emphasis on specialized inquiry as a basis of instruction, the Graduate School program seeks to equip students with those clinical experiences that will prepare them in a more practical way for pastoral service in the modern community. Mention must also be made of the development of the clinical pastoral movement through the Philadelphia Divinity School which in 1937 made full-time clinical training an integral part of its theological

An interesting feature of this development was the introduction of a separate department of clinical training for the purpose of preparing women students for work in the Church. Reference has also been made to the opening of prisons and reformatories as training centers for theological students. This was made possible by the cooperative activities of the Federal Bureau of Prisons and the Commission on Prison Chaplains of the Federal Council of Churches. In 1936 a training program was begun in penal and correctional institutions, which in 1940 was broadened to include institutions for juvenile delinquency. The Reverend Wayne Hunter who received his clinical training at Elgin State Hospital opened the first training center in a correctional institution—the Federal Reformatory at Chillicothe, Ohio. Since 1936 training centers have been established in several other places.

iv. Institute of Pastoral Care

Perhaps the most significant development since the founding of the Council for Clinical Training is the Institute of Pastoral Care. The Institute is the outgrowth of Cabot's long-standing interest in the training of theological students. Its beginnings of course go back to the training

center which Boisen opened at Worcester in 1925. Cabot, however, believed that theological students would secure better clinical experience in the general hospital. Accordingly in 1933 he sponsored a program at the Massachusetts General Hospital under the supervision of the Reverend Russell Dicks. About the same time there was organized the "New England Project in Clinical Experience for Theological Students." The following year another special committee was formed—"The Theological Schools Committee on Clinical Training in Boston and Vicinity." This committee carried on summer clinical programs in the hospitals in the Boston area until 1944 when the Institute of Pastoral Care was formally organized. With the help of the Earhart Foundation and the dynamic leadership of Philip Guiles, Paul E. Johnson and Rollin J. Fairbanks the clinical training movement in New England has gained considerable impetus. In accordance with Cabot's wishes the Institute has in the past devoted itself largely to the ministry of the sick in general hospitals. In recent years, however, it has also opened training centers in mental hospitals. The Institute has the advantage of being associated with some of the outstanding leadership in the field of pastoral psychology.

1. Wood, CRC, 159-162.
The purpose of the Institute is to organize and develop a comprehensive educational program in the field of pastoral care and counseling, using clinical training as a primary basis for its program of research and instruction. To this end the Institute has organized the Summer School which provides six weeks courses in clinical pastoral training in general and mental hospitals. Occasional winter programs are also sponsored. The Boston University School of Theology carries a year-round program of clinical training in association with Massachusetts General Hospital, Massachusetts Memorial Hospital, Boston Psychopathic Hospital, Boston Dispensary, Judge Baker Guidance Center, and the Psychosomatic Institute at Boston City Hospital. The Institute also publishes a quarterly journal, *The Journal of Pastoral Care*. This experimental journal seeks to bring together the results of clinical findings and discussions, to clarify specific pastoral problems and situations and to make available the insights of other professions as a means of strengthening the minister's understanding of the needs and resources of his people.

v. Further Developments

Since 1925 many other significant developments have taken place in the field of clinical pastoral work. In 1927 the New York Academy of Medicine joined forces with
the Federal Council of the Churches of Christ in America in establishing a Joint Committee on Religion and Medicine. This Joint Committee sought to improve religious work in hospitals, to stimulate medical interest in religious elements in healing, and to give help and guidance to the movement for clinical training of the clergy.\(^1\) In 1937 this group was utilized as a frame-work around which the Federal Council organized the Commission on Religion and Health, with Howard Chandler Robbins as Chairman; and in 1938 Seward Hiltner was called to serve as Executive Secretary. Five aims were adopted by the Commission: (1) to show that health of the body, mind and spirit is an essential concern of religion; (2) to demonstrate the distinctive function of religion in the maintenance of health and emotional balance; (3) to revitalize pastoral ministry to individuals in need and difficulty; (4) to promote inter-professional and interdenominational cooperation; and (5) to improve the religious work in hospitals.\(^2\) The Commission has made large strides toward attaining these aims. The clinical pastoral training program has been supplemented with other specific means of training and education; good devotional and mental hygiene materials and standard pamphlets

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on pastoral care and counseling have been made available for the use of clergy and lay people; chaplaincy programs have been developed and enlarged; counseling seminars and interprofessional conferences have been conducted with many fruitful results. In all these undertakings Seward Hiltner who is the Executive Secretary of the Commission has made an outstanding contribution in all phases of its work.

Two national conferences of clergy and psychiatrists have been held in Washington during the years 1947-48. They were sponsored by the Institute of Pastoral Care in cooperation with the Commission on Religion and Health, the Council for Clinical Training, and the National Committee for Mental Hygiene. The net result of all this has been a growing spirit of understanding and cooperation between the two professions.¹ The recent journal *Pastoral Psychology* which began its publication in February, 1950, demonstrates this fact. This journal also meets the felt need on the part of the minister for the insights and skills of modern psychology and psychiatry. Recent trends in the clinical pastoral movement are towards increased intra-professional cooperation and closer coordination of available resources and

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facilities in the field. For the last two years representatives of both the Institute of Pastoral Care and the Council for Clinical Training have been exploring the possibility of union between the two organizations. Current discussions seem to be in the direction of some kind of a joint committee for supervision of clinical pastoral training.

In 1946 the Federal Council created the Department of Pastoral Services in order to keep pace with the growing functions and greatly increased responsibilities of the Commission on Religion and Health. This new Department served three purposes: (1) it helped to free the Commission to focus its attention on basic aspects of religion's relationship to health; (2) it served to demonstrate to the churches the full scope of the program which is actually being carried on; and (3) it coordinated, under its general supervision, the activities of the Commission and its sister Commission on Ministry in Institutions. ¹ In addition to its coordinating functions the Department of Pastoral Services now concentrates on education for pastoral work and personal counseling. The newly created Commission on Ministry in Institutions has taken over the

¹ Federal Council, DPS, 1-2.
functions previously performed by the Commission on Prison Chaplains in cooperation with the Commission on Religion and Health. It nominates candidates for Protestant chaplaincy in federal and correctional institutions and promotes more and better chaplaincy work in hospitals and other institutions.

vi. Concluding Observations

As we close this rather brief account of the origin and growth of the clinical pastoral movement we note a slow but steady process of evolution and expansion. Hiltner compares it to the gestation, crawling, walking and puberty stages of childhood development. The analogy is rather amusing but it nevertheless illustrates the progress of the movement not only organizationally but also in its ideology, breadth and perspective. The clinical movement started with a particular point of view and with a particular emphasis; it has now grown towards larger perspectives broad enough to provide for variation and expansion and high enough to maintain worthy goals. From the period of confusion of religion with psychiatric interests we have come to the period when there is a much better understanding of the therapeutic resources of religion and of the psychological processes whereby they can be mediated to others. Thus

understanding and skill, learning and serving have gone hand in hand. Among the many significant gains that have come to us and possible developments that we may expect in the future, we may include: (1) increased appreciation of the health resources of religion; (2) better understanding of people, their problems and infirmities; (3) psychological techniques of counseling and group therapy; (4) application of scientific tools of systematic observation, interview, case study, note-taking, psychometric and projective testing, sociometric measurement, and action research; (5) production of scientifically sound literature on mental hygiene and pastoral care and counseling; (6) establishment of clinically trained ministry in general and mental hospitals, as well as in penal and correctional institutions; (7) provision for church clinics and counseling centers; and (8) development of cooperative relationships between clergymen and psychiatrists and other professional groups and agencies. These represent some of the significant developments as a result of the clinical pastoral movement. The movement is still in the "adolescent stage" but upon these developments we can hope to see built an even more permanent and bright future for clinical pastoral training in the total program of theological education.
This concludes our discussion of the problem which formed the subject of this dissertation. Our discussion has centered around Boisen's studies in schizophrenia. We began our investigation with a survey of psychiatric literature on schizophrenia, followed by a brief history of Boisen's life and illness. The next two chapters have been concerned with Boisen's theory of schizophrenia and its critical evaluation. Finally we discussed the religious implications and applications of his views. In the next chapter we propose to present a summary of the previous chapters and to bring together our main conclusions.
CHAPTER VII

SUMMARY AND CONCLUSIONS

We have concluded our discussion of Boisen's studies with schizophrenia and have considered their implications for psychiatry and religion. This closing chapter will summarize the main aspects of our inquiry and the conclusions that we have reached.

