AN EXPLORATION AND ADAPTATION OF
ANTON T. BOISEN’S NOTION OF THE PSYCHIATRIC CHAPLAIN
IN RESPONDING TO CURRENT ISSUES IN CLINICAL CHAPLAINCY

by

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Abstract

The author of this dissertation responds, within the context of pastoral theology, to clinical chaplaincy’s increasingly isolated and diminished place in contemporary North American health care delivery. The dissertation explores what is particular about clinical chaplaincy by focusing on its origin: that is, it analyzes the life and work of Anton T. Boisen (1876-1965), with specific attention to both Boisen’s mental health context and his explicitly pastoral and theological intentions. The author argues for a contemporary and adaptive retrieval of Boisen’s original innovation: the specific position of the clinical psychiatric chaplain.

Literary research is used to analyse Boisen in critical dialogue first with the historical insight of clinical psychologist Paul Pruyser (1916-1987) that the innovation of the psychiatric clinical chaplain as a member of the multi-disciplinary team is rooted in Boisen’s fascination with his own life. Second, this author analyses the hitherto mostly archived, understudied, and largely unpublished doctoral efforts of Boisen’s seminal contribution to chaplaincy by pastoral theologian Henri Nouwen (1932-1996). Nouwen strategically recasts this contribution by linking it to Boisen’s experience of alienation, an effect of his mental illness. Third, the author engages the work of practical theologian John Swinton (b.1957) as a contemporary echo of Boisen’s commitment to an ecclesiological dimension for mental health care. Fourth, the author uses Charles Taylor’s (b. 1931) recent philosophical work to suggest that Boisen’s pioneering contributions may continue to inform, in significant ways, the contemporary search for God among those living with mental health issues.
The author concludes the dissertation by offering a conceptual framework which makes room for a religiously spiritual clinical chaplaincy within the multi-disciplinary team: the ‘re-membering God’ model, based on Nouwen’s insights into Boisen and on the anthropological work of Barbara Myerhoff (1935-1985). The dissertation applies these findings in the specific context of Catholic sponsored mental health care, suggesting that the ‘re-membering God’ model is not only significant for the future of chaplaincy as a professional discipline, but also has important pastoral implications for mental health care ministry.
Acknowledgements

Although my name appears as the author, and indeed I am ultimately responsible for its success and failures, this dissertation is more than just mine. I am especially indebted, as Anton T. Boisen would say, to the “living human documents” who shared with me their journey into that not so faraway “little-known country” of mental illness. It was by listening to the spiritual lives of psychiatric patients, especially while I worked at the Mental Health Centre Penetanguishene (now Waypoint), that I first began to ponder the uncertain status quo of clinical chaplaincy.

I thank foremost my doctoral director, psychologist Joseph Schner SJ, of Regis College, who critically guided the ideas you read here. Special thanks to Anne Anderson CSJ, President of St. Michael’s College in the University of Toronto, who served on my dissertation committee. Joining these two scholars, the following academics assembled for the defence of this dissertation: the Rev. Dr. Pam McCarroll, Assistant Professor of Pastoral Theology and Director of Theological Field Education at Knox College; Gilles M. Mongeau, SJ, Associate Professor of Systematic Theology and Director of the Master in Divinity Program, Regis College; and Dr. Michael W. Higgins, Vice President for Mission and Catholic Identity, Sacred Heart University (USA). These experts were exactly what I needed in the cross-disciplinary work before you: a work in pastoral theology which connects the practice of psychiatric chaplaincy with Catholic sponsored mental health care.

Writing the dissertation also made me grateful for the many academic and mental health care colleagues I have met along the way. Each of them has been critically important with inspiration and/or feedback: I thank Ron Mercier SJ, the first person I remember explicitly encouraging me to become a theologian. This invitation made sense I think, thanks to the early influence of Professors Janine and the late Thomas Langan, who guided my undergraduate work in Christianity and Culture/Philosophy. I thank the late Joan Whelan GSIC and the Reverend Bob Sinclair, who first introduced me to clinical health care ministry, and Jim Hannah and Jan Kraus, for their passionate CPE supervision.
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I owe a deep debt to my family. I thank my brothers Angelo and David for their genuine and at times amusing curiosity about what I had been thinking about all these years. I recognize my brother Reno’s example of being the first in our extended Maltese immigrant family to study for the PhD. The fact that all my brothers pursued higher education owes much to my parents’ determination their children might have what was denied them. My father, Francis, a skilled
electrician, left Malta for Canada in 1952 at the age of 22 with the dream of a better future. My mother, Rena, followed in 1961. My father saw only the beginning stages of this dissertation, having died in 2007. I remember fondly how, even in the midst of advanced Parkinson’s, he read my early course work papers. Both of my parents have shown me that with disciplined human effort, God’s grace, and time, something new and beautiful is possible.

Finally, this dissertation would have been impossible without my wife, Susannah Johnson. She has been with me every step of the way. My need for quiet study has taken me away from her for longer periods than I would have preferred. I especially thank her for reminding me when the inevitable doubts surfaced during the long loneliness of doctoral work, why I started out on this re-creative writing pilgrimage in the first place: A dissertation must reflect one’s deepest passion. What follows is certainly mine.
Statement Regarding the Use of Inclusive/Unbiased Language

All of the original writing contained in this dissertation reflects the policy of The Toronto School of Theology and The University of Toronto regarding inclusive and unbiased language. Nevertheless, most of the primary sources for this literary research were written before inclusive language became the academic norm for scholarship. In order to respect the integrity of works as cited, I have chosen to reproduce the original texts as they were written, refraining from the use of “[sic]”. Of course, in my critical reflections on them I follow the contemporary norm.

An additional complicating factor in terms of language is the fact that Henri J.M. Nouwen’s archived manuscript material (which forms the core of chapter 2) was written primarily in English by a Dutch-born man. These unedited manuscripts are, in places, replete with errors in grammar and spelling, as well as the crossing out of texts with inserted rewrites. Except for obvious grammatical or spelling corrections, I have cited Nouwen as he appears in the original texts. As will be argued in that chapter, this record of Nouwen’s struggle to find the best English word is often helpful for better understanding his contribution to scholarship.

Finally, it needs to be acknowledged that attention to unbiased language reflects a core feature of this dissertation: it intentionally reframes Anton T. Boisen’s critical writings about mental illness and religious experience, uncovering how historical trends marginalised his reported experience of living with mental health problems. Boisen, for his part, was well aware of the historical bias, writing in his 1960s autobiography, “as long as I remain a patient, I am by that very fact discredited.”* This dissertation proposes that Boisen’s critical texts—and his original voice—require a contemporary and unbiased hearing.

As chaplain in an institution for the insane, the writer is dealing constantly with the mentally ill. He is seeking to interpret the experiences of his patients not merely from the standpoint of current psychiatry but also from the standpoint of the student of religion.

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INTRODUCTION

Anton T. Boisen’s (1876-1965) insight, first published in 1930, that hospitalised mental health patients could be understood as “living human documents”1 capable of revealing a clinically and theologically relevant experience of God led to the creation of the new2 discipline of the mental health chaplain. For Boisen, integrating a person’s experiences of God into clinical psychiatric work was a challenge both to the pastoral care practice of the Churches and to the clinical psychiatric establishment of his day. In “The Challenge to our Seminaries,” Boisen outlined his fundamental two-fold critique: the Protestant Churches were taking “no interest in the case of pronounced mental disorder” and certain medical approaches presumed pathology when mental health patients presented religious experiences.3

The insight was also profoundly personal. Boisen was a mental health patient and a Presbyterian clergy person turned clinician who believed, in the midst of one psychotic break in 1920, that he had “broken an opening in the wall which separated religion and medicine.”4

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fact, as pastoral care historian Charles Hall has pointed out, Boisen had the audacity to claim that his achievements were precisely because of the illness, not in spite of it. In fact, much of his original thinking comes from his tireless empirical study to test the insights formed during the periods of acute conflict.⁵

In 1925 he did just that, inviting theology students to spend a clinical summer inside the psychiatric Worcester State Hospital in Massachusetts.⁶ Thus began his teaching of a revolutionary method⁷ of clinical theology which moved theology students away from “books to the raw material of life.”⁸ Chiefly because of Boisen, the mental health chaplain became a multidisciplinary health care team member⁹ whose primary task it was to attend to the experience of God as presented by the “living human documents” admitted to the psychiatric clinic.

Since these origins, debate about clinical chaplaincy’s identity and role has focused on expanding, renegotiating, and even pushing beyond Boisen’s ideas of psychiatric chaplaincy.¹⁰ The plethora of images of pastoral care post-Boisen’s “living human documents” has made the pastoral theologian and historian Robert C. Dykstra wonder if this “relentless pastoral scrutiny [is not] in part an unfortunate legacy of our inauspicious origins in that Boston Psychiatric Hospital so many decades ago?”¹¹ Indeed, Dykstra’s question about origins is very important.¹² Contemporary chaplaincy started in a psychiatric hospital at the juncture of psychology and

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⁶Boisen, Out of the Depths, 153.
¹¹Dykstra, 3.
¹²Chapter One will develop this early history by focusing on clinical chaplaincy’s origins in Boisen.
religion, the locus James Dittes called the “arena for the beginning and foundation of theological study,” where one comes “to focus on the awesome moment of a person meeting God—or struggling to meet God.”

A work in pastoral theology, this thesis proposes that chaplaincy’s “inauspicious” origins—to use Dysktra’s terms—should not be forgotten. Boisen’s innovative notion of the psychiatric clinical chaplain as a member of the interdisciplinary team is unintelligible without his fundamental experience of God in the psychiatric clinic. Moreover, this thesis will argue that a return to chaplaincy’s origins in Boisen and his mental health context is critical to the future of chaplaincy as a professional health care discipline.

