

# A Christian Response to the Crisis in Psychiatry

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Callie Joubert, 81 Sander Road, 3 The Chesters, New Germany, South Africa 3610.

## Abstract

Psychiatry is intimately connected to the problems of our time and those of people. However, psychiatry is facing a crisis, and it is well known that psychiatry has taken over many concepts from the Bible and secularized them. The first part of the paper focuses on seven problems facing psychiatry, which explain why psychiatrists are unable to escape their crisis. It then stipulates two crucial areas in which psychiatry conflicts with the book of Genesis. The second part of the paper focuses on, respectively, 1) shame, guilt, the conscience, and remorse, and 2) psychosomatic illnesses. The aim is to show that scientific discoveries in each of these areas are consistent with the teachings of Scripture, and is therefore a powerful apologetic for Christian witness in our medicalized world. It suggests that it would be wise if psychiatrists and their service-users accept the Bible as serious on all matters about which it speaks.

**Keywords:** brain, conscience, disorders, emotion, guilt, heart, illness, physicalism, psychiatry, psychosomatic, reductionism, remorse, shame, soul

## Introduction

A psychiatrist is a physician who specializes in the diagnosis, treatment, and prevention of mental illnesses or mental disorders. Psychiatry, according to psychiatrist Jonas Robitscher (1980), far more than any other medical discipline determines what is normal and abnormal, and what is good and is bad for people (p.xii).<sup>1</sup> But psychiatry is facing a perpetual crisis, and psychiatrists want to know why.

Recently, psychiatrist Heinz Katschnig (2010) put the following question to his colleagues: “So, 200 years after its birth, is there something wrong with psychiatry? And, if so, what is it?” (p.21). The reality is that psychiatrists are telling each other (not their patients!) that psychiatry has a “crisis of credibility” (Moran 2005); “psychiatry is currently at risk of going on the endangered species list” (Craddock and Craddock 2010, p.30); “there is a sense that psychiatry as a profession is in crisis” (Oyebode and Humphreys 2011, p.439), that “academic psychiatry has become more or less irrelevant to clinical practice” (Kleinman 2012, p.421), and that “progress in our field will not come

from neuroscience and pharmaceuticals” (Bracken et al. 2012, p.431). These statements are not new.

Over fifty years ago, O. Hobart Mowrer (1961) published *The Crisis in Psychiatry and Religion*. Three years later, psychiatrists were told that “no other medical specialty is as insecure in its therapeutic approach” as psychiatry (Von Bertalanffy 1964, p.30). Nine years later, psychiatrist Solomon Hirsh (1973) concluded that the “nature of psychiatry, the complexities of its relationship to medicine, the humanities and religion...have contributed to a chronic and increasing identity problem among psychiatrists” (p.1090). And 35 years later we find almost the exact same words in an article coauthored by 37 psychiatrists, which they titled “Wake-up call for British psychiatry.” The first sentence reads: “British psychiatry faces an identity crisis” (Craddock, et al. 2008, p.6). Last, but not least, 36 years ago, George Engel (1977) told psychiatrists that “psychiatry’s crisis revolves around the question of whether the categories of human distress with which it is concerned” are really “diseases” (p.129), and the crisis has not yet been resolved.

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<sup>1</sup> One area is, for example, abortion, which is considered illegal unless certain conditions exist. “Mental illness” is one such condition. The late Thomas Szasz (1973), who was himself a psychiatrist and a critic of psychiatry, reported that in Colorado (Denver General Hospital) in 1967, 109 therapeutic abortions were performed, 90% for psychiatric reasons. In California in 1968, the first six months of the year, 1777 pregnancies were terminated, all to “safeguard” the “mental health” of the women. In contrast, only 115 abortions were performed to preserve physical health (pp.87–88). There are at least three ways to interpret this phenomenon: 1) a “mental illness” diagnosis as an excuse for someone’s wrong actions; 2) allowing women the freedom to live out their desires and refrain from coercing them to accept responsibility for the consequences of their sexual acts; and 3) neither the mother nor the psychiatrist regard an unborn child as a human being. Szasz therefore contended that psychiatry is a “covert redefinition of the nature and scope of ethics” (p.25).

## The Crisis: Psychiatry is the Secular Analogue of the Bible

Philosopher Osborne Wiggins and psychiatrist Michael Schwartz (2004) noted that in early human history “unusual behavior” was interpreted in moral and religious (i.e., biblical) terms. “Today these modes of behavior would be *medically* conceived. The person would no longer be morally condemned... He or she would now be seen as suffering from an ‘illness’ somewhat similar to other (i.e., physical) illness” (p.473). In other words, these authors would have others believe that mental disorders are no longer ascribed to moral failings or character weaknesses; mental disorders are legitimate illnesses that are responsive to specific medicinal treatments. A person diagnosed with a mental disorder is seen as not responsible for his condition as a result of wrongdoing, and therefore not blameworthy.

Benjamin Rush (1745–1813) wrote the first systematic treatise on psychiatry in America and is considered the “father” of modern psychiatry and the patron saint of the American Psychiatric Association. He believed that crimes and immoral acts, such as murder, theft, and lying were medical diseases, and that lying was incurable (Szasz 1970, pp. 137–159). In *Whatever Became of Sin?* psychiatrist Karl Menninger (1973) admitted that behaviors associated with pride (synonymous with self-centeredness, arrogance, self-love), impermissible sex, infidelity, gluttony, violence, sloth (laziness), envy, cheating, and cruelty have been reappraised and framed in medical terms (pp. 17, 133–172).

In stark contrast to psychiatry which reduces these sins to biology (i.e., disorders of the brain, as we shall shortly see), in the Bible they are essentially spiritual problems. They are referred to as “evil things,” and, as such, means anything that is the opposite of what is good, right, and true: “For from within, out of the heart of men, proceed evil thoughts, adulteries, fornications, murders, thefts, covetousness, wickedness, deceit, lewdness, an evil eye, blasphemy, pride, foolishness. All these evil things come from within and defile a man” (Mark 7:21–23).

These examples suffice to illustrate that psychiatry is the secular analogue of the thought patterns of the Christian Scriptures. It must, therefore, be said that the crisis calls for a decision (Greek: *krisis*) or choice

between alternatives. The inevitable result of a wrong decision or choice is that the crisis does not go away.

## Seven Core Problems of Psychiatry Which Explain Why Psychiatrists are Unable to Escape their Sense of a Crisis

1. *The subject of treatment in psychiatry.* It is now more than 35 years since George Engle claimed that psychiatry is “the only clinical discipline within medicine concerned primarily with the study of man and the human condition” (Engel 1977, p.134), yet psychiatrists are still not entirely sure what it is that they are actually studying or treating. Some say that psychiatrists are “most concerned with the relationship of mind and brain” (Kendler 2001, p.989). Others say, begin “at the practical starting point, namely the person (patient) rather than a mind or a brain” (Van Staden 2006, p.93). Still others argue that psychiatrists treat the self, but avoid questions about what the self is (Crossley 2012). As to what a “brain,” “mind,” “person,” or “self” is, there is also very little agreement. What is beyond doubt, however, is that most psychiatrists have decided to make the brain the central focus of their attention.