1. SUMMARY

The present inquiry was initiated with a view to examining Boisen's studies with schizophrenia and to discussing their implications for psychiatry and religion. The subject has been discussed in terms of psychiatric investigations in schizophrenia, Boisen's life, illness and studies, and the implications of his inquiry for religion. The following is a reconsideration of these main aspects.

Schizophrenia constitutes a serious problem for society. At present perhaps more than fifty per cent of all state hospital inmates are schizophrenic patients.1 The cost of this illness, either in terms of dollars or human lives, is staggering. Psychiatrically, it is a baffling

1. White, AP, 521.
problem, and has been attacked from every conceivable angle of pathology and etiology. There is, however, generally increasing optimism at the prognosis of schizophrenia and a much better understanding of its nature and causation, its symptomatology and dynamics. We have today a fuller knowledge of the causes of schizophrenia, improved therapeutic methods of dealing with it, and better organization for its prevention and treatment.

The concept of mental illness has undergone quite a transformation during recent years, and this has, in turn, thrown a flood of light on the nature of schizophrenia. Man first began with a demonological conception of mental illness and we find a wide prevalence of this conception in ancient and medieval times. With the Renaissance there came a revival of the Greek theories which regarded mental illness as due to a generalized pathology of humors and tensions. But pathological research soon led to an abandonment of this view in favor of a localized pathology, and attempts were made to find cerebral lesions for particular mental symptoms. Humanitarianism went hand in hand with scientific inquiry, and during the closing years of the eighteenth century we find Pinel in France advocating humane treatment of the mentally ill. Similar movements took place in England and America. The founding of the
Mental Hygiene Movement in 1909 marked the culmination of these humanitarian activities.

On the medical side, the investigations of Pinel, Esquirol and Kraepelin led to an increased interest in the physiological concept of mental illness and its classifications. The psychogenic point of view won its way into modern psychiatry largely through the dynamic psychologies of Freud and his associates. In Meyerian psychobiology we again see a shift of interest from intra-psychic to inter-personal aspects of mental illness. Boisen’s studies have thrown a flood of light on the religious and subjective aspects of schizophrenia. Thus the psychogenic viewpoint has not only increased our understanding of schizophrenia, it has also given an impetus to prophylactic and meliorative efforts.

One result of the psychogenic theory has been the demarcation between psychoses with organic pathology and those that are essentially functional in nature. Among the first group are included general paresis, senile psychosis, Kor-sakoff’s psychosis, cerebral arteriosclerosis, epilepsies, encephalitis, post-traumatic states, etc. Functional psychoses include schizophrenias, manic-depressive psychoses, involitional psychosis, paranoia and paranoid conditions. Psychosis may involve organic or psychogenic factors or both.
In 1911 Bleuler introduced the term schizophrenia in psychiatric literature, thus replacing the Kraepelinian term dementia praecox. There seems to be a tendency among psychiatrists today to reserve the latter term for "process" or constitutional schizophrenia, and to regard its functional disorders as "schizophreniform" reactions, having no organic pathology. It also seems to be generally agreed that schizophrenia represents a unity, having certain common features of its own: indifference to reality, affective rigidity, impulsiveness, automatism, negativism, mannerism, speech confusion and regressive thinking. It must, however, be recognized that the symptomatology of the various subvarieties varies according to the type and individual trend of the patient. Other symptoms that schizophrenia shares with other psychoses include hallucinations, delusions and somatic sensations.

Schizophrenias are sub-divided into four clinical types: hebephrenia is characterized by the absence of any definite trend. It is regarded by some as the basic constitutive deterioration, from which subsequent schizophrenic groupings result. Hebe-phenoria, in its prodromal stages, is hardly distinguishable from paranoid or catatonic states. In most cases, however, it starts rather abruptly and represents a definite history of fantasy tendencies and
alternating moods. Its most characteristic features are mental confusion, emotional depression and verbal distortions. Paranoid schizophrenia develops later in life than other types and deterioration is slower. The paranoid, in many cases, achieves a measure of integration on the basis of his projective and delusional devices. The onset in most cases of catatonia, begins with a profound stupor, definite alternating conditions of stupor and excitement appearing only after the initial disturbance. Prognostic indices for this condition are much better than the other three types. These clinical types are not easy to differentiate, and the problem of differential diagnosis becomes difficult when mixed types are represented.

The etiology of schizophrenia has been discussed from different points of view. Histopathology has so far failed to establish any organic basis for schizophrenia. Cotton's theory of focal infection has received no acceptance. Neuro-endocrine researchers have noted certain endocrine deficiencies in schizophrenics. Kallman's genogenic theory has shown that schizophrenic psychosis carries a certain inherited predisposition but his profound optimism is not shared by many investigators. Kretschmer and Sheldon have pursued an interesting line of inquiry in body types, but it is still in its experimental stage. Psychoanalytic theories have done much to advance the psychiatric under-
standing of schizophrenia, but they have contributed little in terms of therapeutic formulations. Meyerian psychobiology has approached the question of etiology from a synoptic point of view, and has explained schizophrenia on the basis of faulty habits of reaction determined by one's internal and external situation. Sullivan's interpersonal psychiatry of schizophrenia has brought out the full implications of Meyerian psychobiology. Boisen's sociodynamic approach to schizophrenia represents a remarkable synthesis of psychiatry, sociology and religion. Like Sullivan, he regards schizophrenia as representing a failure in interpersonal relationships.

While the exact etiology of schizophrenia is still unknown, certain things seem to be clear: (a) psychogenic factors may bring about a schizophrenic reaction in constitutionally normal or otherwise predisposed individuals; (b) in most cases schizophrenic reactions occur between the ages of fifteen and twenty-five; (c) certain conditions of stress and strain may precipitate the breakdown; and (d) the schizophrenic represents a shut-in or schizoid type of personality. Schizoid traits include withdrawal tendencies, emotional instability, cerebrotonic features, defective sex or vocational adaptation, marked feelings of inferiority, repressed hostility, and day-dreaming.
Various attempts have been made to understand the dynamic processes involved in schizophrenia. Freud viewed it as a narcissistic disorder and explained it in terms of regression to infantilism. Shakow conceives of schizophrenic regression as a gradual backtracking over the steps of the developmental stages, while Jung explained it as a regression to the collective unconscious. Schizophrenic thinking has been compared to dreams, primitive thinking and children's thinking. Psychodiagnosis has shown that the schizophrenic confuses symbols with the objects they symbolize, lives in a world of perception, and is concerned with mere verbalization of words rather than their connotation and denotation. Sullivan regards schizophrenic states as distortions of interpersonal relationships, an attempt to preserve one's personal security and achieve satisfaction for disowned cravings. Boisen's view of schizophrenia makes use of the theory of "symbolic interactionism" and explains it as a desperate attempt to reorganize one's self in the face of overwhelming sense of personal failure. He shows us that the "wilderness of the lost" is not a world of mere fantasy or nirvana, but a world of meanings and motivations, a world of intense mental acuteness and activity.