**Current Issues in Contemporary Clinical Chaplaincy**

Today clinical chaplaincy is in an acute critical crisis and has an increasingly isolated and diminished place as a hospital funded service in contemporary North American health care delivery. The American Association of Professional Chaplains handles on average one consultation per month from health care institutions planning for the “downsizing or elimination of funded spiritual care programs or chaplain positions.” In Canada, clinical chaplaincy is also in numerical decline. A recent example is the elimination of twelve of fourteen chaplains by British Columbia’s Fraser Health System in order to cut costs. The Chief Executive Officer justified the decision with the proviso that this “non-core” service will now be provided by

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14 This thesis will routinely use the term “pastoral theology” for this discipline which is sometimes also called “practical theology,” except in citations by other authors who prefer the latter. For an excellent consideration on how these terms reflect “historical and normative values” see Elaine L. Graham, *Transforming Practice: Pastoral Theology in an Age of Uncertainty* (Eugene, OR: Wipf and Stock, 2002), 11, FN 1. See also Robert P. Imbelli and Thomas H. Groome, "Signposts Towards a Pastoral Theology," *Theological Studies* 53, no. 1 (1992): 127-137.

15 L. VandeCreek, "Defining and Advocating for Spiritual Care in the Hospital," *Journal of Pastoral Care and Counselling* 64, no. 2 (2010): 1.

16 The Canadian Association of Spiritual Care/Association canadienne de soins spirituels does not officially track these statistics as does its American counterpart, but it did strike an “advocacy committee” in 2010 to address the increasing number of cuts in the Canadian health care system, according to its Advocacy Committee chair. Doug Longstaffe, telephone interview by author, December 3, 2010.
“social workers and volunteers from faith communities.” From such evidence, it appears that contemporary clinical chaplaincy is no longer an essential and fundable part of contemporary multi-disciplinary clinical care.

Larry VandeCreek, one of North America’s leading advocates on the “role and importance in health care” of “professional chaplaincy,” has recently concluded that “funded spiritual care programs are not essential to hospitals in the same way as scientifically based health care professionals.” Some ten years ago, VandeCreeck analyzed the growing corpus of health care literature about spirituality and concluded that chaplaincy was an “absent” profession, not only in terms of the authorship of this literature but most importantly in terms of chaplains not being referred to in the discourse. He considered this a kind of

negative fall-out from the historic religion-science conflicts, the perception that both religion and clergy are irrelevant, and the belief that interdisciplinary professionals themselves can improve their patient services by giving attention to spirituality without the involvement of chaplains.

His work was prophetic, anticipating some of the arguments being advanced today in support of the elimination of chaplaincy as a “non-core” service. The critical contemporary idea is that clinical spirituality is not essentially related to chaplaincy but is within the scope of practice of other disciplines.

VandeCreek’s most recent emphasis on addressing the scientific deficit inherent to chaplaincy is conceptually very important. It points to both a definitional problem inherent in much of the advocacy work done by chaplains and the dominance of the scientific paradigm in the way in which health care services are structured.

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19 VandeCreek, "Defining and Advocating for Spiritual Care in the Hospital," 1.
Chaplains attempt to create a definition and enhance advocacy when they characterize spiritual care as meeting spiritual needs, providing presence, engaging in active listening, or similar descriptions. To many chaplains and decision makers, such definitions are amorphous, lacking sufficient substance to merit hospital funding.\textsuperscript{21}

VandeCreek turns to scientific literature in order to re-define chaplaincy, endeavouring to change the way people in decision making roles might think about its clinical funding. He focuses in particular on the work of psychologist Kenneth Pargament who, along with Peter C. Hill, B.J. Zinnbauer and other psychologists, is a pioneer in the scientific community when it comes to considering spirituality. A central idea for Pargament is that the spiritual is to be “understood and addressed as a legitimate dimension of human experience in itself,”\textsuperscript{22} not reducible to health care’s already accepted biological, psychological, or social dimensions. So, where the typical bio-psycho-social perspective is found in most health care clinics, he argues for a bio-psycho-socio-spiritual perspective.

The basic definition of spirituality that VandeCreek seeks to borrow from Pargament is that spirituality is a “search for the sacred.” By this word sacred, Pargament means to suggest that which “is qualitatively different from everyday life because it is regarded as holy.”\textsuperscript{23} For Pargament, the holy is a broad category including but not limited to the religious. “At the heart of the sacred lies God, divine beings, or a transcendent reality”\textsuperscript{24} but “sacred matters extend beyond these fundamental spiritual constructs to encompass other parts of life (i.e. objects) that are associated with or represent the sacred core.”\textsuperscript{25} These can include other aspects of life, such as meaning, children, nature, time, marriage, soul and place.

\textsuperscript{21} VandeCreek, "Defining and Advocating for Spiritual Care in the Hospital," 1.


\textsuperscript{24} Pargament, \textit{Spiritually Integrated Psychotherapy}, 33.

\textsuperscript{25} Ibid., 34.
What is particularly rich conceptually in Pargament’s model is that it reveals that people ascribe sacredness, a process he calls “sanctification,” in a variety of ways. For Pargament, this is a strictly non-theological issue: “first it focuses on perceptions of what is sacred and second, the methods of studying sacred matters are social scientific rather than theological in nature [emphasis added].” In this model, the matter of attribution of sacredness by human persons may be identified as theistic or non-theistic, but the focus is on the attribution considered primarily in psychological and social scientific terms.

Pargament’s psychological and social scientific approach to spirituality substantially informs VandeCreek’s conclusions about how best to define spirituality and spiritual care in health care.

The spiritual dimension is part of the existential map of each individual. Everyone searches for and establishes sacredness in their life although they may not use that word to describe it. This means that spiritual care is relevant to all patients, not just those who engage in theistic sanctification by professing a religious faith.

[Spiritual Care] ... consists of giving professional attention to the subjective spiritual and religious worlds of patients, worlds comprised of perceptions, assumptions, feelings and beliefs concerning the relationship of the sacred to their illness, hospitalization, and recovery or possible death. It gives attention to the role of the sacred in the worldviews of patients.

Pargament’s influence is readily obvious in VandeCreek’s definitions. Sacredness is claimed as a central part of the spiritual life. It has to do with a dimension which is part of the “existential map” for everyone. Some will attend to it religiously, others not, but everyone searches for it and attributes it somewhere. It has an effect on their health care which calls for “professional” attention to help “patients link their concerns to what they perceive as sacred and its positive or negative influences.”


29 VandeCreek, "Defining and Advocating for Spiritual Care in the Hospital," 3,4 [underlining in original].

30 Ibid., 4.
Having established the concern for the ways in which an existential spiritual search can be demonstrated scientifically and the effect it has in the lives of health care patients, VandeCreek then suggests that the health care professional who should primarily do this is the chaplain. After a review of the literature concerning physicians, nurses, and even parish clergy, he concludes that having any of these do professional spiritual care is “problematic. Certified health care chaplains possess a theological education, faith group endorsement, and specialty training.”

It is the logic of this argumentation that needs critical attention. While it is important to recognise that Pargament’s approach is one of the friendliest to a religious discourse about the sacred, the question remains: does expertise in religious and theological discourse automatically make the chaplain the expert in all things scientifically spiritual? VandeCreek attributes an expansive scope of practice to the chaplain, and this may explain, in the final analysis of his own article, why VandeCreek asks, “What additional definitions are possible? Should the definition be based more clearly in the theological/pastoral care tradition of Church and synagogue rather than the psychology of religion?” This is very important for it queries the basic “theoretical system” or framework that informs chaplaincy practice. VandeCreek’s effort to define the chaplain scientifically leaves some important gaps. The primary problem is to understand why a theological education in pastoral care from the Church or synagogue—and one could easily add the temple, mosque etc.—justifies the chaplain moving into the non-theistic but sacred (according to Pargament’s broad scientific approach) dimension. One could argue that other professionals, psychologists, social workers or nurses, for example, could expand their practice to consider non-theistic spirituality if he/she were trained in it and allotted clinical time for it. The acquisition of skills in spirituality is certainly what Pargament recommends in his

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31 Ibid., 7.
33 VandeCreek, “Defining and Advocating for Spiritual Care in the Hospital,” 10.
seminal text *Spiritually Integrated Psychotherapy*, as have others. Social workers, nurses, and occupational therapists already claim or are reclaiming spirituality within their scope of practice.

My intention here is simply to draw attention to the change in emphasis concerning the religious dimension for chaplaincy. VandeCreek does not seize on the expertise of the chaplain in theistic and religious spirituality, a scope of practice which is arguably large on its own. When chaplaincy’s most vocal advocate embraces Pargament’s broadly scientific, psychological and explicitly non-theological approach to spirituality, he is taking the opportunity to justify an expansion in the scope of practice of the chaplain into all things spiritual. However, “religious is not a synonym for spiritual but rather describes a sizable subset within the category of spiritual.” Historically, the clinical chaplain’s expertise was in this subset. Rooted primarily in the realms of religion and theology in the experience of illness, the chaplain’s primary responsibility was the care of souls, conceptually conceived of in terms of the person’s

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relationship with their God as experienced in their day to day problems and experiences. It is true that Boisen deepened this concern by explicitly expanding the chaplain’s practice in the scientific milieu of his day, but his intention was not to abandon his pastoral focus. In fact, the reason that Boisen’s creation of the clinical chaplain was so innovative and even remains controversial is that it admitted and attended to a religious and God dimension in the clinical care of the patient. It is one thing to align with Pargament that the theistic and non-theistic can make up the sacred, but it is quite another to co-opt the entire area as the expertise of chaplains.

It is important to ask why VandeCreek would not seize on religious or theistic expertise as the particular scope of practice for the chaplain. In part, the answer relates to the controversies that arise when a chaplain, whose role is defined in primarily religious terms, serves as a core constituent of the health care team. Rebecca Springer Loewy and Erich Loewy, health care analysts and ethicists, argue that chaplains should never have been considered health professionals in the first place. In addition to voicing their own grave concerns about the expansion of chaplaincy into a more than religious scope of practice, they argue that primary health care is strictly biomedical and each and every health care professional must engage the patient from a strictly scientific foundation. There is a role for chaplains in health care but Loewy and Loewy are deeply concerned about the demands on the part of some chaplains and chaplaincy associations to be treated as full-fledged members of every patient's healthcare team and/or to have complete access to patients' medical records whether to gather patient information or to make notations of their own.

They argue that there is no bio-medical basis for what religious chaplains do.