A few psychiatrists and many critics of psychiatry have argued that a central problem of psychiatry is an ideology which goes by the name of “biological reductionism,” an off-shoot of naturalism.<sup>2</sup> For proponents of this ideology and philosophy, disordered (i.e., “abnormal”) thinking, emotion, or action is, “by definition, the product of a disordered brain” (Deacon and Lickel 2009, p.115). They embrace the idea that the brain and chemical imbalances in the brain are keys to understanding the causes and treatment of mental disorders (Cohen 1993; Eisenberg 2000; Erickson 2010; Shah and Mountain 2007; Uttal 2011; Wyatt and Midkiff 2006). Christian and physician Michael Emler (2012) concurs; in psychiatry “more and more problems in living are attributed to brain-based dysfunction. Medication is touted as an important (if not the most important) aspect of treatment within the psychiatric community” (p.11).<sup>3</sup>

This illustrates that psychiatrists, following the example of neuroscientists,<sup>4</sup> assume that what has been traditionally identified with the immaterial soul can now be accounted for largely in terms of the brain. In other words, immaterial entities, such as

<sup>2</sup> Philosopher Charles Taliaferro (2009) describes “naturalism” as “a scientifically oriented philosophy that rules out the existence of God, as well as the soul” (p. 2). For proponents of naturalism, man and his capacities (i.e., human nature) are the products of the evolutionary process of natural selection. Psychiatrist Jerome Wakefield (2012) put it as follows: “Today, we understand that human nature—specifically, species-typical biological design—is due to evolution through natural selection” (p. 18).

<sup>3</sup> For a brief history of events that contributed to this approach and practice, see David Healy (2000). Of significance to this paper is his statement: “Where once blame has been put on families, or mothers in particular, the 1990s became the decade of blaming the brain” (Healy 2000, p. 2).

<sup>4</sup> Bullmore, Fletcher, and Jones (2009) are greatly concerned that some psychiatrists are reluctant “to embrace the theoretical and therapeutic potential of neuroscience.” The “danger,” as they call it, is that if disconnected from “the physical mechanisms of the body, specifically the brain,” psychiatry will be “intellectually adrift” (p. 293). According to Giovanni Fava (2009), psychopharmacology or pharmaceutical psychiatry has found a most favorable climate in the progress of the neurosciences. It is not widely known, but almost all neuroscientists believe that “You are your brain” (Greene and Cohen 2004, p. 1779; Beauregard and O’Leary 2008, p. x). For people such as Patricia Churchland (2002), this is good news: “there is no soul to spend its postmortem eternity blissful in Heaven or miserable in Hell” (p. 1).

the soul, spirit, and mind, make no sense unless they can be eliminated or reduced to the brain.

However, there are a few psychiatrists who are courageous enough to say they think differently. They tell their colleagues that “progress in our field will not come from neuroscience and pharmaceuticals”; psychiatry “is not neurology; it is not a medicine of the brain” (Bracken et al. 2012, pp. 430, 432); and, “the focus on biology has distorted [psychiatric] practice and research” (Kingdon and Young 2007, p. 288). The following six problems substantiate the truth of these statements.

2. *Pharmaceutical medication and the chemical imbalance hypothesis.* Psychiatrist Arthur Kleinman (2012) writes that “evidence from treatment outcome studies is that the effects of standard psychopharmacological medications, now many years old, seem less and less impressive” (p. 421; cf. Bracken et al. 2012, pp. 431–432; Cohen 1993, p. 519). David Cohen (2004) is more comprehensive in his depiction of the problem:

Despite the reliance on psychopharmaceuticals, however, not even modest improvements in the incidence, prevalence, relapse rate, duration, or long-term outcome of *any* condition routinely treated today with psychotropics, such as depression and schizophrenia, can be discerned... On the contrary, despair, distress, and dysfunction are regularly announced to be increasing (and untreated) in the affluent West and throughout the world, (Cohen 1997; 2004, p. 1)<sup>5</sup>

As was earlier noted, underlying the reliance on psychiatric drugs is the hypothesis (unproved assumption) that a chemical imbalance in the brain is the cause of “diseases” such as depression,<sup>6</sup> which presents psychiatrists with at least four obstacles.

First, the hypothesis is difficult to accept. According to the National Institute of Mental Health Laboratory of Clinical Science, SSRIs (Selective Serotonin Reuptake Inhibitors) cannot be used as primary evidence for serotonergic dysfunction in the physiology of the brain (Lacasse and Leo 2005, p. 1212); according to the *American Psychiatric Press Textbook of Clinical Psychiatry*, serotonin deficiency is an unconfirmed hypothesis (Leo and Lacasse 2007, p. 4); and the textbook *Essential Pharmacology* states that there is no clear and convincing evidence that monoamine deficiency accounts for depression (Leo and Lacasse 2007, p. 8). Drug companies’ concealment of unfavorable research data from

clinical drug trials, selective reporting, and the abuse of public trust moved *The Lancet* editors to make the following declaration: “The story of research into selective serotonin reuptake inhibitor (SSRI) use in childhood depression is one of confusion, manipulation, and institutional failure... In a global medical culture where evidence-based practice is seen as the gold standard for care, these failings are a disaster” (Anonymous 2004, p. 1335). The “story of research” can be put as follows: “The game is clear: to get as close as possible to universal consumption of a drug, by manipulating evidence and withholding data” (Fava 2009, p. 221).

Second, “antidepressants are no better than placebo” (Katschnig 2010, p. 23; cf. Beaugregard 2007; Cohen and Jacobs 2010; Jacobs and Cohen 2010; Mayberg et al. 2002; Moncrieff and Kirsch 2005). One study found that 80% of the responses to six<sup>7</sup> of the most widely prescribed antidepressant medications were duplicated by placebo control groups—in the case of Prozac it was 89% (Kirsch et al. 2002). In other words, only one or two out of every ten people are truly benefitting from the medication. But what seems clear is that a false belief, but positive expectation, has as much an affect on a person as a true belief: the service-user shows a positive response to a placebo prescription because he believes, and expects, it will have a healing affect while it has absolutely none! Therefore, if the placebo-effect does not differ from an antidepressant, then the latter is clinically negligible.

Third, there is a logical problem with the chemical imbalance hypothesis; the validity of the reasoning is problematic. The fact that aspirin cures headaches does not prove that headaches are due to low levels of aspirin in the brain. Researchers conducted, for example, a controlled clinical trial investigating the antidepressant effects of psilocybin (an ingredient in mushrooms). What they found was that 79% of the respondents reported moderately or greatly increased levels of life satisfaction (Leo and Lacasse 2007, p. 3). Does it follow that, because psilocybin causes “satisfaction,” it restored a chemical imbalance in their brains?