There is an increasing optimism as to the prognosis of schizophrenia, more especially its schizophreniform reactions. Of the various types, catatonia shows the best prognosis.
Among favorable prognostic indices may be included healthy pre-psychotic personality, sudden and acute onset of symptoms, good affective responses, freedom from defective heredito-constitution, attitudes of frankness, and favorable life situation. Among the medical therapies generally applied to schizophrenia we may include narcosynthesis, hypoglycaemic therapy, convulsive therapy, electro-shock therapy and prefrontal lobotomy. Some measure of success has been reported with these therapies. Whether they can affect any permanent cure in cases where psychogenic factors are deeply rooted, is a debatable question. Prognosis depends, in most cases, primarily upon factors inherent in the individual patient, rather than upon either treatment with shock therapy or upon the type of therapy.\(^1\) These medical therapies have their values when used early and in conjunction with psychotherapy.

While the former belief that schizophrenia cannot be psychotherapeutically treated no longer exists, there are difficulties which cannot be minimized. The schizophrenic erects autistic barriers between himself and the outside world, and the problem of creating a therapeutic relationship becomes difficult. Alexander and Fromm-Reichmann have attempted modified psychoanalysis with schizophrenia and

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have reported some success in incipient cases. The psychobiologic approach has proved especially useful in incipient psychoses and affective disorders, and in certain types of schizophrenia. The interpersonal psychotherapy is an extension of Meyerian techniques and Sullivan has used it with considerable success. The application of non-directive psychotherapy with schizophrenia is still in an experimental stage. In dealing with schizophrenics Alexander has stressed the importance of rapport and flexibility. Group therapy seems to be a very promising line of approach to schizophrenia. Rosen's participation technique with schizophrenic patients at Boston State Hospital has shown very encouraging results. In addition to these psychotherapeutic aids and methods, an effective mobilization of all the resources in the mental institution can have great therapeutic possibilities. The importance of religious activities as adjuvants to psychotherapy is being recognized. The schizophrenic has withdrawn from society; he must be helped to reintegrate himself back into it on a higher level of integration.

Before we proceed to reconsider Boisen's studies with schizophrenia it may be well to refer to a few significant aspects of his life and illness. Boisen comes from a highly distinguished family of leading churchmen and educators in
American history. His father distinguished himself in the academic world and in spite of his highly emotional temperament was a generous, warm-hearted person. He died at the early age of thirty-seven, when Boisen was only seven years of age. His mother came from the illustrious Wylie family which has been associated with the Indiana University since the days of its inception. His grandfather, in whose home Boisen was brought up and educated, was a great scholar and master of several languages. A modest and retiring man, he was nevertheless a very effective teacher, very exacting in his requirements. Thus Boisen has absorbed the best from the two streams of culture represented in his family.

Boisen was brought up in the social and religious traditions of the psalm-singing Presbyterians of Bloomington, Indiana—a group of people characterized by their strong loyalty to family and clan, and by their common religious fervor and seriousness. They jealously debarred from their fellowship those who did not subscribe to their creed, or lapsed from their standards by their "neglect of the ordinances" or by "breaking the sabbath." Such were the influences that shaped the life of Boisen during his early years. Indeed he represents in his own personality a remarkable synthesis of the many and varied cultural refine-
ments and potentialities of his distinguished ancestry, and of his social and religious environment.

Boisen's school and college days were spent mostly in Bloomington. The foundations for his diversified career were laid at Indiana University, under the care and tutelage of his grandfather. He graduated in 1897, a year after the death of his grandfather. His scholarship and superior intellectual endowments soon engaged the attention of the University Faculty, and within less than two years, he was appointed as instructor in Romance Languages. In 1903 he entered the Yale Forestry School and, on graduation, joined the United States Forestry Service. What made him give up his forestry career and join the Union Theological School is not known. He began his ministry for a year as Field Investigator for the Presbyterian Department of Country Church Work. From 1912 to 1917 he served as rural pastor and during the World War I spent two years with the A. E. F. On his return he was in charge of a survey of North Dakota for Interchurch World Movement. In 1920 Boisen suffered a mental breakdown that led to his confinement in a mental hospital for fifteen months. Following his recovery he engaged his attention in a special study of the religious aspects of mental illness and was graduated from Harvard University in 1923 with the degree of Master of Arts. From 1924 to 1931 he served as
Chaplain at Worcester State Hospital where he also collabor­rated with Hoskins and his associates in a special research in schizophrenia. In 1932 he became Chaplain at Elgin State Hospital which has been the scene of his activities since then. He has occupied a number of other important posts and has carried on extensive surveys and research projects. His pioneering efforts resulted in the founding of the Council for Clinical Training in 1930. He has written extensively in scientific and religious journals. In 1942 he was honored with the degree of Doctor of Divinity by Washburn College. At present he is Acting Chaplain at Elgin State Hospital and Research Consultant for the Council of Clinical Training for Theological Students.

We are reminded of Fromm-Reichmann's remark that "a person can emerge from a severe mental disorder as an artist of rank."¹ So did Boisen. He converted his liabilities into assets and became the fountainhead of the clinical pastoral movement. His schizophrenic breakdown in 1920 was the end result of a series of internal conflicts that had their roots in "a precocious sexual sensitivity" in his early days. There were five previous periods of inner conflicts, each of which was associated with some crucial experience in his life. As a mental patient he went into alternating periods

¹ Art., (1946), 425.
of catatonic stupor and excitement, and nihilistic delusions and cosmic ideas characterized his thinking. He became intensely interested in the relationship of mental illness to religious experience. The fifteen months' sojourn in "the wilderness of the lost" resulted in a reorganization of his life around new goals and new purposes.

We cannot help pointing to the striking similarity between Boisen and Clifford Beers--both pioneers in their respective fields. They both passed through severe mental illness and emerged from it as artists of rank. Their psychotic behaviour and ideation had some common features, although one was given the psychiatric label of schizophrenia and the other manic-depressive. As we follow the biographies of these two great men we find that they found solution to their vocational goals not in spite of their illness but because of it.

Turning now from Boisen's illness to his contribution, we find that several writers have given attention to the problem of mental illness in its relationship to religious experience: some have been concerned with the pathological aspects of religion; some have seen in both religion and insanity a common concern with the "subliminal regions"; others have described religion as a "cultural neurosis." Common mental mechanisms in schizophrenia, dreams and primitive thinking have been traced by Jung, Storch and others.
Teleological aspects of crisis experiences, including mental disorders, have been emphasized by a few writers. Meyer, White and Sullivan have cast into bolder relief the inner dynamics of schizophrenia. But the most comprehensive work dealing with the subjective and religious aspects of schizophrenia has been done by Boisen. His studies are not only based upon a thoroughgoing scientific inquiry, but, what is more, they bear the stamp of his own personal experience. Boisen initiated his investigations with a view to testing the validity and implications of the hypothesis that grew in his mind as a mental patient and further to launch out a program of clinical pastoral training in the service of the mentally ill.