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42 This history and its implications will be developed in Chapter One.


44 Ibid.
Anthropologist Frances Norwood is critical of such a selectively dichotomous approach to the place of chaplaincy in medicine. She suggests that the relationship between science and religion is more porous and less defined. While Norwood affirms that it is true that the experience of most chaplains in the “modern-day hospital medicine is largely one of marginalization,” she posits that the experience adds value to the medical enterprise. It is precisely the chaplain’s religious context, she argues, that offers something valuable to those issues of health such as the meaning of loss, pain and suffering that often fall outside of a strict and narrow bio-medical paradigm:

Chaplains are alive and well, if at the margins of medicine. By balancing paradigms of medicine and religion, the modern-day chaplain has been able to forge a strategic, ambivalent existence. Alternately embracing and distancing themselves from the language of medicine and the language of religion, skilled chaplains demonstrate the power in even marginalized practices.

Norwood’s assessment of the value of chaplaincy is strongly rooted in the “difference” its religious and theological orientation make in medicine, even if it is occasionally and strategically downplayed by chaplains themselves.

It appears, however, that some chaplains may not be as convinced as Norwood of the importance of navigating the tension that comes from bridging these two paradigms. Just as there is historical evidence that the clinical pastoral movement struggled with how to integrate the new psycho-social methodologies into their theological clinical pastoral practice, there is evidence

46 Ibid., 4.
48 Ibid., 21.
49 This analysis is reminiscent of earlier historical considerations of the 70s and 80s on the awkwardness of chaplains in professional and scientific clinical settings. See for example the work of Heije Faber which used the “clown” metaphor to express this tension. Heije Faber, Pastoral Care in the Modern Hospital (London: S.C.M. Press, 1971). Heije Faber, "Second Thoughts on the Minister as a Clown," Pastoral Psychology 28, no. 2 (1979): 132-137. See also: Lawrence E. Holst, "The Hospital Chaplain: Between Worlds," in Hospital Ministry: The Role of the Chaplain Today (New York: Crossroad, 1985), 12-27.
50 Holifield; Myers-Shirk.
that contemporary chaplaincy training and its practice has been avoiding theological references. Canadian clinical pastoral supervisor Peter VanKatwyk’s recent article, “God Talk in Therapeutic Conversation” betrays this contextual assessment, concluding that “in clinical [pastoral] education the emphasis has been on self-talk and relationship-talk rather than God-talk.”\textsuperscript{51} While VanKatwyk argues for a return to the language of theological concern as something “in line with the tradition of the care of souls” this movement away from a traditional theological grounding may not be accidental. Anthropologist Simon J. Craddock Lee suggests this in his 2003 article, “In a Secular Spirit: Strategies of Clinical Pastoral Education.” There he argues chaplaincy is intentionally transforming itself away from a “religiously-based theological practice” towards a “secularized spiritual care service.” Even the nomenclature is important here: “‘Spiritual’ is a label strategically deployed to extend the realm of relevance to any patient’s ‘belief system’, regardless of his or her religious affiliation (or lack thereof).”\textsuperscript{52}

Changes in nomenclature have recently emerged in what was called the Canadian Association of Pastoral Practice and Education/\textit{Association canadienne pour la pratique et l'éducation}, the national organization responsible for professional education/certification and institutional site certification for supervised training in what has historically been described as pastoral care and pastoral counselling. At its 2010 Annual Meeting, the association adopted a motion to change its name to the Canadian Association for Spiritual Care/\textit{Association canadienne de soins spirituels} or CASC/ACSS.\textsuperscript{53} Brian Walton, the 2010-11 president of the association, suggested in the June 2010 communiqué that members expressed their appreciation for the philosophical shift from a “ministry” that was described as “pastoral”, to a “clinical discipline” with its emphasis on “spiritual care.”\textsuperscript{54}

\textsuperscript{51} VanKatwyk: 69.


\textsuperscript{53} CASC, "Canadian Association of Spiritual Care " \url{http://www.cappe.org/} [accessed February 18, 2011].

Of significance here is the explicit articulation of a philosophical shift. “Ministry” and “pastoral” give way to new terms, the “clinical” and “spiritual.” Putting aside for a moment the historical inaccuracy implicit in this conceptualisation—it must be remembered that Boisen’s innovation was to make the pastoral clinical, and after all the movement was called clinical pastoral education\(^55\)—the president’s observation captures an important change in the way this Canadian chaplaincy organization is conceiving of itself.

It is possible this shift has to do with helping chaplaincy fit\(^56\) into contemporary healthcare’s increasingly scientific and secular conceptualisations of clinical spirituality. Walton explains this philosophical shift by stressing continuity with the organization’s predominantly religious past but makes clear that “a new era” exists and that new expertise will be in attending to the “existential and spiritual concerns.” He suggests that the members of the new organization continue to value the legacy of faith communities with their attention to providing care and counsel to those in need, irrespective of creed. Many of us are still influenced by the formation we received within those communities and continue valuable connections with our denominational roots. A new era calls us forward however: to discern how best to meet the spiritual and religious needs of the culturally and ideologically diverse population of Canada of the 21st century. We are proud to name our important place in the counselling milieu and within clinical healthcare teams as persons with expertise in attending to the *existential and spiritual concerns* that arise in times of crisis. *Standing on the shoulders* of our faith communities we look forward to discerning ever new ways to respond to the spiritual needs of the future.\(^57\)

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\(^55\) This clinical innovation of Boisen in the creation of the chaplain as part of the multi-disciplinary team will be addressed in detail in Chapter One. See also the work of Frank Lake whose whole enterprise concerned clinical theology. Frank Lake, *Clinical Theology: A Theological and Psychological Basis to Clinical Pastoral Care* (London: Darton, Longman & Todd, 1966). The work of physician and founder of social work Richard Clarke Cabot, which was of considerable influence on Boisen, is also relevant here. As historian John Hall states, “His [Cabot’s] emphasis was on the application of theology in clinical situations.” Charles E. Hall, *Head and Heart: The Story of the Clinical Pastoral Education Movement* (Decatur, Ga.: Journal of Pastoral Care Publications, 1992), 8.

\(^56\) The idea that clinical disciplines change to fit into a culture or environment is not unique to chaplaincy. Jerome Bruner, commenting on the influence of the cognitive revolution on his own discipline of psychology, wrote “And it has always been a rather intellectual reflux of academic psychology to redefine man and his mind in light of new social requirements.” Jerome S. Bruner, *Acts of Meaning*, Jerusalem-Harvard Lectures (Cambridge, Mass.: Harvard University Press, 1990), 6.

\(^57\) Walton.; [emphasis added].
This posture of “standing on the shoulders” of the faith communities is an excellent metaphor in so far as it signals a change in the “new ways” the organization considers the historical faith community foundations of chaplaincy.

In 2008, Dutch Professor of Psychology of Religion Hetty Zock, who specialises in the domain of spiritual care, concluded that chaplaincy in Holland had essentially entirely divorced itself from religion. Chaplaincy there, she argues, has become a kind of existential counselling that focuses on “the search for meaning and life orientation of the clients/patients/residents, irrespective of their religion [emphasis added] or philosophy of life.”58 She argues that on account of the secularisation and the individualisation of religion, chaplaincy has divorced itself from its theological and ecclesial roots, rendering for itself a “split professional identity.” As a result it has become difficult to separate the identity of the chaplain from her peers in social work and psychotherapy.59 Communicating these ideas in the North American Journal of Pastoral Care and Counselling, she wondered if the same trend is true in the United States. She concludes her article with a call for a “new theoretical underpinning” and “a new conceptualisation of the profession” of chaplaincy.60

When clinical spirituality is effectively limited to a kind of immanent, scientific or as Arthur Frank calls it “medicalised spirituality,”61 it is hardly surprising that “the very structure of current intellectual discourse ... is re-enforcing adherence to secular definitions of reality.”62 This


59 More than thirty five years earlier, Pruyser also shared this concern about a discipline like chaplaincy becoming indistinguishable. Specifically in terms of adopting group dynamics over and above religious goals, he notes “the pastor becomes indistinguishable from any other trained group expert...” Paul W. Pruyser, "The Use and Neglect of Pastoral Resources," Pastoral Psychology 23, no. 7 (1972): 9.

60 Zock: 137.


can be understood as a kind of “discourse change” where religion is no longer referenced as a meaningful way to describe or reflect reality. Charles Taylor’s recent work, *A Secular Age*, demonstrates that the “mainstream master narratives of secularization” argue that “religious transcendent views are erroneous, or at least have no plausible grounds.” A consequence of this is that religious discourse becomes of no or marginal importance in public life and health care. As this thesis will indicate, the current crisis concerning the role of the chaplain in a medical setting relates directly to this shift in discourse. For example, Ursula Franklin suggests that “today scientific constructs have become the model of describing reality rather than one of the ways of describing life around us.”

Louis Dupré suggests that because we are living in “an age that has lost the very idea of God,” contemporary society is essentially divorced from the fundamental religious view of reality which sources all meaning in God. Secular humanism, he points out, does not bother to start with “the denial of God, but with the affirmation of the human, the sole source of meaning.” Such a frame of reference is necessarily immanent and the scope of concern is what is human. Taylor puts it this way: “The ‘lower’ order – the immanent or secular- is all there is, and that the higher, or transcendent, is merely a human invention.” From this perspective, the very idea of theological transcendence and any interaction with it is meaningless. The late Pope John Paul II challenged this approach while speaking with members of the American Psychiatric Association and The World Psychiatric Association in 1993. The Catholic Church is

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65 Ibid., 768.


68 Ibid., 133.

convinced that no adequate assessment of the nature of the human person or
the requirements for human fulfilment and psycho-social well-being can be
made without respect for man’s spiritual dimension and capacity for self-
transcendence.\textsuperscript{70}

The Church’s assessment being that the human person is “made in the image of God and called
to a transcendent destiny.”\textsuperscript{71}

The trend of a scientifically secular and medical paradigm for an immanent spirituality is
well represented in a recent study by a social worker and psychiatrist. Social work was the
“core” health care discipline proposed in this thesis’ original example\textsuperscript{72} about other disciplines
providing spiritual care in place of chaplains.