The fourth obstacle to the neurochemistry hypothesis relates to the difficulty of a physician or psychiatrist to distinguish between disorders. The most well known study, known as the Rosenhan experiment, was published in 1973 by D. L. Rosenhan in the leading scientific journal *Science*. Eight volunteers (pseudopatients) were admitted to 12

<sup>5</sup> One reviewer of this paper holds that the statement is erroneous. However, the writer quoted does not say that medication does not work. My point is that placebos do as well, as we shall shortly see. In fact, all psychiatric drugs “work,” but the “data on antidepressants... indicate that most recoveries on antidepressants would have happened whether or not the person was put on treatment” (Healy 2009, p. 23).

<sup>6</sup> For the history on the origin and development of this notion the reader is referred to Gary Greenberg (2010). Greenberg ends his book *Manufacturing Depression: the Secret History of a Modern Disease* on the following note: “don’t settle for being sick in the brain” (p. 367; cf. Rose 2003). For reasons why addiction is not a disease of the brain, see Steve Pearce and Hanna Pickard (2010; cf. also Pickard 2012, 2013).

<sup>7</sup> Zolof (sertraline), Paxil (paroxetine), Prozac (fluoxetine), Effexon (venlafaxine), Serzone (nefazodone); Celexa (citalopram).



psychiatric hospitals in five different states on the East and West coasts of America saying they were hearing voices saying “empty,” “hollow,” or “thud.” Although all immediately acted normally upon admission, all were discharged with a diagnosis of “schizophrenia in remission.” The problem is, however, that hearing a voice saying a single word is not a typical feature of people with a psychotic disorder. Furthermore, “hospitalization ranged from 7 to 52 days, with an average of 19 days”; but the pseudopatients were “administered nearly 2100 pills, including Elavil, Stelazine, Compazine, and Thorazine, to name but a few. (That such a variety of medications should have been administered to patients presenting identical symptoms is itself worthy of note)” (Rosenhan 1973, pp.252, 256). The author concluded that it “is clear that we cannot distinguish the sane from the insane in psychiatric hospitals” (Rosenhan 1973, p.257). Another study found that pseudopatients (actors trained to behave as patients) presenting with symptoms of adjustment disorder (a condition for which antidepressants are not usually prescribed) were frequently prescribed Paxil by their physicians (Lacasse and Leo 2005, p. 1214).

Now if this practice of physicians and psychiatrists cannot be attributed to inexperience or incompetence, then the only alternative is to interpret their readiness and decision to prescribe drugs as consistent with their fundamental presupposition: the brain is the cause of personal problems, therefore should be the target for treatment and drugs the chief means. Dr. K.W.M. Fulford (2002) observed that this is a trend that has its origin the nineteenth century; “and much of the appeal of modern ‘biological’ psychiatry lies in its promise of translating mental disorders into...brain diseases” (p.360).

3. *Confirmation and diagnoses of mental disorders.* The prescription of a specific drug does not suggest “a biological basis for a problem” (Cohen 1993, p.517). The truth is, there is no “single way to diagnose any mental disorder—and don’t let any expert tell you that there is....There are no objective tests in psychiatry, no X-ray, laboratory, or exam finding that says definitely that someone does or does not have a mental disorder,” even if a service-user might find a diagnosis fairly straightforward (Frances and Widiger 2012, pp.115, 116). Kleinman (2012) describes this “as an extraordinary failure” (p.421). His statement

applies as much to the chemically disordered brain hypothesis as to neuroimaging. Contrary to what most people believe, no expert can look at a neuroimage (or photo) of a scanned brain and make a psychiatric diagnoses, nor can it help clinicians to confirm such a diagnosis (see Uttal 2011, pp.313–361).<sup>8</sup> Underlying the idea that a scan of the brain can tell experts about the functions of the mind is, among other things, the false belief that a brain is the thing that thinks, feels, and decides, which must be questioned (Bennett and Hacker 2003; Joubert 2014; Williams 2012).<sup>9</sup>

4. *What is a “mental disease” and what is a “mental disorder?”* There is, after over 60 years of debate, no consensus among psychiatrists about the difference between the concept of “mental disorder” and “mental illness” (Frances and Widiger 2012; cf. Aragona 2009; Kendell 2002; Kleinman 2012). It is therefore not strange to find that psychiatrists are accused of “disease mongering” (Moynihan and Henry 2006), a phenomenon that is otherwise known as the medicalization of normality—the “process by which nonmedical [personal and interpersonal] problems become defined and treated as medical problems, usually in terms of illness or disorders” (Conrad 1992, p.209). Coupled with this is the involvement of pharmaceutical companies in the classification and treatment of disorders (Baumeister and Hawkins 2005; Cohen 2004; Lewis 2009; Rose 2003).

It is therefore useful to look at the numerical increase of disorders listed in the DSM (*Diagnostic and Statistical Manual of Mental Disorders*), otherwise known as the “psychiatric bible.” By the time of the U.S. census in 1880, there were seven official “mental diseases”: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy (Kutchins and Kirk 1997, p.39). But a revolution occurred since 1952. It began with the publication of the DSM-I, which listed 106 disorders. DSM-II (1968) increased them to 182; DSM-III (1980) listed 265 disorders, which increased to 292 in the revised DSM-III-R (1987) edition.

Four months after the publication of the DSM-III-R, the American Psychiatric Association met to explore the publication of DSM-IV, which listed 365 diagnoses seven years later (1994).<sup>10</sup> The DSM-IV-TR (“text revision”) listed 445 mental disorders (Ahn, Proctor, and Flanagan 2009, p.16) when it appeared in 2000, and DSM-V was published in May 2013.<sup>11</sup> Experts opine that DSM-V will include more

<sup>8</sup> The field of neuroimaging is characterized by conceptual confusion, misinterpretation, and logical inconsistencies (see, for example, Bennett and Hacker 2003; Crawford 2008; Leo and Cohen 2003; Roskies 2008; Van Horn and Poldrack 2009; Van Orden and Paap 1997).

<sup>9</sup> A general belief among neuroscientists, including psychiatrists, is the notion that it is the brain that makes us human. For reasons why the notion is ill-conceived, see Joubert (2011).

<sup>10</sup> See Wikipedia in the References section below.

<sup>11</sup> The reader might be interested to know that the decision to include or not to include disorders during preparation of some of the DSM versions was reached by way of a vote and under pressure of political interest groups (see Kutchins and Kirk 1997). The reader may therefore wonder if this resembles anything remotely scientific. Furthermore, the reader might be interested to know that it has been pointed out that about 70% of the DSM-V taskforce members had ties to the pharmaceutical industry. For DSM-IV, all of the members who worked on mood disorders, schizophrenia and other psychotic disorders had ties to drug companies (Collier 2010).

diagnoses and criteria sets, all designed to expand the population of the “mentally ill,” and exposing individuals unnecessarily to medications (Phillips et al. 2012).