Boisen's theory of schizophrenia is rooted in sociology. Basically, schizophrenia is a failure in social relationships. The acute schizophrenic reaction represents a desperate attempt at reorganization in the face of an overwhelming sense of personal failure and guilt. The basic problem in this disturbance is a sense of isolation. Having accepted the ideals and standards of his group as his own, the individual finds himself continually failing to measure up to them. This conflict is intensified by the presence within him of certain disowned cravings which he can neither control nor acknowledge for fear of condemnation. In other
words, the individual fails to socialize and thus assimilate new experiences and to bring them into harmony with the social standards he has accepted as his own.

Boisen recognizes the importance of the early childhood influences in the development of personality. He sees their potency in the sphere of ideals and standards which implant themselves within the growing child. These then become his primary loyalties from which "there is no escape except through growth into a larger loyalty."\(^1\)

Conflicts arise when there is an inability to achieve integration on the basis of one's accepted ideals. The delinquent solves this conflict by lowering his conscience threshold, and finds in a gang of easy standards social approval and support. The schizophrenic, on the other hand, is at war with himself.

Schizophrenia is a failure in social capacity and interpersonal relationship. When the sense of failure is associated with feelings of isolation and segmental desires, a pattern of withdrawal and apathy develops. Avoidance of people makes socialization increasingly difficult; protective defenses only serve to transfer the locus of conflicts

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1. Boisen, Art., (1932)\(^1\), 58.
from the outer to the inner world and thus result in their intensification. In this state of inner turmoil the stage is set for a final show-down; any situational factor of sufficient strength may set this whole smoldering structure ablaze. The acute schizophrenic disturbance begins with a tremendous stirring of profounder levels of mental life. There is a stadium of frustration, indefinite psychotic mood and strange, uncanny feelings, preceding the psychotic breakdown. The indefinite abnormal mood is characterized by intense preoccupation with one's self. Then, like an automism, an upsetting idea darts into the mind, and the patient makes his entry into a mental institution. Subsequent psychotic ideation is characterized by further extensions and elaborations of this "upsetting idea."

In panic reactions of the profounder type there is a common constellation of ideas centering around cosmic identification, cosmic catastrophe and nihilistic delusions. When these occur in conjunction with feelings of guilt and personal responsibility the outlook for recovery is hopeful. On the other hand, open eroticism is generally to be viewed as advanced deterioration of self-respect, and is regarded as poor prognostic indication.

Three types of solution may result from acute schizophrenic reactions: (a) Instead of making a determined
effort to combat his psychosis, the patient may simply give up the struggle and drift down toward progressive disintegration; (b) he may refuse to acknowledge defeat by denying it and achieve a measure of integration in terms of his delusional misrepresentation of reality; (c) panic reactions, in both their agitated and stuporous forms, are desperate attempts at reorganization in the face of an acute awareness of danger. In these cases ideas of cosmic reference arise, to be distinguished from ideas of earthly reference, of fictitious self-importance and incapacitation. Acute panic reactions may result in happy or unhappy solutions: progressive unification of personality around higher goals, or progressive deterioration associated with concealment reactions. Happy outcomes of schizophrenic reactions are marked with cosmic or religious concern, frankness, self-blame and acceptance of responsibility.

Boisen calls attention to certain principles of psychotherapy which are based upon his findings and upon his experience as pastoral counselor to acutely disturbed mental patients. Nature itself is the chief factor in most of the cures that are actually affected in schizophrenic patients. The physician acts as a catalyst and his primary task is to bring into light the inner resources and inner conflicts of the patient. Interpersonal communication provides
catharsis for repressed emotions, reduces the sense of isolation, and concretizes and clarifies one's generalized fears, anxieties and worries. The real evil in schizophrenia lies not in the conflict but in the sense of isolation and estrangement from the fellowship of those upon whom one depends for love and whose ideals and standards one has accepted as one's own. Therefore, it is not necessary to lower the conscience threshold in order to deal with the conflict but to restore the individual to the fellowship of "that social something which we call God."\(^1\) How the patient looks at his own situation is more important than what the physician thinks about it. Psychotherapy is a matter of personal relationship between the patient and the physician; techniques have their place but they are of secondary importance. The importance of group relationship is recognized.

Acute schizophrenic reactions are analogous to certain types of religious experience, especially the eruptive or cataclysmic type. In both certain common features are noted—ecstatic visions, auditions, automatisms, archaic symbolisms, alternating feelings of extreme depression and morbid depression. The onset of schizophrenic disturbance is compared to the process by which mystical experiences

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1. Boisen, EIW, 268.
are induced. Both are explained as arising from a sense of personal failure. There is no essential difference between Jesus' exalted idea of himself and the catatonic's delusion that he is Christ. Both represent crisis experiences in which there is a tendency to raise personal values and loyalties to the level of the cosmic. From this arise ideas of personal responsibility and personal mission. But the schizophrenic fails to correct or harmonize his ideas with social experience. The significance of Jesus lies in the fact that with a sense of personal mission and social responsibility he achieved also the highest degree of harmony within and without. The experiences of the prophets and saints are similarly interpreted. It has, however, been pointed out that to put the two types of experiences in the same category or order of relationships, on the basis of mere analogy, is a dangerous fallacy. It is nevertheless recognized that religious experiences are generally associated with crisis experiences, whether physical, mental or social. In normal times people do not, as a rule, feel or strive intensely for personal and social issues as they do when crises come upon them. These crises arise in the context of interpersonal relationships. When tensions and conflicts are allowed to accumulate and are carried into life unresolved, they may make an emotional
explosion almost inevitable; while the outcome, in some cases, may be constructive, in most cases it results in serious personal and interpersonal tragedies. The normal type of experience is a gradual "blossoming out into life."

The therapeutic significance of religion in health or in mental illness must be recognized. Religious concern on the part of the schizophrenic is not necessarily an escape from reality but represents a serious attempt to reorganize his life in terms of values and loyalties that are cosmic and abiding. It arises spontaneously when one is facing the issues of life and death, of one's role and place in the scheme of things. Religion offers support and fellowship to one suffering from a sense of isolation; it reduces guilt not by lowering the conscience threshold but by restoring one to the fellowship of God. In dealing with the spiritual needs of the schizophrenic the minister makes use of the principles of flexibility, empathy, rapport and permissiveness. He has a special responsibility for those who are involved in religious or moral conflicts. Religious worship, in addition to its therapeutic values, gives meaning and reality to interpersonal activities by providing mutually shared goals and aspirations. To attain these goals the minister must be adequately aware of them and of the psychological processes whereby they accrue.
Group worship with schizophrenic patients must be adapted to their discovered needs. Elements of positive emphasis, group participation and flexibility must be stressed; imprecatory, judgmental and interpretative materials and references are to be avoided. Sermons should be short, concrete and illustrative; they should not be problem-centered but goal-centered. Hymns should avoid doctrinal conflicts and disturbing elements. The aim of religious worship is not merely to awaken faith and arouse emotion but redirect them along constructive channels of socialized living. Wholesome, healthful religion must take the place of one which may have been responsible for the patient's difficulties.