We note that much of the research in social work and spirituality conceptualizes
spirituality and spiritually-sensitive practices as distinct from religion and
religiously-based practices such as prayer or attending Church.\textsuperscript{73}

Chaplain Carlton Brown suggests this conceptualisation represents a preference for the “new” in
health care. In his article “Old Religion, New Spirituality, and Health Care” he writes,

Health care is enjoying a spiritual revival, not a religious one, and its growth is
being championed by a multi-disciplinary team of health care professionals,
which excludes chaplains and pastoral counsellors.\textsuperscript{74}

\textsuperscript{70} Pope John Paul II, “Address of His Holiness John Paul II to the Members of the American Psychiatric
http://www.vatican.va/holy_father/john_paul_ii/speeches/1993/january/documents/hf_jp-
i_i_spe_19930104_psychiatric-association_en.html [accessed November 11,2009].

\textsuperscript{71} Ibid.

\textsuperscript{72} Tremonti.

\textsuperscript{73} Jan-Stella Methany and Diana Coholic, "Exploring Spirituality in Mental Health:Social Worker and
http://www.uwindsor.ca/criticalessocialwork/exploring-spirituality-in-mental-health-social-worker-and-psychiatrist-
viewpoints [accessed November 18, 2010]. "Exploring Spirituality in Mental Health:Social Worker and Psychiatrist

\textsuperscript{74} Carlton Brown, "Old Religion, New Spirituality, and Health Care," in \textit{Spirituality and Health: Multidisciplinary Explorations}, ed. Augustine; O'Connor Meier, Thomas St. James; VanKatwyk, Peter L.
(Waterloo: Wilfrid Laurier University Press, 2005), 191. This theme appears in more popular books on
of spirituality has three components: connection, compassion, and contribution or service. It is “a book about
This non-theistic focus is taken to its logical conclusion in the work of Daniel A Helminiak, who argues “some kind of treatment of spirituality apart from theology is possible, and, for human science, it is desirable.”

My conclusion here is three fold: first, contemporary inpatient models for clinical health care privilege a scientifically secular and medical approach to reality. Second, there is an important development in many allied health care disciplines claiming or re-claiming that their scope of practice can address spiritual care issues without chaplains being integrated members on the clinical team. Third, many clinical chaplains are distancing themselves from their theological, religious and ecclesial roots, often embracing more existential, entirely immanent and otherwise non theistic approaches to practice.

It is difficult to know with certainty the intentions behind such a trend of chaplains moving towards this scientifically secular and medical approach. VandeCreek appeals to a scientific paradigm to justify a fundable chaplaincy, Zock describes chaplaincy’s move away from theological and ecclesial roots as a consequence of secularisation, and CASC/ACSS claims it is “discerning ever new ways to respond to the spiritual needs of the future.” Whatever the intentions, a scientifically secular and medicalized chaplain is somewhat paradoxical and counterintuitive to the roots as well as patient expectations of chaplaincy. In a study in 2008, “Patients’ Expectation of Hospital Chaplains,” the Mayo Clinic reported:

The primary reason for wanting to see a chaplain selected by respondents was “to be reminded of God’s care and presence”... Of respondents, 83.8% responded this was “very important” (62.5%) or “somewhat important” (21.3%) to them... Prayer or the reading of religious texts was a “very important” (42.3%) or “somewhat important” (27.5%) reason to see a chaplain.

spirituality and therapy, not religion and therapy,” ibid., 6. The focus on spirituality is meant to be inclusive, avoiding religion’s “doctrinaire difficulties.” Ibid., 7.


Walton.

While these patients appear to suggest that chaplains are *par excellence* reminders of God and purveyors of religious resources in the clinical milieu—and that this is the key benefit or expectation in having them on the team—the current paradigm does not.

That chaplaincy is moving away from its original scope of practice as distinctly representative of God and the religious world view in clinic is not only a matter of changing professional identity in the new paradigm. It appears to be synchronous with the demise of religious commitment to the health care enterprise. Anthropologist Norwood is not the only person who has called attention to the difference the religious world view can make to medicine. In the realm of ethics, Edmund Pellegrino and David Thomasma affirm that while a predominantly secular and successful approach characterizes mainstream contemporary health care ethics, “it neglects one of the most pervasive and significant sources of morality – namely religious commitment.” They caution that “if religious influence is denied, insights about the deeper meanings of illness and healing in a community of healers may also be missed.”

Pope Benedict XVI has framed this ethics’ problematic in the following way. “Scientific discoveries in this field and the possibilities of technological intervention seem so advanced as to force a choice between two types of reasoning: reason open to transcendence or reason closed within immanence.”

This introduction has argued that contemporary chaplaincy appears to be adapting itself to an immanently existential approach. This thesis however will suggest that contemporary chaplaincy needs to re-appropriate and retrieve a distinctly religious meaning and practice; that is to say, one which understands, integrates and advocates for theological transcendence, God, as meaningful in the clinical milieu.

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Purpose and Methodology of this Dissertation

Proposing a new conceptualisation of clinical chaplaincy is therefore the purpose of this thesis. It will creatively engage contemporary clinical practice while not abandoning theology and religion. By exploring and then adapting the particularity\(^{80}\) of clinical chaplaincy’s origins—that is by re-analysing with specific attention both the mental health context and the explicitly pastoral and theological intentions of the life and work of Anton T. Boisen (1876-1965)—a new approach to clinical practice will emerge.

The primary methodology for this thesis is literary research. The development of this thesis will involve a critical analysis of Boisen’s life and work\(^{81}\) in dialogue with the work of other scholars who have made significant contributions to understanding and reclaiming Boisen’s innovation of clinical psychiatric chaplaincy, to exploring the intentional place of theology and religion in Boisen’s clinical pastoral practice and his experience of alienation, and to advocating for a “friendship” model for the Church’s role in clinical mental health practice: clinical psychologist Paul Pruyser (1916-1987), pastoral theologian Henri Nouwen (1932-1996), and practical theologian John Swinton (b. 1957). This explorative and adaptive analysis of Boisen and his ideas will then be brought into dialogue with insights from Canadian philosopher Charles Taylor (b. 1931) and cultural anthropologist Barbara Myerhoff (1935-1985). This will yield a new conceptualisation of clinical chaplaincy that can explicitly make space for theological transcendence in the contemporary clinical care process. In what I will call a “re-membering” model of ministry, the primary task of the clinical chaplain will be to create clinical space such that it is possible to credibly “add” God as a potential “member” or partner for the patient in the clinical process.


The contextual starting point, therefore, is the crisis in clinical chaplaincy. However, this effort to re-conceptualise the meaning of contemporary chaplaincy lies more broadly in what Cambridge Divinity Professor David Ford has called the “interrogative mood” of all intellectual disciplines, including theology. As he puts it, the “deepest questions are rarely satisfactorily answered, but there is impoverishment if they are not continually being pursued.”[82] Personally, asking what a chaplain is in the clinical milieu is rooted in my own ethnography[83] and clinical experience.

An Auto-Ethnographic and Clinically Inspired Inquiry

In my ten years as a chaplain, I have worked in acute care centres for adults, children, and neonates. I also piloted a community chaplaincy program for a home care organization, and worked in mental health care, both as a front line chaplain and a manager of spiritual and religious care. This mental health work included work in a maximum secure forensic hospital. My own successes and failures in this discipline, my own effort at critical reflection on my practice as well as my study of the existing literature will therefore inform this thesis. But most importantly, it has been my personal and my staff’s encounters with real people admitted to the hospital with persistent and severe mental health issues which have generated this thesis’ question about the critical meaning of contemporary clinical chaplaincy. Two examples follow here in order to illustrate this point.

Fifty five years old, Roman Catholic, male, diagnosed with schizo-affective disorder, single with no dependents, “John’s”[84] only surviving relationship outside the hospital is his ailing mother whom he visits annually. John has been hospitalised for 27 years at a maximum secure forensic hospital for an index offence of murder for which he was not responsible for

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[83] For more on how ethnography is relevant to research, and the importance of researchers sharing their personal starting points, see Carolyn Ellis, *The Ethnographic I: A Methodological Novel About Autoethnography* (Walnut Creek, CA: AltaMira Press, 2004), 48.

[84] This patient’s name and all identifying details have been changed.
reasons of insanity. The ongoing high risk nature of his severe, persistent and paranoid ideations as well as his social phobias currently indicate that long term care in a maximum secure hospital is necessary. In addition to pharmacological treatment, his care plan includes the development and maintenance of therapeutic relationships. One objective of these relationships is to monitor his perceptions and ideations of others. This is to mitigate risks to his safety and that of others.

John is referred to me by the clinical team on account of his “religious ideations.” Quite simply, the team is not sure how to understand what appear to be an almost “monastic” presentation of this patient: he isolates himself in his room to pray, claims he has a relationship with God, structures his day with religious readings, and in the past has spoken about religious ideas that appeared strange to the staff. He even has a long beard.

When I meet with John, I ask if we can speak about his spiritual and religious life here in hospital. He immediately asks why I am interested. I tell him that as a clinically trained chaplain, I consider his relationship with God to be a potentially important part of his life, not only for coping with his mental illness but most importantly as something that might be affected by his illness. Then I ask him if this answers his question. His response: “In my experience, talking about this, about God, only leads to one thing: more medication.” This response from my experience is echoed by many psychiatric patients.

At the time, this case made me wonder why this patient’s experience of discussing God was apparently always being interpreted pathologically. My own assessment revealed that some but not all of his religious experiences were pathological; certain ones were very helpful for his coping, and more often than not, they brought him comfort. In fact, in terms of risk issues, the same social problems and paranoid ideations he sometimes experienced with others, whether patients or staff, also sometimes showed up some of the times he described his relationship with God. Clinically, therefore, this patient’s beliefs about and experiences of God were both sometimes normal and sometimes problematic. Chart audits revealed that none of my chaplaincy predecessors were ever consulted or ever charted on this patient’s beliefs and the role they played in his life.
Jesuit psychiatrist and psychoanalyst William Meissner (1931-2010) had experienced this clinical pattern. His cleverly titled article, “The Pathology of Beliefs and the Beliefs of Pathology,” was very helpful to me in assisting other clinicians to break free of the residual grasp of Freud’s still powerful ideas about the nature of religious beliefs. Meissner’s work differentiates that simply because some patient beliefs may be pathological does not mean that all religious beliefs are pathological. His research confirmed my experience in this case, and in many others. Too often in the mental health care context, there is little or no space for the possibility of healthy religious beliefs, especially given the presence of high levels of religious pathology.