Is there an explanation for this grotesque spectacle? In light of what has been said so far, it seems reasonable to conclude that it is the manifestation of naturalism, biological reductionism, and physicalism, the proponents of which seek a limitless expansion of the category of illness; it is the expression of the psychiatric presupposition that everyone is, without exception, diagnosable; and it could be a covert struggle for power and control. The crux of any diagnosis, however, is this: if the service-user chooses to accept any disorder or disorders attributed to him by a psychiatrist, then he is expected to undergo the standardized psychiatric treatments planned for him. But the outcome is not always predictable. Two days after his physician prescribed Paxil to Donald Schell for depression, he shot his wife, daughter, granddaughter, and then himself. And David Hawkins, two weeks after using Zoloft, killed his wife. The Judge’s words at his trial state the point well enough: “I am satisfied that but for the Zoloft he had taken he would not have strangled his wife” (Rose 2003, p.55; for the irreversible and long term side-effects of psychiatric drugs, see Breggin 1991).

5. *Reliability and validity of mental disorders.* A closely related problem to the previous one is that after more than 60 years there is still no consensus about the reliability and validity of most of the mental disorders listed in the DSM (Katschnig 2010; Kutchins and Kirk 1997; Widiger 2011). The bottom line is, if clinicians and researchers cannot agree on who has a particular disorder, or whether someone has any mental disorder or not, then the agreements about them are suspect. Put differently, “if reliability is not good, the practical validity [i.e., truth] of the constructs that DSM embodies, that is, the diagnosis, is called into question” (Kutchins and Kirk 1997, p.50).

6. *Character and misconduct as mental disorders.* The sixth problem contributing to the sense of crisis in psychiatry is the overlap between and mischaracterization of character and misconduct as mental illnesses or disorders.<sup>12</sup> It is disconcerting to find in the psychiatric literature questions such as “how might the topic of ‘morality’ be of interest to clinicians and mental health researchers?” (Lewis

and Whitley 2012, p.735), and “Are the ‘patients’ involved in our sample cases [of criminal misconduct] involved in sick behavior, immoral behavior, both, neither, or some other metaphysical kind altogether?” (Sadler 2008, p.12). These questions are bothersome, given that psychiatric diagnosis cannot possibly be value-free. Use of words such as “better,” “bizarre,” “disorder,” “dysfunction,” and “worse” underlines the point that psychiatrists are concerned with values (for example, true and false beliefs, good and bad thoughts and desires, appropriate and inappropriate emotions, and right and wrong actions); anguish is psychological, spiritual, and moral in nature simply because it involves relationships that are psychological, spiritual, and moral in nature.

It is therefore not surprising to find complaints about the abuse of psychiatric diagnosis in the justice system (Erickson 2008). One explanation for this is, as Peter Conrad and Joseph Schneider (1992) observed, the medical profession began to redefine deviant behavior (i.e., misconduct, bad, or immoral behavior) as illness. In addition, psychiatrists and neuroscientists increasingly posit the brain as the exclusive agent of behavior (Erickson 2010).

7. *Dualism.* The seventh source of frustration and cause of a sense of crisis in psychiatry and, of course, the scapegoat for biological reductionists, is dualism. In the words of Leon Eisenberg (2000): “the problem that continues to bedevil us conceptually is how to integrate” the “brain and mind” (p.1). And since dualists believe that the material world is not all there is, and that immaterial beings form part of reality, all kinds of tactics are deployed by reductionists and physicalists to convince people that dualism is false. One such tactic is to argue that mind-body dualism, meaning substance dualism,<sup>13</sup> is the source of the crisis facing the health profession today (Mehta 2011; cf. Brown 1989; Joubert 2014). The logical implications behind such tactics to reject substance dualism include the belief that all mental disorders are biologically, specifically, brain-based dysfunctions.

However, it should be evident from what has been said above, that dualism is not the primary cause of a sense of crisis among psychiatrists. If it is, then it is because substance dualism is consistent with the teachings of Scripture, and therefore presents an obstacle for proponents of naturalism, biological reductionism, and physicalism in psychiatry and neuroscience (cf. Boyd 1997; Dilley 2004; Gardoski

<sup>12</sup> It is and was not only Szasz’s (1961) view that “psychiatry, as a theoretical science, consists of the study of personal conduct” (p.25). For example, Fulford et al. (2005) argue that “almost every major diagnostic category” has “a moral counterpart” (p.78). Louis Charland (2006) argues in favor of the view that personality disorders are moral problems. John Sadler (2009) asks, “Why are some categories of criminal misconduct classified as mental illnesses (e.g., child molestation/Pedophilia) whereas other categories of criminal misconduct are not?” (p.7).

<sup>13</sup> Substance dualism is a view of the constitutional nature of a human being, according to which a person is not identical to any physical thing or process; the human person is a non-material (non-physical) soul or spirit that interacts with its body in functional unity.

2007; Joubert 2011, 2014; Moreland and Rae 2000; Welch 1998). Yet, dualism is consistent with scientific research.

Research has shown that most people, including very young children, are soul-body dualists (Bering 2006). Paul Bloom's (2004) review of the literature of developmental and cognitive researchers who investigate people's conception of themselves led him to state that "we are dualists who have two ways of looking at the world: in terms of bodies and in terms of souls" (p. 191). In other words, they think of biological and psychological causes of phenomena as ontologically distinct. The point not to be missed, however, is that children do not have to be taught to be dualists; they have no conceptual understanding of, or access to, their own brains, yet they are well-aware of what they themselves think and believe about themselves and other objects, including the direct and immediate causal relation between themselves and their bodies. We shall shortly see that scientific evidence in the field of psychosomatic illnesses shows that a disordered soul (person) can cause its body to become dysfunctional.

But first, it is important to highlight two crucial areas in which psychiatry conflicts with the book of Genesis.

### Genesis and Psychiatry

For the sake of brevity, I have selected only those features that are of immediate relevance to what has been discussed so far.

1. *The subject of care in Genesis.* In contrast to the prevalent uncertainty among psychiatrists about what precisely it is that they are studying and treating, Genesis lays emphasis on mankind as created beings in the image and likeness of their Creator (Genesis 1:26–27, 2:7, 5:1–3, 9:6).<sup>14</sup> Further revelation indicates that humans are unified entities and consist of two ontologically distinct parts: a material body and an immaterial soul or spirit (Genesis 35:18; 1 Kings 17:17–21; Psalm 31:9; Micah 6:7; Zechariah 12:1; Matthew 10:28; 1 Corinthians 7:34; 2 Corinthians 7:1; James 2:26; 3 John 2). This implies and entails at least three things. First, Christians accept their Creator as a paradigm of what a person is, and accept God as ontologically, epistemologically, and morally analogous with themselves. Second, man is neither an animal, nor a human-animal, or the accidental product of mindless processes of natural selection (evolution) over billions or millions of years (cf. Mortenson and Ury 2008). And third, it is a mistake to assume that humans can be fully understood and treated as they ought to be understood and treated apart from our Maker.