One of the important functions of institutional ministry is in terms of liaison action and community extension. Through encouraging public interest in the mental patient the minister can do much to ameliorate the lot of the latter. The return of the mental patient to the community is a task beset with problems and difficulties for both. One has only to read the life of Beers or Boisen to realize the problems of recovered patients. The minister's job lies in the areas of interpersonal adjustment and personal counseling. In preventive psychiatry the minister's role is an
important one. He can teach his people about the health resources of religion, the dynamic quality of family living, the need for healthy, wholesome attitudes toward sex, and habits of prayer, meditation and group worship. Mental health programs must become a regular feature of our Protestant churches, including special seminars, weekly meetings, courses in religion and mental health, group projects, church clinics and guidance centers, classes in human relations.

The clinical pastoral movement in theological education has important implications for the Church's work in the field of counseling and prevention. It is important from three points of view: (a) it brings the student of religion into personal contact with the problems and needs of people in trouble; (b) it helps him understand their conflicts and develop adequate methods of work in dealing with them; and (c) it teaches him how to work cooperatively with other professions in the prevention of mental ills. The clinical pastoral movement started with a particular emphasis and with a particular point of view; it has now grown toward larger perspectives broad enough to provide for variation and expansion and high enough to maintain worthy goals.
2. Conclusions

We have briefly summarized the main aspects of this study. The following represent some of the more important conclusions which we have reached.

(1) Boisen's psychiatry of schizophrenia presents a remarkable synthesis of the fields of religion, sociology and psychopathology, and is a strong argument in favor of a cooperative inquiry into the problems of human personality. His approach to the problem is refreshingly different, for he comes to it not only as a student of religion but as one who has himself been through a most acute form of schizophrenia.

(2) For the psychiatrist Boisen's studies have important implications. They help him to understand the subjective aspect or ideational content of schizophrenic thinking in terms of inner meanings and motivations. But whether the ideational differences in patients can be used as a possible basis for prognosis and therapeutic effort is not well established. Further research along this line is necessary. It is inadvisable for the minister to base his religious approach to schizophrenic patients on any particular psychiatric theory, especially one that has not received sufficient confirmation from psychiatric sources.
(3) There are certain difficulties and inconsistencies in Boisen's point of view which must be pointed out: He has consistently failed to distinguish between dementia praecox or process schizophrenia and its schizophreniform reactions—a distinction which modern psychiatrists are always careful to make. He likewise tends to use schizophrenia and mental illness as synonymous terms, and regards the principles derived from the former as applicable to all cases of mental illness. This tendency to generalize is most obvious when he deals with the relationship between mental illness and religious experience. One often gets the impression that, in Boisen's view, schizophrenic disturbances are distinct from the psychosis of schizophrenia, something approaching the normal. He criticizes the psychiatric classification of schizophrenia as being unsatisfactory, yet it seems to be the core of his therapeutic formulations. He has further failed to show how his acceptance of the concept of schizophrenic regression is consistent with his view that the schizophrenic is capable of conceptual and rational thinking. His insistence that no judgment should be passed on objective behaviour alone is inconsistent with his view that open erotism represents an advanced stage of deterioration. These are some of the points which Boisen has not sufficiently or carefully defined and explained.
(4) However, Boisen has done much to clarify the teleological, problem-solving and ethical character of schizophrenia. In doing so he gives ground for hope to many an unfortunate sufferer, while at the same time helping the psychiatrist and society to look upon mental illness, and in fact all suffering, in a new light.

(5) Boisen's views have important prophylactic implications. If his theory is sound, as Klein points out, then schizophrenia can be prevented. If the primary evil in this psychosis is a sense of failure and social isolation, this can be prevented in improving interpersonal relationships and thus building up positive mental health. It is also a convincing argument in favor of the psychogenic theory of schizophrenia. However, in the absence of any record of prophylactic accomplishment it is difficult to test the soundness of Boisen's conflict theory.¹

(6) Boisen has pointed out certain striking similarities between schizophrenia and certain types of religious experience, but he has fallen into the error of identifying the two on the basis of such similarities. Besides, there is the constant danger that in the effort to subordinate unique insights and crucial experiences into fixed categories of classification derived from study of

exclusively psychiatric material, one may fail to reckon adequately with the delicate laws of the spiritual world.

(7) Crisis experiences—whether physical, mental or social—tend to be associated with religious concern. Boisen's findings to the effect that religious concern is associated with schizophrenic reactions have important implications for religion. If the schizophrenic patient has religious needs and conflicts which need attention, then surely the minister of religion alone is competent to deal with them. In brief, there is a place for religious therapy in schizophrenia.

(8) Boisen has shown that religious ministry for schizophrenic patients is needed to deal with his sense of isolation and guilt. Religion provides social support and emotional undergirding; it reduces guilt by providing a sense of forgiveness and fellowship. Boisen's findings show that the patients with guilt feelings reveal a greater incidence of social recoveries. Further research is needed to check these findings. Boisen's view of guilt as arising from a sense of isolation from those upon whom one depends for love and those ideals one has accepted as one's own is worthy of consideration.

(9) Group worship has significant therapeutic value for the schizophrenic patient, provided the minister is
adequately aware of these values and knows the psychological processes whereby they can be attained. Boisen's twenty-five years' of service to the mentally ill is a demonstration of a psychiatrically oriented Protestant ministry.

(10) The success of the minister's work in a mental hospital depends upon his ability to maintain his own role as a minister of religion, to collaborate with the psychiatric staff, enlisting their support for his work, and to establish liaison between the patient and the Christian community.

(11) The primary responsibility of the Church lies in the fields of rehabilitation and prevention. The problems of rehabilitation with which the minister is particularly concerned are in the areas of inter-personal adjustment and counseling. His preventive task consists of pre-counseling, counseling, preaching and worship, health and sex education, and group activities.

(12) The clinical pastoral movement is a great means to educate and train young ministers for institutional ministry and for the task of prevention. The object of clinical training is not to turn ministers into pseudo-psychiatrists but to furnish them with means and methods to deal with people in trouble.
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APPENDIX A

WARD OBSERVATIONS

Patient________________ Place________________ Date________________
Observer________________ Period of Observation________________

APPEARANCE AND GENERAL BEHAVIOR (neatness, output of energy, mannerisms, etc.)

MOOD: placid, complacent, cheerful, euphoric, elated, silly, boastful, facetious, morose, suspicious, irritable, sad, hopeless, bitter, gloomy, anxious, perplexed, thoughtful, timorous, indifferent, apathetic, stuporous.
Variations_______________________________________________________
Appropriateness_________________________________________________

SOCIAL ATTITUDE: co-operative, amiable, submissive, friendly, expansive, self-assertive, antagonistic, fault-finding, selfish, seclusive, self-pitying.

WORK PERIOD: Kind of Work________________ TIME SPENT
General Attitude: initiative__ interest__ spec. Total
Efficiency: skill________ steadiness________
Time spent in actual work
Time spent in loafing (from________________________) __________

LEISURE PERIOD: Facilities available
Social intercourse: with whom__ attitude________
Reading: kind________________ interest________
Writing: kind________ application________
Games: kind________________ interest________
Reaction to success or failure____________________________________

Supervised Play: kind________________ TIME SPENT
Interest________ skill________ steadiness________
Revery: posture________ facial expression________
Evidences of response to hallucinations________________
Evidences of erotic indulgence________________________

Total time________________
RESPONSE TO SPECIAL SITUATIONS (church, visitors, reprimands, withdrawals of privileges, annoyance by other patients, et cetera.)