A second example has to do with the role of chaplains in attending to the isolation of mental health patients. This issue presented itself to me just as chaplaincy programs were being cut across Canada and I was trying to grow the clinical Spiritual Care program I was recently hired to manage. I procured temporary funding to hire a chaplain for a pilot project in the maximum secure site, having determined that this population rarely saw a chaplain. The goal was to build evidence for the “added value” a chaplain would bring to the clinical process and then secure core funding. I directed my then new staff person, Patricia Mannion, to begin with a spiritual and religious care needs’ assessment of as many of the forensic patients she could survey. The results indicated this central finding: the patients expressed profound isolation. “We long to belong,” they said and they thought chaplaincy could assist with this. At first, this sociological finding was interesting but somewhat clinically embarrassing. Surely clinical chaplaincy is, I thought, more than attending to the social isolation of people living with


87 These findings were presented at a national conference for Chaplains. Christopher De Bono and others, "The Honeymoon's Over: Spiritual Care Needs to Procreate or Die." CAPPE Conference (Niagara Falls: February 2007).
persistent and severe mental health issues? Isn’t this more relevant to recreation services, social work, volunteers even?

The literature certainly demonstrates that isolation is a serious concern for this population. The 2006 Standing Senate Committee on Social Affairs, Science and Technology’s Final Report on Mental Health, Mental Illness and Addiction, Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada, described isolation as an almost certain outcome for those diagnosed with mental illness.

For many years, researchers characterized mental illness as generating an inevitable downward spiral—both in function and in social status. The prognosis was bleak: permanent disability, isolation and poverty.88

Psychiatrist John Strauss drew attention almost twenty years ago to the fact that some isolation may be caused by the radical depersonalisation many feel under psychiatric care. He called for making the person “key to understanding mental illness.”89 According to the more recent work of psychiatrist Rachel Freeth, contemporary mental health practice is often “oppressive and dehumanised.”90 Louise Bradley R.N., President and CEO of Canada’s Mental Health Commission, writing about the devastating effects of stigma confirms this as well. Convinced that discrimination against the mentally ill is often found on the “very front lines of health care,” she has made education for health care professionals this commission’s first priority.91

Perhaps the most important issue this program assessment brought up for me as a clinical director was to think about the intentionality of my chaplaincy team’s practices. In order to distinguish our work from that of social workers and others, I engaged this chaplain and the rest of my team to better determine what was unique in how clinical chaplains might conceptualise

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88 The Honourable Michael J. L. Kirby, Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, Final Report of the Standing Senate Committee on Social Affairs, Science and Technology, 2006, Sec. 10.2.3, 230.


and practically respond to this isolation. For example, were we asking how existing religious gatherings addressed isolation? Or were we asking whether we needed to find a new way to do this?

Our discussion generated two theologically and religiously important ways to conceptualise this data. When patients say they “long to belong,” could God be one of those primary relationships to which they long to belong? That is to say, was God even identifiable as potentially “belonging” to the patient’s relationships? A recent study by Baetz, Griffen, Bowen and Marcoux included research about the prevalence of belief in God among a cohort of hospitalised and online mental health patients. It determined that 71% believed in God, a number reflective (when the nature of this study’s questions are taken into account) of the Canadian average of 81%. Secondly, my clinical team wondered if it was possible that the patients’ voices captured in this study reflected God’s desire to be in a relationship with those living with severe and persistent mental illness. By this we meant, does God also “long to belong”?

In summary, these cases point to questions about clinical practice in general and how it can open up or close off communication with patients. In the first case, the question was to explore whether or not attending to this patient’s religious beliefs might help him grow in his relationship with God as well as whether attending to how these beliefs might also serve to assist the clinical team in caring for the safety of the patient and others. In the second case, it was curiosity about the place of the human/divine encounter in those experiences of social isolation.

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93 From 1985 to 2000, the statistical range for belief in God is 84% to 81%. Reginald Wayne Bibby, *Restless Gods: The Renaissance of Religion in Canada* (Toronto: Stoddart, 2002), 140. In 2005, Bibby found that 82% [Yes, definitively (49%) and Yes, I think so (33%)] believe in God or a supreme power. Reginald Wayne Bibby, "Canada’s Dataless Debate About Religion: The Precarious Role of Research in Identifying Implicit and Explicit Religion," *Implicit Religion, North America* 12, no. 3 (2009): 264. Bibby’s most recent work suggests that, while the number of adults who definitely do not believe in God (atheists) has not changed in any statistically important way between 1975 (6%) and 2005 (7%), the more important growth is among theists who moved away from the certainty of definitely believing in God. “At this point in time, 40% of the population are sitting in the middle of ‘the God continuum,’ undecided on belief versus non-belief.” Reginald Wayne Bibby, *Beyond the Gods & Back: Religion’s Demise and Rise and Why It Matters* (Lethbridge, AB: Project Canada Books, 2011), 49-50.
brought on by the experience of mental illness. Both cases suggest that these primarily theological and religious questions fall between the cracks when the religious dimension is pathologised or ignored.

The insights of pastoral theologian Elaine Graham concerning pastoral theology in an age of postmodern uncertainty inform this inquiry when she suggests that:

To ask of any practice -“What does it disclose/foreclose?” is to attempt to identify the values and preconceptions by which practices are informed. This enables a critical renewal of such values in the light of changing contexts, but honours the strategic nature of any dimension of practical reasoning.94

From Graham and these ethnographic examples, the central finding concerns the importance of paying attention to the practices of the chaplain in the contemporary clinical process. This includes determining how he/she is different from other multi-disciplinary professionals, and specifically whether the practice discloses on a patient’s experience of God in the clinic. Such subjective experiences are at the origin of this thesis, and reveal its bias.95

Delimitations

This thesis will be delimited in two significant ways. First it specifically focuses on the historical Boisen and his application to the contemporary mental health context; and second, its adaptation of Boisen’s notion of the clinical chaplain is specifically applied to the context of Roman Catholic board sponsored mental health centres.

Anton T. Boisen and the Mental Health Care Context

Several works have proposed that both Boisen and psychiatric care be reclaimed by contemporary pastoral care. Ten years ago, John Foskett called for such a return in his article “Can Pastoral Counselling Recover its Roots in Madness?”96 His historical assessment was that

94 Graham, 163.
95 Ellis, 89.
96 John Foskett, “Can Pastoral Counselling Recover Its Roots in Madness?,” British Journal of Guidance & Counselling 29, no. 4 (2001). On Foskett’s use of the word “madness,” he writes: “Madness is used in this article as the most generic and least euphemistic word to describe and not narrowly label the experience of many people in our society.” Ibid., 411, FN#1
“in both Europe and America pastoral counselling has largely forsaken its roots in psychiatry.”\textsuperscript{97} Quite ironically, while Boisen’s innovation of the three month clinical placement for clergy is standard practice in most training programs for ministry in North America and beyond, he notes that many “students of clinical pastoral education are unaware of its origins of madness.”\textsuperscript{98}

Foskett’s call is not intended to be strictly historical, but also concerns the recovery and retrieval of this dimension for contemporary mental health care. He presents research from Britian’s Mental Health Foundation that indicates that religion and spirituality continue to play a role “for better and for worse” in how contemporary patients experience their mental illness.\textsuperscript{99} The practical issue is that there is “an acute need for professional counselling services which can effectively meet the spiritual needs of service users/survivors.”\textsuperscript{100} Foskett’s clinical call is supported by much of the literature researching the relationship between religion, spirituality and mental health.\textsuperscript{101} While there continues to be a critical need for definitional clarity of the terms religious and spiritual,\textsuperscript{102} a sizeable percentage of the literature indicates that “aspects of

\begin{footnotesize}
\begin{enumerate}
\item Ibid., 403.
\item Ibid., 404.
\item Mental Health Foundation, Knowing Our Own Minds (London: MHF,1997); MHF The Courage to Bare Our Souls (London: MHF, 1999); MHF Strategies for Living (London: MHF, 2000). Referenced by Foskett: 404.
\item Foskett: 404.
\end{enumerate}
\end{footnotesize}
religious and spiritual involvement are associated with desirable mental health outcomes.\textsuperscript{103} These findings remain controversial from both a methodological\textsuperscript{104} and theological\textsuperscript{105} perspective but there is increasing research recommending that the spiritual and religious dimension should at least be acknowledged in clinical care.\textsuperscript{106}

There is a final reason to turn particularly to Boisen and the mental health context. Both represent expressions of marginality. Recovering the voices of those on the margins is now a recognized approach central to practical theology and other health care disciplines.\textsuperscript{107} Like many people living with mental illness,\textsuperscript{108} Boisen suffered from a certain invisibility, voicelessness and isolation. In his autobiography, written five years before he died, he wrote, “as long as I remain a


patient, I am by that very fact discredited.” Boisen and his psychiatric context (as will be shown in Chapter One) quickly lost favour in the very movement he started. “Despite his lifelong resistance to these developments, the majority of his descendents practiced in non-psychiatric settings.”

This dissertation’s engagement of Boisen and the mental health care context follows Foskett’s call to remember and rediscover that contemporary pastoral care’s foundation lies at the intersection of Boisen’s mental health problems and his search for spiritual and religious development. Thus, in mining its potential for spiritual and religious development, the thesis will permit what Elaine Graham calls:

a way of valuing the insights into suffering and salvation elicited by accounts of vulnerability and illness whilst being able to distinguish those forms of mental illness that express themselves in religious delusion and distorted spirituality.

**Roman Catholic Board Sponsorship**

The dissertation explores the life and work of Boisen in order to identify its application to clinical chaplains working in hospitals governed by faith based boards of directors, in particular, Roman Catholic ones, as opposed to those that are run by secular boards of directors. The primary reason for choosing Catholic hospitals is pastoral, as well as geographically contextual for this author.