2. *The source, cause of, or reason for man's problems.* In contradistinction to psychiatrists and their focus on the brain, Genesis identifies the heart of man as the focus point of their troubles. And since it cannot be a physiological organ, it must be an unseen, immaterial, and spiritual reality. Genesis teaches that mankind's troubles started with a single act of wrongdoing (disobedience)—a deliberate rebellion against the word of God motivated by a desire to be like Him—that has affected every person ever since. Spiritually, he began to honor and worship the Creation and creature rather than the Creator (cf. Genesis 3:1–6; cf. Romans 1:18–32); morally he degenerated, and began to shed innocent blood (Genesis 4:1–8), and mentally "every intent of the thoughts of his heart *was* only evil continually" (Genesis 6:5; cf. "madness *is* in their hearts"—Ecclesiastes 9:3, and "the heart is deceitful above all things, and desperately wicked; Who can know it?"—Jeremiah 17:9). Scripture, therefore, admonishes every person to be responsible and watch over their hearts (Proverbs 4:23; cf. Mark 7:21–23). In a word, Scripture teaches that "a man's heart [not the brain!] *reveals* the man" (Proverbs 27:19; cf. 1 Peter 3:4).

In addition to Genesis' teaching on wise living (for example, Genesis 4:6–7; cf. Job 28:28; Psalm 111:10; Proverbs 1:1–7), Scripture teaches that an important part of a person is his mind, which is a power or capacity for rational thinking and forming true beliefs. Restoration of man's fallen state begins with what is usually referred to as the "new birth" (John 3:3–7), an act of repentance toward God, and a turning away from sin (Matthew 4:17; Acts 2:38) as well as the thought patterns of this world (cf. Romans 12:1–2; Ephesians 4:17–24; Philippians 4:7–8).

To conclude, there should be no doubt in anyone's mind that psychiatry deeply affects people's beliefs about the world, the kind of beings they believe they are, how they themselves can be known, how they think about their own problems and those of others, and how they ought to be treated. Thus, it helps us to understand why Thomas Szasz (1973) was convinced that psychiatry is "an ideology and technology for the radical remaking of man" (p. 11). The evidence, however, shows that despite this project, sinful human nature has not changed since the entrance of sin into this world.

There exist several ways to demonstrate this, but none is as obvious and revealing as human emotions involving moral wrongdoing. I therefore consider it as an embarrassment for psychiatrists who claim to study mankind and are now advising one another to take emotions, such as shame, as a departure point for understanding the self and psychiatric care

<sup>14</sup> For an explication of the concept of the "image of God," the reader is referred to Kenneth Gardoski (2007) and Robert Saucy (1993, pp. 17–52).



because “our task as psychiatrists is in trying to understand the multifaceted implications of hearing our patients say they are not who they want to be” (Crossley 2012, p.100).

In the next section I shall focus on shame, guilt, the conscience, and remorse. Of importance would be to take a brief look at the literature on shame, including the reason why shame holds a particular attraction for psychology researchers. After clarifying the characteristics of the self-ashamed individual, I will describe the biblical picture of shame as presented in the book of Genesis. I will then further clarify our understanding of shame by contrasting it with guilt and remorse.

### Shame, Guilt, Conscience, Remorse

A few observations about the meaning of the term “self” are in order. According to Christian and psychiatrist Jeffrey Boyd (1997) the “self” is “the secular name of the soul” (p.26), and by now we understand why, and I shall not repeat it here. J.P. Moreland (1998) has not only showed how the “self” came to replace “soul” in the discipline of psychology, but also explained what the self is. He states that the “pronoun *I* refers to a substantial self [i.e., the soul/person] because such a self uses *I* in acts of self-reference,” which “makes the term *I* a personal pronoun in the first place” (p.40). Therefore, contrary to those who would have us believe that the “I” is an aberration of language, not a referring term, or just a word people have learned to use in language (cf. Bennett and Hacker 2003, pp.331–334, 346–351), when I say “I am in pain,” then the “I” is not an illusion. The simple reason is, if it is, then the Creator of mankind is also an illusion, and by implication, not a self-conscious knowing person. He said “I AM WHO I AM” (Exodus 3:14), and these are words which Jesus repeated in reference to Himself (John 8:24, 28, 58). The “I” that people use to refer to themselves explains why Christians are justified to accept God as a paradigm of what a person is and why they accept God as ontologically, epistemologically, and morally analogous with themselves (“God is Spirit”—John 4:24). With this in mind, let us see what scientific research discovered about shame.

### Shame

Shame forms part of a group of emotions that is referred to in the empirical literature as self-conscious emotions, the other three being guilt, embarrassment, and pride (Tangney, Stuewig, and Mashek 2007). They are self-conscious emotions because they presuppose awareness of oneself, and are evoked by self-reflection and self-evaluation. The scientific literature reflects three main reasons why shame is of special interest to researchers.

The first, and obvious reason, is because emotions explain behavior. When something has occurred, is occurring, or is about to occur, that a person is aware of, and the person judges that he or she stands to be affected by it (positively or negatively), the person will experience various emotions and be motivated to behave or act in various ways. The research reveals a consistent relationship between shame, criminal conduct, and psychological problems (Tangney, Mashek, and Stuewig 2007; Tangney, Stuewig, and Hafez 2011). Shame is also significantly linked with disorders such as psychotism, the narcissistic (arrogant, self-seeking) personality, the histrionic personality, avoidant personality, schizoid personality, self-defeating personality, borderline personality, obsessive-compulsiveness, symptoms associated with depression, anxiety, post-traumatic disorder, eating disorder symptoms, suicidal behavior, substance abuse, and problems related to the body’s endocrine and immune system (cf. De Hooge, Breugelmans, and Zeelenberg 2008; Dickerson et al. 2004; Tangney 1991; Tangney, Stuewig and Mashek 2007; Tangney and Tracy 2012).

The second reason is because shame, like guilt, is considered “as a predominantly moral emotion” (Tangney, Stuewig, and Mashek 2007, p.3); it involves rules and standards of right and wrong, thus of acceptable/unacceptable, and appropriate/inappropriate behavior, and it helps clinicians to understand both the uniqueness of shame and the involvement and orientation of the self in shame.

The third main reason is because shame seems difficult to explain. Researchers think that shame “offers little opportunity for redemption” (Tangney and Tracy 2012, p.452). It is generally regarded as the more painful and disruptive of the moral emotions (Tangney, Stuewig, and Hafez 2011, p.2), and shame is, accordingly, in contrast to guilt, regarded as an “ugly feeling” (Tangney 1991, p.600).