SIGNIFICANT BEHAVIOR AND UTTERANCES:
# A Pastoral Interview with a Schizophrenic Patient

## Comments

His childhood had been particularly unhappy. A question as to why he wanted to go back to that childhood was called for here.

## Interview

Q. I was much interested in what you had to say this morning. You must have done a lot of thinking.

A. (Laughs) I must agree with you there.

Q. You have done a good deal of studying?

A. The first thing I do when I come to a town is to locate a flop-house, then a dairy lunch. I spend two or three hours every day in some library.

Q. You read serious books?

A. I touch on everything—biblical criticism, theosophy, evolution, morals, book-keeping. I have studied some Spanish.

Q. How long has this been going on?

A. Over a period of seven or eight years.

Q. You seem to have been interested in religion.

A. Yes, I have always been looking for an ideal. I traced this ideal as coming from the church. I wanted to be the same religious person I was when I was a child.

Q. You have been thru some experience which has impressed this upon you?

A. Yes.
Q. Is it something you feel free to tell me about?

A. Physically it has been a very severe lesson. It cost me an awful lot. Mentally it came so fast I found it hard to digest and to make a formula for it. The spiritual took in so much - creation, damnation, churches. It brought me proof that there is a spiritual type.

Q. You had a revelation of some sort?

A. Yes, I would see cavalry in the sky. I saw cloud formations like cavalry and I heard a voice, a tender, mellow voice saying, "You don't need me yet." I took it to be some guardian who knew best.

Q. You must have been a good deal excited then.

A. Yes, I was in a terrible condition.

Q. Where were you then?

A. Working in a restaurant in Boston. That was three months before I came to the hospital.

Q. Were you much disturbed here in the hospital?

A. No, my first impression of the hospital was that it was a third or fourth heaven. I was feeling much elated. All day I felt a light in me. It was like touching the Holy Grail.

Q. You felt yourself under the influence of some outside Power?

A. Yes, as if directed by someone on a higher and holier plane than my own.
Q. You spoke this morning of passing from the red to the white and from the white to the red?

A. Yes, I could see myself going from this life into the spiritual.

Q. You felt as tho you were dead?

A. I crossed the divide long ago and then came back again.

Q. You thought there was a new era coming?

A. Yes. It is a terrifying experience. People don't like to face it.

Q. Did you have some idea about the Second Coming?

A. Yes, just before coming here. At that time the name "Judas" flashed across my mind. It seemed to be written in bright letters across my forehead.

Q. Did you feel that you had betrayed Christ?

A. No, it impressed me as Judas. That is all. Judas must have been holy for his name was written in light. I haven't ever betrayed my fellow men.

Q. Did you have some mission in connection with the Second Coming?

A. (pause) No, not of any great importance. Every place I went the atmosphere would seem to change to what it had been where I last was.

These questions were suggested by talks with other schizophrenics.

Q. What did the sun mean to you?

A. The sun meant paradise. It was associated with the idea of God.
Q. How about the moon?

A. I once said I reached the height of my brilliancy just at the time of eclipse. Then it went dark for a time. The moon seemed to have some sort of influence on me and regulate my activities.

Q. Did you believe that there were spirits in the moon or that the moon itself was alive?

A. Yes, I had the idea that there are moon men who are in cahoots with the men of this world. If anyone is in a hard fix here they are welcomed to the moon. But there must be transference. If I went to the moon, my prototype would have to come here.

Q. Did you think there were spirits in the sun too?

A. I thought the sun was a burning lake and to pass thru it one must be of the same temperature.

Q. How about the stars?

A. I thought they were highly developed persons who have had experience and won independence and give messages to people on earth.

Q. What have you been reading along this line?

A. I have read Dante's Inferno, also Paradise Lost and Regained. I have read a little in spiritism and the occult.

Q. How much have you thought about getting married?

A. Well, I had a little objection there. I thought I ought to get married to
preserve my branch of the family tree. But a voice said, "Nothing serious will happen to you until you get married."

Q. Then you have never been in love?

A. Yes, I have. That was five years ago. I had awful feelings around my heart. I didn't care if I lived or not.

Q. You have thought a good deal about sex matters?

A. Yes.

Q. How about "jacking off."

A. It gave me a lot of trouble. I would sometimes go three or four months without yielding; then it would happen every other day until I lost respect for myself. Then I would snap out of it.

Q. What sort of thoughts went along with it?

A. I thought people could see into my mind, that the barriers were let down.

Q. Well, you have indeed been thru a searching experience.

A. I don't see how any man could carry the load I did. It was agony. And yet there was the sense of holiness there. I could also see partly into hell.

Q. Do you feel that this experience has helped you?

A. Yes, my aim was to find the religion I had lost. I think I have found it.
Summary:

Throughout the interview this patient's attitude was remarkably friendly and responsive. His answers were prompt and relevant, the speech coherent, the voice pleasant and well modulated and the expression thoughtful and always in keeping with the ideas expressed. No mannerisms were observed. It is to be noted that this patient gave expression to the entire constellation of ideas which have been found to characterize the schizophrenic experience and the interviewer's familiarity with these ideas furnished a bond between them. New ideas may have been suggested but he did not feel them as new. They were rather evidence that someone understood him and his experience. The interview was closed with an attempt to interpret the experience as something which had elements of truth and value to which he could cling, also elements which must be discarded and forgotten.
APPENDIX C

CASE ANALYSIS

| Name | Age | Race | Education | Worker | Nativity | Occupation | Date | Religion | Civil Condition |

REASON FOR COMMITMENT

PHYSICAL FINDINGS

| Ht. | Wt. | Type | Organic Disease or Disability |

PSYCHOLOGICAL TESTS

Wechsler-Bellevue

Rorschach

T.A.T.

HEREDITY AND SOCIAL BACKGROUND

Race - of father of mother

Length of Residence - in community in state in U.S. of father of mother

Siblings and Other Members of Family

Economic Status

Social Status

Ethical and Religious Standards

Organization and Spirit of Home

Heredity - Strong and Weak Points in Family Record

PERSONAL HISTORY

Early Childhood

Pre-natal Influences

Birth Conditions

Disposition

Walking, Talking, Weaning, Toilet Training

Physical Health and Vigor
School Years
Age of entering school of leaving school grade attained
Rating as student
Special abilities and Disabilities

Social relationships
with members of home group -
over-solicitousness on part of parents?
which parent did disciplining? means employed.
pt.'s reaction to discipline
attachments or antagonisms to members of home group

with teachers
with school-mates
with pets

Work and play attitude toward them
Chores
Play-ground activities
Reading Habits
Day-dreaming

Remarks

Personality
Output of energy
Self-estimate
Self-assertiveness
Communicativeness
Sensitivity
Reliability
Sense of humor
reactions to success and failure

Pre-adolescence

Changes in the above or other particulars associated with the on-coming of adolescence.
Adolescence and Maturity

I. Social Adjustments
Social Identification

Social Contacts
  Membership and participation in organized groups
  Association with informal groups
  Number and type of friends
  Attitude toward others and their attitude toward him

Accomplishments - musical, artistic, dramatic, literary, athletic

Recreations and satisfactions
  Use of leisure time
  Reading habits and types of reading
  Movies
  Day-dreaming

Religion - name of church
  Church membership attendance leadership
  Periods of special awakening, indifference, back-sliding

  Special beliefs and practices

Personality
  Output of energy
  Self-estimate
  Self-assertiveness
  Communicativeness
  Sensitivity
  Reliability
  Sense of Humor
  Reactions to success and to failure

II. Sex Adjustments
Childhood and adolescent difficulties
  What sex instruction?
  how given and by whom?

Frankness in discussing sex problems
Indulgence in masturbation - When did it begin? how long did it continue? how frequent has it been? association with erotic phantasy attitude toward it

His sex code

Attitude toward same and toward opposite sex What type of women does he seek out?