First of all, the Roman Catholic Church considers health care as a ministry, which is to say that “it is first and foremost a work of the Church that is rooted in the healing mission of Jesus. Its purpose is first of all to proclaim the Gospel on behalf of the Church.” In its history, the Roman Catholic Church has developed an evolving structure to support this healing ministry including hospitals and other healing initiatives. Since the 1970s the word used most frequently for this support is “sponsorship,” a term which “refers to the unique relationship of oversight,

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110 Foskett: 404.
111 Graham, 138.
endorsement, or support by a group that commits itself to advancing the ministry of Jesus.”

Canadian canon lawyer Frank Morrissey, who has been very involved in the development of sponsorship models of North American Catholic hospitals, writes “We could say that sponsorship of a health care ministry is a formal relationship between an organization recognized by the Catholic Church and an apostolic work, for the sake of sustaining and promoting the Church's mission.”

One of the consequences of a sponsorship structure is that it makes it possible to ask what difference religious identity or context makes in the practice of health care. John Shea, in his recent considerations on spirituality and health care in the United States underscores this specifically for faith-based health care when he asks “How is the ultimate religious perspective embodied in concrete organizational structures and specific programs?”

For the specific purposes of the dissertation, a central question is whether a Roman Catholic health care ministry has anything to contribute to the debate and to the patients about a clinical paradigm which threatens to eliminate a clinical chaplaincy that is theologically and religiously informed.

According to the Health Ethics Guide of the Catholic Health Association of Canada, the “promotion of spiritual/religious care” is identified as one of the ten “tangible signs” for Catholic hospital identity. Morrissey, for whom holistic care is one of the markers of Catholic identity,


117 The entire list is “Among the tangible signs that should identify Catholic Health organizations are the following: Catholic sponsorship and management; quality care; proper stewardship of resources for the community served; a culture that supports Christian ethical values and spiritual beliefs; recognition by the bishop of the diocese as an integral part of the apostolate; promotion of spiritual/religious care; mission and values integration; just working conditions; the availability of the sacraments; and the prominence of various Christian symbols.” Catholic Health Association of Canada, Health Ethics Guide (Ottawa: Catholic Health Association of Canada/Association catholique canadienne de la santé, 2000), 8. [Emphasis added].
adds that a Catholic institution “would have to ask itself also how the spiritual care of persons is integrated into the overall care program.”

Secondly, there is also an important geographical, contextual reason for focusing on faith based hospitals. The issue of Catholic sponsorship reflects an important change in the way mental health care is currently being delivered in the province of Ontario. This was part of a larger provincial plan, mandated by parliament and administered by an arms-length body, to restructure the shape and delivery models of health care. Over ten years ending in 2009, the Ministry of Health for the Province of Ontario divested all of its Provincial Psychiatric Hospitals (PPHs) it used to manage to community based hospital boards. Half of these went to Roman Catholic sponsored boards.

This dissertation focuses particularly on this faith based governance context because it permits one to ask, in view of increasing demands on healthcare funding, whether Ontario’s Catholic sponsored mental health hospitals will succumb to the trend to eliminate chaplaincy as a clinical service altogether. Aware that James Kavanaugh has found evidence budget cuts were responsible for the elimination of pastoral services in psychiatric wards and emergency services in a private American Catholic hospital, Daniel Sulmasy has argued that Catholic hospitals

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118 Morrissey, 9.


120 Mental Health Care Penetanguishene is the 10th and last provincial psychiatric hospital to be divested to the public hospital system and the fifth to be entrusted to Roman Catholic governance. “This is an exciting day for us as we move into the mental health field,” said John Barrett-Hamilton, then chair of the Mental Health Centre Penetanguishene Corporation. “We will carry forward with the Catholic tradition of health care, continuing to make quality services available to all who need them.” Ministry of Health and Long-Term Care,"Mental Health Service Transfer Now Complete," nr-121(2008). http://www.health.gov.on.ca/en/news/release/2008/dec/nr_20081215.aspx [accessed January 4, 2011]. The other four psychiatric facilities in Ontario that have Catholic governance are: Providence Care, Kingston; St. Joseph’s Health Care, London; St. Joseph’s Care Group Thunder Bay; and St. Joseph’s Healthcare, Hamilton.

121 John F. Kavanaugh, "Capitalism's Cost to Care (Decline of Chaplaincy at Privatized Catholic Hospitals)," America 178, no. 8 (14 Mar. 1998).
should never come to be known as “places that have decimated their pastoral care staff.”

A critical concern here is whether Catholic hospitals might follow the trend to turn chaplaincy into the kind of existential profession Zock described, one that no longer stresses the importance of religious and theological beliefs.

The challenging words of the late theologian Richard McCormick querying “The End of Catholic Hospitals” are not without resonance here. Written specifically in response to the changes being brought about in the United States of America by managed care in 1990s, he asks “does not the claim of distinctiveness dissolve in the reality of practice?” McCormick’s line of thought echoes that of Elaine Graham and her emphasis on exactly what a “practice” discloses or forecloses. If care in Catholic hospitals, as McCormick understands it, is meant to “involve a whole attitude towards life, and death, a theology” then a pastoral care devoid of this theological distinctiveness would lack integrity.

In 2003, the Catholic Health Association of Ontario, commissioned a report to “assess the status of spiritual and religious services currently being offered in [its...] facilities to patients, residents, visitors, volunteers, and staff.” This report begins with the contemporary context of health care restructuring and references the emerging practice that other disciplines claim to do spiritual care.

Nevertheless, the past five years have witnessed decreased funding, cutbacks, and organizational restructuring. Consequently, questions have arisen: How are services funded? What changes have occurred in spiritual and religious care? And for what reason(s)? Has provision of spiritual and religious care been

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124 Graham, 163.

125 McCormick.

Eroded? Concern exists that the ministry of spiritual and religious care offered by an autonomous Pastoral Care Department with its own department head may be reduced, absorbed by other departments and/or disciplines, or eliminated completely. Nurses, for example, are mandated to address the biological, psychological, social, cultural, and spiritual needs of persons in their care. Is it possible that pastoral care might be subsumed into the discipline of nursing or that of social work, particularly, when nurses and social workers have societal licensure to serve the complex interests of the persons in their care?

Although many questions can be asked about spiritual and religious care in Ontario today, few attempts have been made to provide answers.127

The authors interpreted their own research results as being “limited” on account of the open ended nature and scope of their survey questions. However, they also note that at the time of publication of their study, theirs’ was the most comprehensive study of the “state of spiritual and religious care in Ontario’s Catholic health facilities” that had ever been attempted.128 While there has not been a follow up study since then, the 2003 report does acknowledge some important issues. It acknowledges changes in understanding of the terms spirituality and religion, addresses the lack of universally accepted standards for assessing basic pastoral care practice, cautions against conceptualising spirituality as only a therapeutic tool for healing, calls for a more thorough accommodation of religious and sexual diversity, and concludes with a call for more research. To guide that future research, it raises ten questions; the last four are particularly relevant to this dissertation:

- If nurses have the total care of the patient - physical, psychological, emotional and spiritual - as their mandate, what is the “added value” of the pastoral care worker?
- How do Catholic health care facilities respect/foster the diverse spiritual needs of Canadians?
- How is spiritual and religious care valued in the hierarchy of health services (this question needs to be addressed by members of the pastoral team as well as other staff and administration)?
- What is needed in order to make sure that spiritual and religious care can thrive in today’s health care system (resources, shift in attitudes, legitimacy

127 Ibid., 4.
128 Ibid., 15.
The dissertation proposes to use these local developments in Catholic sponsored governance in mental health centres as an important contemporary context in responding to the contemporary problematic of clinical chaplaincy.

Key Terms

The terms “spirituality” and “religious spirituality” will be used throughout this dissertation. This section is intended to differentiate them. This distinction will primarily be marked with the adjective “religious.” It is meant to reflect the dissertation’s initial contextual analysis of the trend towards a scientifically secular and medically informed clinical spirituality. That trend, it has been suggested following Dupré, Taylor and Franklin, affirms the human as the source of meaning and reality as immanent. The adjective religious is meant to identify a conceptual space for spirituality reflective of the religious world view which affirms a transcendent reality, sometimes as a personal reality and sometimes as an impersonal reality. This is, according to John Hick “the necessary postulate of the religious life.”

Sandra Schneiders anthropological approach to spirituality is exceptionally helpful in providing a conceptual framework to accommodate this contemporary trend. For her, spirituality

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129 Ibid., 17.

130 John Hick, Dialogues in the Philosophy of Religion (Basingstoke: Palgrave Macmillan, 2010), 17. Hick calls this the “Real.” See especially pages 15-17. Another way to conceptualise this difference is in terms of a naturalistic opposition to theology. A basic assumption of theology is, as John F. Haught writes about David Tracy’s work in this area, that the “universe has an infinite depth and ground known as ‘God’. Without positing the reality of God theology has always maintained the universe’s existence is unintelligible. Naturalism on the other hand, is the belief that the natural world is self contained and self-sufficient. It is its own ground and explanation. Thus there is no need to look beyond the physical world for a distinct source of its being. The universe ‘just is.’” John F. Haught, “Tillich in Dialogue with Natural Science,” in The Cambridge Companion to Paul Tillich, ed. Russell Manning (Cambridge: Cambridge University Press, 2009), 226. In his work, George M. Furniss distinguishes between a substantive definition of religion and a functional one. The former “relates to religion’s object, God, the gods, or spiritual reality. […] The latter focuses on the individual’s attitude toward cultural objects.” George M. Furniss, The Social Context of Pastoral Care: Defining the Life Situation, 1st ed. (Louisville, Ky.: Westminster John Knox Press, 1994), 4.

is “the experience of consciously striving to integrate one’s life in terms not of isolation and self-absorption, but of self-transcendence toward the ultimate value one perceives.”