The affects of shame, and the seriousness thereof, in a person’s life, following a wrongful act or acts, become all the more evident when we consider the reasons cited by those who cut themselves (the most common form of self-mutilation): “to get relief from ‘a terrible state of mind’” (Fagin 2006, p.194); “to stop bad feelings,” “to relieve anxiety and terror,” “to punish myself for being bad,” to “punish self for being bad/[for having] bad thoughts,” “I did not like myself”, “I felt like a failure”; “I was angry at myself” (Klonky 2006, pp.231, 232). How should we explain these expressions, since shame is consistently related to a host of disorders and their associated symptoms, and that shame can be an intense, painful, and disruptive emotion? If it is reasonable to see self-inflicted bodily pain as the sufferer’s way of seeking relief from unbearable psychological/

moral suffering related to shame and wrongdoing, then it is also consistent with associating it with self-punishment, guilt, remorse, and the desire to “wash away sins”<sup>15</sup> (cf. Bastian, Jetten, and Fasoli 2011; Nelissen 2011; Nelissen and Zeelenberg 2009). The least that can be said is that these expressions are manifestations of a deeply disturbed or distressed person as the result of realizing who one is and not who one wants to be.

Empirical evidence further reveals that ashamed people, following a wrongful action (for example, lying, stealing, failing to help or care for someone, disobedience to parents, and impermissible sex) typically focus on themselves—their shortcomings, attributes, or qualities (Tangney and Tracy 2012, p.448). In other words, objectionable behavior is seen as a reflection of a defective or objectionable self, and the person is experiencing himself as bad. It is observed in a typical response of the shameful person, when he says “I did a horrible thing,” and places the emphasis on “I” (Tangney et al. 1996, p. 1257). Since disapproval of oneself and significant others is assumed to be a key component of shame, it can be expected that the suffering would be especially acute when the moral wrong committed causes alienation and loss of intimacy between the wrongdoer and a loved one—that is, those whose approval the ashamed person needs and is seeking. This implies and entails that a shamed person is one who perceived and realized that he is no longer the kind of person others thought him to be (i.e., the person is aware that his moral identity is damaged). It helps explain their self-directed anger, why they often feel contempt for and disgusted with themselves (Tangney et al. 1996, pp.1258, 1262; Tangney, Stuewig, and Mashek 2007, p.17), why typical self-reports include feelings of being worthless and exposed, which, in turn, helps explain the tendency to hide themselves and their desire to withdraw and escape from others (Tangney and Tracy 2012, p.448). Alternatively, the shameful person will make attempts to “turn the tables” by shifting blame (i.e., seeking a convenient scapegoat). It could, therefore, be a reasonable conclusion that shame will not always manifest in pure form; it could be intermixed with, or covered over with, hostility or anger the person directs at himself or someone else. Fear of punishment and/or fear of rejection could also be added to the list since shame involves transgressions others, including God, disapprove of.

## Shame and Genesis

The Christian record of human history reveals that shame entered the world when Adam decided to disobey the standards of conduct which God had set for him and his wife (1 Timothy 2:14). God allowed them the freedom to eat from the fruit of every tree in the garden in which they were placed, except the tree of knowledge of good and evil (Genesis 2:16–17, 3:1–6). The very first result of Adam’s disobedience was a radical change in his and Eve’s self-consciousness or self-awareness. They knew immediately that they were no longer how they used to be: “the eyes of both of them were opened, and they knew that they *were* naked” (Genesis 3:7).

Instead of approaching God, confessing their transgression, and seeking His forgiveness, they decided to embark on their own project, which can be referred to as self-repair. It essentially comprised a three-step process. First, they sought ways to deal with their self-appraisal in a way which they took to be right in their own eyes: “they sewed fig leaves together and made themselves coverings” (Genesis 3:7). By covering their nakedness—a most profound sense of exposure—they revealed their realization of who they have become—wrongdoers. Their second step involved attempts to escape from or avoid the scrutiny of the omniscient and omnipresent Creator: “Adam and his wife hid themselves” (Genesis 3:8). The third step can be interpreted as either an attempt to deal with their fear of punishment, rejection, and/or to avoid accepting responsibility for their actions by blame shifting. When God turned to Adam, he said “The woman whom You gave *to be* with me, she gave me of the tree, and I ate,” and when God turned to Eve, she said “The serpent deceived me, and I ate” (Genesis 3:12–13). Adam simply tried to find the source of, or cause for, his shame (and perhaps his guilt, but without any sign of regret for his own wrongdoing)<sup>16</sup> in his wife, and she in the serpent.

A multitude of things can be the cause of shame. Scripture teaches, for example, that “poverty and shame *will come* to him who disdains correction” (Proverbs 13:18); “He who mistreats *his* father and chases away *his* mother is a son who causes shame and brings reproach” (Proverbs 19:26); “the thief is ashamed when he is found out” (Jeremiah 2:26); and the unjust steward was “ashamed to beg” because of his self-respect and/or how he wanted to be esteemed by others (Luke 16:3).<sup>17</sup> It is therefore important to ask what purpose does shame serve in a wrongdoer’s life.

<sup>15</sup> After Pilate decided to deliver Jesus into the hands of His murderers, “he took water and washed his hands,” saying, “I am innocent of the blood of this just Person” (Matthew 27:24).

<sup>16</sup> One reviewer of this paper correctly observed that many young people can talk about their sin with little guilt, and seem to lack any sense of shame. One clear reason from Scripture is that that happens when people no longer consider certain actions as wrongful (cf. Jeremiah chapters 6-8; Hosea 9:7).

<sup>17</sup> It is not wrong to think that self-respect, self-approval, and self-condemnation are favorable aspects of a normal (healthy) self-concern.



God seems to teach us that rules and standards of conduct are necessary and good things, including a person's character. The Bible teaches that God is more interested in how a person looks on the inside rather than in his outer appearance (cf. 1 Samuel 16:7; John 1:47; 1 Peter 3:3–4), and that He, therefore, weighs (Proverbs 21:2) and tests our hearts (1 Thessalonians 2:4). As was noted earlier, the heart reflects the person (Proverbs 27:19; 1 Peter 3:3–4).

The function of shame is rather obvious: shame provides immediate and salient feedback to a person about himself, including the effects of his character and actions on others; shame tells a person there is something in him that requires his attention to be made right; and, rather than withdrawing from those whose approval he desires and needs, including that of his Creator, he should seek reconciliation with them. The person who fails to deal with his sense of failure and wrongdoing could therefore expect to worsen his condition. How else should we explain the connection of shame with much psychiatric disorder, their associated symptoms, and self-mutilating behavior?

### Guilt, Conscience, and Remorse

Empirical evidence shows that, in contrast to the ashamed person who is primarily self-focused, the focus of the guilt-stricken is their actions and the consequences thereof (Tangney, Stuewig, and Mashek 2007, pp.4–6). Their concern, in other words, is the offense committed, such as consciously breaking the law, or having failed to comply with a rule, standard, or protocol. Thus, if a guilty person is aware of morally wrong thoughts, words, or deeds, then it follows that the person must have perceived and realized that he has committed a moral wrong. It helps explain why people “stricken with guilt are drawn to consider their behavior and its consequences, rather than feeling compelled to defend the self” (Tangney, Stuewig, and Hafez 2011, p.2). A common response of a guilty person is to say “I did that horrible thing” with the emphasis on “did that” and “thing” (Tangney, Stuewig, and Hafez 2011, p.2). It may be indicative of a sense of responsibility, especially if the transgressor attempts to make reparation for his actions (for example, offering an apology where appropriate, or when seeking opportunities and ways to undo the harm caused; cf. Zacchaeus in Luke 19:1–10).