At ease, or bashful with girls? popular or shunned by them?

Evidences of homosexuality

Attachment or antagonism to either parent or to other member of family

Love affairs and disappointments

Sex irregularities before and after marriage

To what extent have sex tensions interfered with work or with social relationships? When and under what conditions?

MARRIAGE
Date Age of each at time of marriage
Courtship length circumstances under which they became acquainted
Wife's race religion education
health personality
social background

Mutual Compatibility common interests
frequency of intercourse degree of satisfaction
frigidity or impotence
Children: Names
Age
Sex
Health
Grade in school
Academic rating

Present Home
Neighborhood
Type of dwelling
Ownership
Sleeping arrangements
House
House-keeping

Budget vs. income
Organization and Spirit of home

III. Vocational Adjustments
Plans and ambitions

Vocational record (positions held, compensation, proficiency, reasons for change)

Attitude toward work - interested or indifferent?
How much thought and study does he give to it outside of hours?

Manner of work (with regard to endurance, distractibility, exhaustibility, fitfulness or regularity)

Relationship with employers and with fellow workers

Opportunity for self-expression in creative activity; in the organization of the industry

IV. Physical Condition and Health
Physique Ht. Wt. Type
General Impression - distinguished? attractive? or inconspicuous? homely? unprepossessing?
Vitality (strength, endurance, virility)

Disabilities
Illnesses and accidents

Use of tobacco - alcohol - drugs

Established neurotic patterns
PRESENT ILLNESS

Date of admission Type of onset (abrupt or gradual?)
Duration of illness before admission

Precipitating factors

Symptoms of present disorder which first attracted attention

Presence of anxiety, absorption in thought, sleeplessness

Changes in behavior, in mood, in attitude toward others and toward work

Appearance of suspicions, peculiar beliefs, unusual interests, strange behavior.

Religious concern - accentuated or diminished? manifestations interpreted as superhuman

Attitude of family with reference to illness

Previous attacks - dates, duration, severity, outstanding characteristics, social and vocational adjustments during period of remission.

CHARACTERISTICS OF THE DISORDER
during acute phase in hospital

Changes in condition
What changes have occurred during period of observation in hospital? When was the disturbance at its height? What is the present condition?

General Appearance and Behavior
Output of energy

Neatness

Talk (readiness, fluency, vocabulary, peculiarities).
Oddities and Mannerisms
Intellectual Functions
State of consciousness (clear, clouded, dream-state, stupor)
Field of Attention (narrow or diffuse? external or internal?)
Orientation
Memory
Sequence of Thought (type of association, flight of ideas, confusion, blocking retardation, circumstantiality)

Mood
General cast of mood
Variability
Appropriateness
to actual situation
to content of thought

Social Attitude
To what extent is he aware of and responsive to the wishes and attitudes of others?

General Attitude
self-assertive or submissive?
fault-finding, self-pitying or self-accusatory?
frank or reticent?
friendly or antagonistic

Response to special situations (visits, letters, reprimands, examinations, etc.)

Content of Thought
Sense of the Mysterious and Uncanny
Hidden meanings
Strange thoughts, hunches, auditory hallucinations etc.
Visions
Peculiar feelings, electrical currents etc.
Motor automatisms
Ideas of mind-reading, of being hypnotized
Sources and motives of these influences?
Sense of Peril

Ideas of death
- accepted (as required by God)
- resisted (attributed to machinations of enemies)
- interests at stake

World involvement
- general calamities
  - millenniums - of superhuman origin of human origin
  - pt's role

Sense of Responsibility

Willingness to recognize own mistakes as factors in difficulty
Where guilt is acknowledged, how far does pt. discuss the real issues? is there a tendency to substitute minor for major sins? is the sin something of the past? or is it still being indulged in?

What is being attempted in the way of rectification or expiation?

Where the responsibility is projected, where is blame placed - on other persons? on occult forces? on physical illness?

What other delusional misinterpretation is in evidence?

How well-established have the delusions become?

Is the mood and attitude consistent with the pt.'s interpretation of situation? with situation as it actually is?

Erotic Involvement

How large a part does sex have in pt.'s ideation?

To what extent does he admit masturbation or other irregularities?

How much of a struggle has he been making against erotic domination? What is the present status of that struggle? Has he given way to it? Is he still in a state of conflict and distress? Has he made some compromise? What is the significance of the present disturbance?
Religious Concern

Degree of concern about vital issues

Forces upon which he conceives himself to be dependent - personal or impersonal? human or superhuman? friendly or unfriendly? monistic or dualistic?

Practice of prayer, Bible reading, attendance at religious services

Self-estimate - exalted or self-depreciative?

Ideas of - communication with God
  conflict with evil spirits
  remorse over sins
  expiation
  cosmic identification
  rebirth
  previous incarnation
  prophetic mission

How far does he think in terms of the accepted symbols of his group? Has he introduced archaic symbols? What is the source of these symbols? Can they be traced to his reading or to his contacts with others?

PRESENT CONDITION

Date

General Behavior(output of energy, neatness, stream of speech, mannerisms)

Intellectual Functions

Mood (general cast, variability, appropriateness)

Social Attitude
  General attitude - self-assertive or submissive?
  fault-finding, self-pitying or self-depreciative?
  sociable or seclusive?
  friendly or antagonistic?
  co-operative or negativistic?
  sensitive or indifferent?
  respected or "razzed"?
Differences in attitude toward those in authority and toward fellow patients.

Attitude toward work
kind of work done
proficiency
steadiness

Use of leisure time
time spent in social intercourse
in reading
in ward games (which ones?)
participation in hospital activities
revery

Reactions to success and failure, to praise and blame

Response to special situations

Attitude toward Disturbance and toward Hospitalization

Plans and Ambitions

RELIGIOUS ATTITUDE AND ORIENTATION

Present Concern about Vital Issues

His Interpretation of the Disturbance

Attendance at - church services
mental health conferences

Practice of Prayer
of Bible Reading

Reasons given for Attendance or Non-attendance at Church

His concept of the Bible

His idea of the chief end of life

His concept of God

His concept of the cross
DIAGNOSTIC SUMMARY

Life Situation
Pt.'s idea of himself (his social identification and his chosen role or vocation)

Vocational adjustments
Sexual adjustments
Social adjustments

Reaction Patterns
Habitual ways of meeting difficulties and frustrations revealed in past history
Attempts at re-organization
religious experience
previous acute disturbances
Reaction pattern represented in present disturbance

Personality Organization
Evidence of profound upheaval or regression
Degree of structuralization
Level of adjustment aimed at

Clinical Label
As agreed upon in staff
Differences of opinion

Prognosis

Plan of Treatment

Remarks
BOISEN'S PIONEER STUDIES WITH SCHIZOPHRENIA

Abstract of a Dissertation

Submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

BOSTON UNIVERSITY GRADUATE SCHOOL

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ABSTRACT

The present inquiry was initiated with a view to examine Boisen's studies with schizophrenia and to discuss their implications for psychiatry and religion. The inquiry concerns itself with four aspects: (1) psychiatric studies in schizophrenia, (2) Boisen's life and schizophrenic episode, (3) a critical examination of his theory of schizophrenia, and (4) religious implications and applications of his views.