For Schneiders, spirituality is a universally true human process, one that is always and necessarily particular in its manifestation. For her, “there is no such thing as ‘generic spirituality.’” Rather, spirituality is always someone’s or some community’s articulated concrete “lived experience” about (a) what it means to be human and (b) what the ultimate value is. As such, it requires at least some degree of relative coherence and some degree of articulation about both these things. These are often then expressed in historical traditions and symbolic systems.

According to this anthropological conceptualisation, it is possible to have secular, scientific or non-religious spiritualities. If the ultimate value is, for example, humanism, then one can speak of a humanistic spirituality for it has an articulated set of views concerning what it means to be human and its ultimate values. But when the ultimate value is “the Absolute” or God, then Schneiders suggests “the spirituality would be religious.”

When this dissertation uses the word “God,” it means to capture that religious reality that Schneiders calls the Absolute, and which she suggests distinguishes religious spirituality from other spiritualities. Harold Koenig’s way of describing the transcendent is especially helpful here for understanding the absolute.

The transcendent is that which is outside the self, and yet also within the self—in Western traditions is called God, Allah, HaShem, or a higher power, and in Eastern traditions is called Ultimate Truth or Reality, Vishnu, Krishna or Buddha.

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132 Ibid., 684.
133 Ibid.
135 Definition shared by Harold George Koenig in a handbook provided at the Summer Research Workshop conducted by the Center for Spirituality, Theology and Health, Duke University, Durham, North Carolina, July 19-23, 2010, 55.
For this dissertation then, “religious spirituality” has to do with spirituality where the relationship with the ultimate value is transcendent reality by whatever name these religious traditions choose to use.\(^{136}\)

In conclusion, this dissertation attempts to identify religious spirituality as something distinct\(^{137}\) within but legitimately related to what can be termed the continuum of spirituality. This is important given the particular delimited context of this dissertation, its Catholic sponsored boards for mental health care and the question about the kind of clinical care such boards might support.\(^{138}\) This dissertation will suggest that the greater challenge for Catholic Health Care is not in accommodating secular spiritualities, but rather in prophetically and explicitly building a practical case for the inclusion of “religious spirituality” in the clinical milieu.

**Organization of the Dissertation**

This dissertation begins with this introduction which identifies current issues in clinical chaplaincy, the dissertation’s purpose, methodology, key terms, and a justification for this dissertation’s delimitation of Boisen’s notion of the psychiatric chaplain within the context of Roman Catholic Sponsored mental health care.

\(^{136}\) It is important to note that some contemporary Christian authors disagree with this approach which assigns the word “spirituality” to human relationships with values or objects other than the absolute or transcendent. Even Harold Koenig from whom I borrow my particular definition of the transcendent writes: “Spirituality is distinguished from other things –humanism, values, morals, and mental health –by its connection to the transcendent.” Ibid., 55. Daniel P. Sulmasy writes, “One’s spirituality may be defined simply as the characteristics and qualities of one’s relationship with the transcendent.” Daniel P. Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, D.C.: Georgetown University Press, 2006), 14.

\(^{137}\) For more on how term conflation and confusion can lead to complications in research about spirituality and religion, sometimes even tautological conclusions, see Alexander Moreira-Almeida and Harold G. Koenig, "Retaining the Meaning of the Words Religiousness and Spirituality: A Commentary on the WHOQOL SRPB Group's "a Cross-Cultural Study of Spirituality, Religion, and Personal Beliefs as Components of Quality of Life" (62: 6, 2005, 1486-1497)," *Social science & medicine* 63, no. 4 (2006): 843-845.

\(^{138}\) I recognise that this Roman Catholic contextualisation narrows my focus. Not every Christian denomination or religious tradition is involved in health care in Ontario the way the Roman Catholic Church is, nor will these other groups necessarily agree with my method or approach to the content. This is not necessarily a bad thing, as the intent of this thesis is simply to contribute to the discourse which is, at this moment, at risk of eliminating a visible representative of the religious perspective from the clinical milieu. This RC contextualisation is more critically addressed in chapter 4 and in the research limits and future scholarship possibilities section of the conclusion of the thesis.
Chapter One, “Anton T. Boisen: Lost and Found,” will present and analyse the life and work of Boisen, with two special emphases: first the way Boisen and his core ideas, as inspired by his life, were moved to the periphery of clinical pastoral education; and second, Pruyser’s work which reclaims Boisen’s innovation of the psychiatric chaplain. This chapter will argue that Pruyser’s focus was meant to explore and adapt Boisen in response to the contemporary challenges Pruyser assessed to be facing clinical chaplaincy in his day. Thus, Pruyser’s insight that “the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation”\(^{139}\) will be critically reviewed and contextualised. Pruyser’s portrait of Boisen will show how Boisen’s religious perspective was brought to bear on the functioning of the clinical psychiatric team, and offer a contemporary critique. Pruyser’s reclamation of Boisen reflected his concern about the future viability of the religious perspective in chaplaincy.

With this historical background and Pruyser’s corrective effort identified, Boisen’s notion of the clinical chaplain will then be explored by engaging previously unstudied and otherwise unpublished archived manuscripts of pastoral theologian Henri Nouwen (1932-1996). It is little known and understudied that Nouwen had an academic and personal interest in the work and life of Boisen. He was especially interested in how Boisen’s case methodology revealed Boisen’s personal experience of isolation and alienation from others and God.

Chapter Two, “Anton T. Boisen and Henri J.M. Nouwen,” will first situate the Boisen-Nouwen connection and critically analyse Nouwen’s core texts on Boisen and his strategic uses of Boisen. This will include a critical review of the unpublished archival material of his two incomplete doctoral efforts. It will also review his documented meeting with Boisen in 1964.\(^{140}\) It will show that Nouwen’s portrait of Boisen focuses on how Boisen’s “commitment to the contextual and situated nature of human experience”\(^{141}\) was pastoral and research focused; the former having to do with how God is made present and attended to (or not) in the clinical


\(^{140}\) Henri J. M. Nouwen, "Boisen," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1964).

\(^{141}\) Graham, 203.
presentation. This insight will also explain Nouwen’s contextual critique of the professional clinical pastoral training models of his day, namely how he considered them to emphasise “the living human document” at the expense of what Nouwen coined to be the “living human God.”

This chapter will suggest that Nouwen’s strategic use of Boisen conceptualises that a chaplain is best understood as a living reminder of Jesus Christ. This theological use of the concept of remembrance will provide the conceptual basis for my own framework to reappropriate and adapt Boisen for today.

Chapter Three, “Chaplain as Friend: Importance, Vulnerability and Relevance,” brings Nouwen’s portrait of Boisen and his notion of the psychiatric chaplain into critical dialogue with the contemporary theology of mental health ministry proposed by practical theologian and Scottish Episcopal priest John Swinton. First it critically reviews Swinton’s radical call—in his early work—for an ecclesial commitment to “friendship” in mental health care. This review suggests that Swinton’s theological attention to social isolation of the mentally ill is important; it captures something essential of Boisen’s innovation of clinical pastoral work among the mentally ill. However this chapter’s second part also argues that Swinton’s ecclesial response of “friendship” is “vulnerable;” it presents serious clinical challenges, concerns that even Swinton confirms. Nevertheless, his work remains “relevant.” This chapter’s third part argues

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142 Henri J. M. Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives, (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1965).


that recent work by Charles Taylor can function as a critical first step both to re-imagining and adapting Boisen’s innovations, as well as re-affirming Swinton’s. Taylor offers the chaplain and the Church a conceptual space to credibly witness—just as Boisen tried to do—to the contemporary challenge and possibility of believing in God in the first place, especially in mental health care.

Chapter Four, “Re-Membering God: A Model for Chaplaincy in Catholic Sponsored Mental Health Care” concludes the dissertation. The first part reviews the essential findings of this dissertation in terms of how contextual models reveal the day-to-day struggle of chaplaincy. Then I propose a new theological model for the clinical practice of chaplains where the psychiatric chaplain “re-members God” in clinical practice. This model has two key sources: the primary source arises out of Nouwen’s strategic use of Boisen, especially his argument that ministry is best considered as a kind of “remembrance.”\textsuperscript{146} The secondary source, particularly this way of spelling “re-member,” is adapted from the work of cultural anthropologist Barbara Myerhoff (1935-1985). Her parsing of the word reflects a social constructivist and now narrative approach to identity formation, thus making room for others, including God, to be “members” of a person’s identity forming social network. This chapter concludes with pastoral considerations on the particular relevancy of this model for Catholic sponsored mental health care. This includes how the model—if adopted—can reveal that “Catholic healthcare has an ultimate identity that relates it to the divine source.”\textsuperscript{147}

The conclusion of the dissertation summarises the thesis’ original contributions to scholarship and identifies how two particular limits to its research point to important future scholarship considerations.

\textsuperscript{146} Nouwen, \textit{The Living Reminder}, 13.

CHAPTER ONE:
ANTON T. BOISEN – LOST AND FOUND

Thirty five years after Boisen first brought theology students into the psychiatric Worcester State Hospital for clinical training, Dr. Paul Pruyser (1916-1987) wrote that the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation. His is a unique function: he represents religion in all its aspects on the psychiatric team and to the patients. ¹⁴⁸

According to Pruyser, Boisen’s innovation was part of a larger historical shift from custodial care to what was to become the new modern mental hospital, where the latter is conceived of as a “social institution which maintains many intimate ties with the community.”¹⁴⁹ He considered Boisen to be part of a new clinical vision which sought to support the totality of the individual with a concern for such issues as their health, legal, social welfare, as well as the “religious welfare” of the hospitalized patient. Through Boisen, this final concern was “channelized and epitomised in a new professional speciality—the mental health chaplain” and so he concluded that “this is the place to highlight one more chapter in the history of the psychology of religion written by Anton Boisen.”¹⁵⁰

While critical histories about the clinical pastoral education movement exist,¹⁵¹ there is surprisingly very little sustained analysis about Boisen’s notion and innovation of the psychiatric chaplain except for Pruyser. The trend in the literature primarily situates Boisen in the origins of the movement: it suggests that while Boisen was instrumental in the development of clinical pastoral education, he quickly became a peripheral figure in its organization as well as in its

¹⁵⁰ Ibid., 121. This citation is repeated in Pruyser, A Dynamic Psychology of Religion, 11.
¹⁵¹ Hall, Head and Heart; Holifield; Myers-Shirk; Powell, CPE: Fifty Years of Learning through Supervised Encounter with Living Human Documents; Thornton.
development. Subsequent leaders, most of whom Boisen himself recruited and trained, moved clinical chaplaincy outside of Boisen’s original mental health and theological focus, the specific context and inspiration which motivated Boisen to view mentally ill patients as the “living human documents” in the first place. By the time of Boisen’s death, the focus became the supervised education and training of theological students themselves as the new living human documents.\footnote{Powell, \textit{CPE: Fifty Years of Learning through Supervised Encounter with Living Human Documents}, 18-19.}

To explore these developments, this chapter has two main parts: the first traces Boisen’s journey, along with his central thesis, to the periphery of clinical pastoral education. This section suggests that one outcome of this shift was a change in the identity of the clinical chaplain. The second part presents Pruyser’s reclamation of Boisen. His careful exploration and adaptation of Boisen’s foundational ideas reflect Pruyser’s corrective effort to counteract certain contemporary trends in CPE’s development. This section will conclude with a contextualisation of Pruyser’s portrait of the chaplain in light of CPE’s much larger search for its own identity.