People with a deep-seated sense of guilt may also express their sorrow, pain, and regret—a feeling of deep disappointment and dissatisfaction with a certain state of affairs that result from their actions—with tears (sadness, sorrow, grief). It must, therefore, be noted that it is possible for a person to be guilty of an offense without feeling any regret,

but difficult to imagine a person experiencing regret without guilt. Thus, in contrast to shameful people who tend to separate and withdraw from those who disapprove of them, people plagued by guilt tend to seek reconciliation or connectedness with those they transgressed against (Tangney, Stuewig, and Mashek 2007). It is also characteristic of the ashamed; cf. Gausel and Leach 2011; Schmader and Lickel 2006).

Researchers also found that wrongdoers suffer not only from guilt but also “pangs of conscience” (Tangney, Stuewig, and Mashek 2007, p.5). Disappointingly, however, it is hardly, if ever, explained in the psychological literature what the conscience is, where it originates from, and why it is the case that wrongdoers suffer pangs of conscience. It must suffice to make four points. Firstly, suffering pangs of conscience is a characteristic of all people across all cultures, despite the fact that there are different things within each culture people may feel guilty about. For the early Greeks, conscience meant “the pain that you feel when you do wrong,” and an American Indian described his concept of the conscience as follows: “In my heart there is an arrowhead with three points to it. If I do wrong, the arrowhead turns, and it cuts me. If I do wrong too much, I wear out the points and it doesn't hurt me quite so much” (Wiersbe 1983, pp.6–7). It is no coincidence that the word “pain” (Latin: *poena*), meaning punishment or penalty, denotes suffering, “particularly if this [pain] had resulted from a blameworthy act” (Tyrer 2006, p.91).

Secondly, etymologically, “conscience” (Latin: *conscientia*) means “to know with” (oneself) or “to know together.” If it is reasonable to conclude that conscience is the human capacity or power of moral self-awareness and moral judgment, then it explains why feelings involving the conscience may result in self-condemnation if an act is wrong and rightful action may arouse self-approval.

Finally, the origin of the conscience is the Creator of mankind. The Apostle Paul described its function as follows:

for when Gentiles, who do not have the [written] law [of God], by nature do the things in the law, these, although not having the law, are a law to themselves, who show the work of the law written in their hearts, their conscience also bearing witness, and between themselves *their* thoughts accusing or else excusing *them* (Romans 2:14–15).

With regard to remorse, it is typical of theorists to think of remorse as a feeling about an action someone knows he has committed in the past, and to connect the emotion with “obsessive thoughts about sin” (cf. Bennett and Hacker 2003, pp.201, 205). According to Tangney, Stuewig, and Mashek (2007, p.5), remorse

and regret focus the self's attention on the "bad thing done." If so, then it becomes reasonable to infer that the nature of the actions and the well-being of those harmed (the victim) would be the remorseful person's focused concern, and not only the wrongful acts. In other words, as a consequence of the nature of his actions and in addition to how he himself feels about and must have come to understand them, is that the life or person that has been harmed is valuable. Could the feelings of remorse be especially acute when it involves the death of an innocent person and the realization that a life or person is irreplaceable? Raimond Gaita (2004) writes that "Nowhere is that sense more sober than in lucid remorse," expressed in the utterance "My God what have I done?" or "How could I have done it?" (p. xxi). The same truth is expressed in Scripture. In the context of scolding the Israelites for having sacrificed their children to idols, God said, "No man repented of his wickedness, [by] saying, 'What have I done?'" (Jeremiah 8:6). However, it would be a mistake to think that remorse is only expressed in an utterance; it can occur as a mere thought. The following two examples illustrate the reality and affect of remorse.

Scripture informs us that when Judas Iscariot saw (i.e., realized) that Jesus had been condemned to death as a result of his (i.e., Judas') actions, he felt remorse saying, "I have sinned by betraying innocent blood" (Matthew 27:4). He immediately tried to make amends for the harm he brought on Jesus by handing back the money to those who rewarded him for his betrayal of Jesus, which was unsuccessful. So overwhelming was his sense of remorse that he hanged himself (Matthew 27:5).

The "American Idol" judge and former lead singer of Aerosmith, Steven Tyler, recently reflected in Aerosmith's "autobiography" (a collection of reminiscences) on an experience he had when, in his late twenties, the woman who was pregnant with his son had an abortion. In his words: "You go to the doctor and they put the needle in her belly and they squeeze the stuff in and you watch. And it comes out dead. I was pretty devastated. In my mind, I'm going, Jesus, what have I done?" (Burke 2012). It is reasonable to conclude that the thought that crossed Tyler's mind was that he immediately realized that what occurred was evil, which he also realized was too late to correct. The sad and subsequent history of Tyler can be interpreted as a series of attempts to escape from his sense of regret and remorse.

In conclusion, despite the conceptual differences between the three moral emotions, there is no reason to think that they cannot co-occur (cf. Schmader and Lickel 2006). Further, it seems that a person does not experience or feel emotion about things concerning which a person is indifferent or ignorant of. To ignore

the function of conscience in distress related to shame, guilt, and remorse would mean to ignore something central to normal human functioning. Scientific research discoveries, when correctly interpreted, can never confound the truth of Scripture. It also applies as much to scientific evidence that shows a disordered soul can cause its body to become sick.

### Psychosomatic Illness and the Bible

It is well-known that a person's disordered thinking, feelings, desires, and attitudes (hostility, being unforgiving) lead to a variety of bodily illnesses. Medical history reveals (Galdston 1954) that the intimate reciprocal relation between the spiritual soul and physiological health has been known to physicians even before Hippocrates (460–377 BC). Illnesses such as asthma, peptic ulcers, anorexia nervosa, rheumatoid arthritis, migraines, irritable bowel syndrome, upset stomach, chronic fatigue syndrome, panic attacks, and disorders of the skin, muscles and joints, endocrine system, immune system, and cardiovascular system are commonly referred to as "psychosomatic" or "psychogenic illnesses" (Arnold 2013; Carson and Butcher 1992, pp. 229–261). The core proposition underlying psychosomatic illnesses is that they are bodily expressions of emotional conflicts (Gitlin, Levenson, and Lyketsos 2004, p. 5) or unresolved emotional issues (Oatis 2002, p. 3). Two examples from, respectively, empirical science and Scripture will illustrate these truths.

The first relates to shame and guilt. Researchers discovered that self-blame, self-punishment, or self-condemnation associated with shame and guilt causes inflammatory products in the body, and that shame causes immunological decline and in some cases, accelerated progression in infection, such as HIV (Dickerson et al. 2004). The second example comes from a study of 87 patients hospitalized with acute ulcerative colitis. It was found that "the onset of the symptoms was associated with the rupture of a relationship with a person on whom the patient was deeply dependent" (Nemiah 2000, p. 302). Here comes to mind the loss of a loved one as the result of death, the loss of intimacy as the result of marital unfaithfulness, and/or rejection (loss of favor) by a loved one for reasons unrelated to oneself (cf. Isaiah 54:6).