Schizophrenia constitutes a serious problem for society. Its cost, either in terms of dollars or human lives, is staggering. Psychiatrically, it is a baffling problem, and has been tackled from almost every conceivable angle of pathology and etiology. There is, however, generally increasing optimism at the prognosis of schizophrenia and a much better knowledge of its nature and causation, its symptomatology and dynamics.

Various theories of causation have been proposed, and there is a wide divergence of opinion on many points. However, there seems to be a certain measure of agreement on the following points: (1) "Process" schizophrenia is to be distinguished from its schizophreniform reactions. (2) Schizophrenias have certain features in common: indifference to reality, affective rigidity, impulsiveness,
automatism, negativism, mannerism, speech confusion, and regressive behavior and thinking. (3) Psychogenic factors may bring about a schizophrenic reaction in constitutionally normal or otherwise predisposed individuals. (4) The schizophrenic represents a shut-in or schizoid type of personality. (5) Among favorable prognostic indices may be included healthy pre-psychotic personality, sudden and acute onset of symptoms, good affective responses, freedom from defective heredity-constitution, and favorable life situation. (6) The dynamics of schizophrenia can be explained largely in terms of regression and projection. (7) The treatment of schizophrenia calls for an effective mobilization and co-ordination of all the resources in the mental hospital.

Boisen has approached the problem of schizophrenia not only as a student of religion but as one who has himself been through a temporary yet acute form of catatonic schizophrenia. He turns the problem inside out, that is to say, he studies it from the standpoint of inner experience and thus gives an authentic description of the mental state and ideation of the schizophrenic patient. Boisen comes from a highly distinguished family of leading churchmen and educators in American history. He was brought up in the social and religious traditions of the psalm-singing
Presbyterians of Bloomington, Indiana. The foundations for his diversified career were laid at Indiana University, from which he graduated in 1897. In addition to this he holds graduate degrees from the Yale Forestry School, Harvard University and Union Theological Seminary. In 1942 he was honored with the degree of Doctor of Divinity by Washburn College. After his recovery from illness he became Chaplain at Worcester State Hospital and there laid the foundations of the clinical pastoral movement. At present he is Acting Chaplain at Elgin State Hospital and Research Consultant for the Council of Clinical Training for Theological Students. We are reminded of Freida Fromm-Reichmann's remarks that "a person can emerge from a severe mental disorder as an artist of rank." So did Boisen. He converted his liabilities into assets and became the fountainhead of the clinical pastoral movement. There is a striking similarity between Boisen and Clifford Beers, both being pioneers in their respective fields.

The essence of Boisen's theory is that the acute schizophrenic reaction represents a desperate attempt at reorganization of personality in the face of an overwhelming sense of personal failure and guilt. As such it must be distinguished from its malignant reactions of withdrawal and concealment. The stages in the development of the disorder are similar to those of insightful thinking; both involve
intense preoccupation, and both are productive of new ideas and new insights which come as "inspired" or "given."
The problem uppermost in the mind of the acutely disturbed patient is an intensely personal one and concerns his role and place of life in the scheme of things. This explains his ideas of cosmic identification, cosmic catastrophe, rebirth, mission, etc. The outcome of an acute schizophrenic reaction is likely to be constructive in so far as it represents an honest attempt on the part of the patient to grapple with his real difficulty. Religious concern is associated with schizophrenic reactions of the more constructive type. This association of religious concern with mental illness is explained on the basis of common psychological constructs and mechanisms involved – ecstasies, visions, auditions, automatisms, archaic symbolisms, alternating feelings of extreme elation and morbid depression. From the sociodynamic standpoint schizophrenia represents a failure in interpersonal relationships, an inability to socialize and thus assimilate new experiences.

Boisen's investigations stress the therapeutic significance of religion. Religious concern on the part of the schizophrenic represents a serious attempt to reorganize his life around values and loyalties that are cosmic and abiding. Religion offers social support and emotional
undergirding to one suffering from a sense of isolation; it reduces guilt not by lowering the conscience threshold but by restoring one to the fellowship of "that social something we call God." In dealing with the spiritual needs of the schizophrenic patient the minister makes use of the principles of flexibility, empathy, rapport and permissiveness. Religious worship, in addition to its therapeutic values, gives meaning and reality to interpersonal activities by providing mutually shared goals and aspirations. To attain these goals the minister must be adequately aware of them and of the psychological processes through which they accrue. The aim of religious worship is not merely to awaken faith and arouse emotion but to redirect them along constructive channels of socialized living.

One of the most important functions of institutional chaplain is in terms of liaison action and community extension. In the field of rehabilitation his job lies in the areas of interpersonal adjustment and personal counseling. In preventive psychiatry his role is an important one. He can teach his people about the health resources of religion, the dynamic quality of family living, the need for healthy, wholesome attitudes toward sex, and habits of meditation and group worship. The clinical pastoral movement has important implications for the Church's work. In the
field of pastoral counseling and mental health. It brings the student of religion into personal contact with the problems of people in trouble, helps him develop adequate methods of dealing with them, and teaches him how to work cooperatively with other professions in preventing mental ills and in building up positive mental health.

The following represent some of the important conclusions arrived at in this study:

1. Boisen's psychiatry of schizophrenia represents a remarkable synthesis of the fields of religion, sociology and psychopathology, and presents a strong argument in favor of a cooperative inquiry into the problems of mental illness.

2. For the psychiatrist Boisen's studies have important implications. They help him to understand the subjective aspect of schizophrenic thinking in terms of inner meanings and motivations. But, whether the ideational differences in patients can be used as a possible basis for prognosis and therapeutic endeavor, is not well established.

3. Boisen's views have important prophylactic implications. It is also a convincing argument in favor of the psychogenic theory of schizophrenia.
4. Crisis experiences - whether physical, mental or social - tend to be associated with religious concern. Religious concern in schizophrenic patients requires the services of a psychiatrically orientated religious ministry.

5. Religious services and activities have great therapeutic values for the schizophrenic patient, provided the minister is adequately aware of these values and knows the psychological processes through which they can be attained.

6. The primary responsibility of the Church lies in the fields of rehabilitation and prevention.
Ram Dutt was born on November 16, 1915, in the small town of Dwarahat (Kumaun), up in the Himalayan mountains of North India. In 1899 his parents - Bhavani Dutt and Besi Dutt - left their Brahmanic faith and embraced Christianity. In 1933 Ram Dutt graduated from St. Andrew's High School, with a major in Science. The following year he entered St. Andrew's College, and completed two years of junior college. The next four years were spent in Leonard Theological College, Jubbulpore, from where he graduated in 1939 with a bachelor's degree in Theology. In 1941 he received his Bachelor of Divinity degree from the Serampore University, Bengal. Following two years of pastoral service in the Methodist Church he was appointed in 1943 professor of Religious Education and Old Testament in Union Theological Seminary, Bareilly, United Provinces - a position which he continues to occupy. He is author of several articles in the Christian journals in India, including a major
paper entitled "The Villager's Mental Folkways as an Important Factor in his Reaction to the Christian Message" (being a preliminary study of such characteristic beliefs as fatalism, spirits, charms and magic as examples of the way in which long-travelled mental folkways condition the villager's reaction to the presentation of the Christian way of life).