The third example is found very early in the Christian record of human history. Genesis 4 provides an account of two brothers who approached God with an offering, thus with what each considered to be acceptable to God. Cain's consisted of "the fruit of the ground" (v. 3), and that of Able of "the first-born of his flock" (v. 4). But God had rejected Cain's offering. First, he became angry, and "his countenance fell." Today we would probably say that his emotions got

the better of him, or that he was depressed. God then counseled him, which is to say, God shared some of His wisdom with Cain: “If you do well” and “rule over” (i.e., take control of) your sinful desires, “will you not be accepted?” (v.7). Instead of taking it to heart and exercising self-restraint, he decided the source of his troubles lay in his environment. The end-result is well-known: he killed his innocent brother during, or after, a walk in the field (v.8). Scripture strongly suggests that Cain did not like what he heard from Abel (Luke 11:49–51). It is also likely that jealousy (“I desire what you have!”—in this instance, God’s favor) and envy (“I desire what you have and take it from you!”) also contributed to his evil actions.

2 Samuel 13 provides an account of a young man who confused his passions (lust) with love and care, and that for his sister. And because the law of God that forbids sexual relations between relatives presented an obstacle to him, he became “so distressed” (“frustrated; NASB) that “he became sick” (“he made himself ill”; NASB). The name for this “illness” was then, as now, is depression (cf., v. 4 in NASB), which even his morally corrupted friend could “day after day” observe in his appearance and actions. Instead of dealing with his passions, he decided to act them out. For his victim the results were devastating: he violated (raped) her, immediately hated her, rejected her, and was unconcerned about her suffering until the day of his own death (vv. 11–17).

Scripture also teaches, for example, that

- trouble and grief go hand-in-hand, and adversely affect both the soul and the body (Psalm 31:9; cf. 3 John 1:2);
- unacknowledged guilt and transgressions (sin) cause the body to waste away (Psalm 32:3, 5);
- anxiety in the heart causes depression; but a good word makes a person glad or happy (Proverbs 12:25);
- a “sound heart *is* life to the body, but envy is rottenness to the bones” (Proverbs 14:30);
- a “merry [joyful] heart does good, *like* medicine, but a broken spirit” has detrimental affects on the body (Proverbs 17:22); and
- “do not let the sun go down on your anger” (Ephesians 4:26). It suggests that if the angry person is to avoid sleepless nights and further troubles then he must make haste to settle conflicts and unresolved emotional issues.

The word “psychosomatic” was introduced into medicine by Christian and physician Johann Heinroth in 1818 (Steinberg, Hermann-Lingen, and Himmerich 2013). According to him, the soul uses the emotions, the mind, and the will as its powers in order to take control of the body. He concluded that all mental illnesses are the result of a disordered soul, which he naturally referred to as “disorders of the

soul” (Steinberg, Hermann-Lingen, and Himmerich 2013, p.12). Over time, however, whenever there was an opportunity, leading psychosomatic theorists paused to attack this view, now commonly referred to as “commonsense dualism” (Bomford 1953, p.637).

The question from critics of soul-body interaction is: How can an immaterial spirit or soul cause an illness in the body? Implicit in the question is the assumption that we must first know *how* causal interaction occurs in order to know *that* it occurs. But if the assumption is true, then we would not know that a hot instrument causes pain when touched by a hand unless we first know how it happens. However, interest in understanding the soul-body relation gave way to what has of late become the new focus in psychiatry and neuroscience, namely the mind-brain relation.

Although a few neuroscientists and psychiatrists agree that a person’s state of mind can influence the proper function of the body (Lane, Waldstein, and Chesney 2009, pp.117, 118), they contend that this fact cannot be understood without studying the brain. In contrast, the writers of Scripture expressed universal knowledge of the interaction of the soul with its body without understanding the functions of the brain. Therefore, knowing that a disordered soul can make its body sick is far more important than knowing how it happens.

### Concluding Remarks

“The World Psychiatric Association took as its banner for its 1996 meeting the slogan ‘One World, One Language’” (Healy 2000, p.2). However, the empire’s language of biological reductionism has been described by psychiatrist René Muller (2008) as a “collective illusion”—“a condition of being deceived by a false perception—if that perception figures prominently in what we believe and in how we live” (p.5). I argued that psychiatrists are unable to escape their crisis; psychiatry has taken many concepts from the Bible and rephrased them in secular/medical terms. From this perspective, very little about what is abnormal, bad, and wrong matches the teachings of the Bible.

The crisis in psychiatry is therefore both intriguing and significant: psychiatrists must decide what man is and what it is that they are treating; antidepressant treatments are not effective, at least not as effective as hoped; debates about the nature and etiology (pathogenesis, origin) of mental disorders continue incessantly; and there are to date no objective tests in psychiatry that definitely indicate someone does or does not have a mental disorder, despite reasonable judgments by those experienced in the field. The reliability and the validity of the disorders and the mischaracterization of immoral actions as disorders of the brain remain problematic; efforts to make



substance dualism the scapegoat for the crisis in psychiatry are misplaced and not successful; and contrary to what most psychiatrists have hoped for, progress in understanding a human person has not yet come from neuroscience. In a word, psychiatry does not yield what psychiatrists and their service-users are longing for. The devotion to, and fascination with, the brain and drugs in psychiatry have a most unfortunate result: service-users are left in the dark regarding the real causes of their spiritual, moral, and mental suffering.

What scientific discoveries reveal about shame, guilt, remorse, and the conscience have been used to illustrate the relevance of the teachings of Scripture to our medicalized world. From a biblical perspective, what ashamed people are ashamed of are themselves, not their brains. The cause of shame is the moral disapproval of oneself, including the disapproval of other persons and God. Experiences of shame indicate to the wrongdoer that his character is in need of attention, and not his brain; to be guilty of an offence is to know and acknowledge that one's actions were wrong, not one's brain; and what remorseful people deeply regret is the badness of their action and the harm caused to the lives of others, and not their own brains, or those of their victims. The moral pangs of conscience that accompany these emotions can therefore only be the suffering of a self-conscious person.

Researchers discovered that adults and young children think of themselves in dualistic terms. This is consistent with people's everyday psychology—the indivisible “I” and direct and immediate knowledge of oneself expressed from a first-person perspective—as well as the teachings of Scripture. From both a scientific and biblical perspective the well-being of the spiritual, moral, and mental soul and the health of its body are inseparable. The source of man's troubles is first, and foremost, the human heart, and affects all relationships. Therefore, those who neglect to care for the hidden person of the heart cannot honestly claim to care for the person, including his body.

Would it not be wise if psychiatrists and their service-users, whether Christian or non-Christian, decide to take the Bible serious on all matters which it speaks?

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