**Boisen’s Move to the Periphery in CPE’s Early History: 1922-1965**

Throughout his career, Boisen felt that the clinical pastoral training movement developed in ways different than he hoped. In his autobiography he notes that, for the 25\textsuperscript{th} anniversary celebration of CPE in October of 1950, organized by the Council for Clinical Pastoral Training, he was somewhat surprised that he had been invited to give the keynote address, given “our differences.”\footnote{Boisen, \textit{Out of the Depths}, 192.} Boisen writes,

> I am happy also in the growth of the movement for clinical training of students for the ministry. For this I claim no special credit myself. It has been the work of many persons and it is due to complex forces. Sometimes I have felt that it has gone forward in spite of rather than because of what I have done. It has gone forward under its own power, \textit{developing a philosophy which differs not a little from mine}. [emphasis added]For this I can be thankful so long as it concerns itself with the living human documents of persons in trouble.\footnote{Ibid., 195-196.}
Boisen’s influence in the early history of the clinical pastoral movement is well documented. Boisen has been called the “father”\textsuperscript{155} of the clinical pastoral movement even though his place as its originator is debated, primarily with one other name, that of Dr. Richard Cabot (1868-1939), and to a lesser degree, Drs. Helen Dunbar and William Keller. According to historian Charles Hall, “Richard Cabot and Anton Boisen are the two most significant founders of clinical training for theological students.”\textsuperscript{156} Hall’s analysis is likely most historically correct, in that it is possible, even though Boisen and Cabot worked closely together for several formative years, to identify different currents of thought and pastoral practice, both between them and in what developed among their followers. These two currents would eventually become duelling with each other, revealing what pastoral theologian Robert C. Dykstra has called

  differing understandings of the nature of the self and its healing, of the appropriate subjects and objects of pastoral and pastoral theological concern, and of the particular cognate disciplines perceived to be of most value to this field.\textsuperscript{157}

This disagreement would be resolved primarily in favour of Cabot’s followers. By 1970, just five years after Boisen’s death, pastoral historian Edward Thornton had concluded that “Boisen’s place in the organizational development of clinical pastoral education is peripheral.” Thornton also maintained that “Boisen’s place in the genesis of clinical pastoral education is instrumental but not intentional.”\textsuperscript{158} In this historical understanding, CPE’s beginnings include


\textsuperscript{156} Hall, \textit{Head and Heart}, 5.


\textsuperscript{158} Thornton, 56.
the necessary collaboration, for a time, of both men. But as Thornton suggests, Boisen ended up “essentially alone” in all things, including the movement he helped start.

Boisen as a Psychiatric Chaplain in 1924: Sources

Boisen was 48 years old when he was hired as the first full time and integrated clinical mental health “chaplain and research worker” at the Worcester State psychiatric Hospital in Massachusetts on July 1, 1924. Before this, he had at least four short lived and temporary efforts at finding his vocation. He trained as a linguist having graduated from Indiana University in 1897, as a forester having graduated from Yale in 1905, as a Presbyterian minister having graduated from Union Theological Seminary in New York in 1911, and as a Church surveyor having essentially failed as a parish minister. This history of changing paths played a pivotal role in the kind of pioneering clinical chaplain he would become and would influence his career as a researcher. At Indiana University, in the fall of 1897, he studied William James’ *Principles of Psychology*. From him he would learn the centrality of empirical study in contemporary mystical religious experience, including the apparently pathological, and that “sickness of soul might have religious significance.” This would be central in Boisen’s research on those actual patients he called “human documents.” Boisen believed that “the man who influenced most of his scientific thinking was Raphael Zon, a Forest Service scientist.”

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159 Ibid., 54, 55.
161 Boisen documents these changes in profession in his autobiography, paying special attention to his mother’s support “when I failed to make the grade after graduation in 1897. She acceded at once to my change of profession in 1903, and again in 1908. And finally in 1922, it was her faith that made possible this new undertaking.” Ibid., 168.
162 Ibid., 41.
166 Boisen, "Theological Education Via the Clinic," 235.
Systematic surveying, of the kind he learned during the three years he worked as a forester with Zon, would characterise the rest of his life as a clinical researcher. His divinity degree at Union, while theological in nature was greatly influenced by George Albert Coe’s empirical approach and expertise in James. Boisen took all of Coe’s classes on the psychology of religion. Boisen would appropriate all these influences and make particularly important contributions in the area of pathology and religion.

The most important contextual influence for Boisen’s innovative beginnings as a psychiatric clinical chaplain relate to an experience he had when he was 44 years old and was admitted on October 9, 1920 to Boston’s Psychopathic Hospital. His presenting problem was a major acute psychotic episode with “violent delirium, hallucinations, and delusions,” as well as religious and suicidal ideations. Boisen reports the diagnosis in his autobiography as schizophrenia of the catatonic type, the kind of which Boisen adds “that my people [those suffering from the same illness] were told there was no recovery.” This diagnosis, following

168 Myers-Shirk, 18.
169 Anton T. Boisen, "George Albert Coe," Pastoral Psychology 3, no. 7 (1952): 8, 64.
171 Boisen, Out of the Depths, 87.
174 The literature disputes Boisen’s actual diagnosis. In so doing it raises some important questions, including the basic difficulty of any diagnosis, and better profiles the genius in the way Boisen engaged these diagnostic questions. Carol North and William M. Clements “challenge the accuracy of this diagnosis as it is understood in contemporary psychiatry and applied retrospectively to the clinical condition detailed by Boisen in his autobiography.” C. North and W.M. Clements, "The Psychiatric Diagnosis of Anton Boisen: From Schizophrenia to Bipolar Affective Disorder," in Vision from a Little Known Country: A Boisen Reader, ed. G. H. Asquith (Atlanta, Georgia Journal of Pastoral Care Publications, 1992), 266. North and Clements suggest, contrary to Pruyser, Powell and others, that the diagnosis of bipolar affective disorder, a mood disorder, might be more accurate than a primary focus on thought disorders for Boisen’s actual case. Curtis W. Hart re-situates this debate, with specific reference to the historical work of Karl Ludwig Kahlbaum (1828–1899), suggesting that if “catatonia can be identified with either thought or mood disorders, then perhaps both sides of this prolonged debate are correct and have a significant piece of the truth.” Curtis W. Hart, "Notes on the Psychiatric Diagnosis of Anton Boisen," Journal of Religion and Health 40, no. 4 (2001): 428. For Hart, the diagnostic question may actually be more of a “both/and” than an “either/or” in that “Boisen was not bipolar and schizophrenic at the same time but demonstrated aspects of both in his thought, affect, and behavior. These aspects of illness overlapped at some points and remained distinct at others.” Ibid., 428. Hart’s analysis suggests that what is most important in this discourse is that it is “Boisen himself who emerges as
the post-Kraepelin work of Eugen Bleuler was called at the time “dementia praecox, catatonia.” Boisen remained in acute psychiatric care for about two weeks and then was transferred to psychiatric convalescent care at Westboro State Hospital in Chicago for almost 2 years.

A mere one and half years after being discharged, Boisen started work as a clinical chaplain and researcher at Worcester State Hospital, Massachusetts. When Boisen took up his post there on July 1, 1924, he had “free access to case records, the right to visit patients on all the wards, to attend staff meetings where cases were being discussed, and to be recognized as part of the therapeutic team.” As David Steere points out, within a year, Boisen had students in a summer program in what “was probably the first program of clinical pastoral training as we know it today.”

These historically unique developments owe their origin to Boisen’s effort to understand his own mental health crisis as a problem solving religious experience. Boisen’s approach is rooted, says Charles Hall, in his “struggle to understand [his illness experience] and to integrate it into a framework of meaning.” While certainly informed by his previous graduate study, what makes Boisen even more remarkable is that this effort to make sense of it all formally began in the very midst of that first hospitalization. As Hall notes, “following the acute phase, he possessing the most holistic and arresting grasp of the diagnostic question” as evidenced by his practice of diagnostic observation in clinical care. Boisen “was exceptionally well versed in the psychiatry of his era but never allowed its authority to inhibit, dominate, or discredit either his direct observations or his theological and philosophical reflections. His creative genius infused a movement that should forever pay close attention to his example.”

175 Boisen, *The Exploration of the Inner World*, 4; Emil Kraepelin and George M. Robertson, *Dementia Praecox and Paraphrenia* (Edinburgh: Livingstone, 1919). “Emil Kraepelin, who incorporated the features of catatonia into his concept of dementia praecox, exerted a persistent influence on the classification of catatonia. Bleuler followed Kraepelin’s conceptual model for catatonia, and, although numerous authors argued against this view, clinicians throughout most of the 20th century considered catatonia as an exclusive subtype of schizophrenia. The idea that catatonia is tied to schizophrenia was codified in all DSM and ICD editions.” Michael Alan Taylor and Max Fink, "Catatonia in Psychiatric Classification: A Home of Its Own," *Am J Psychiatry* 160, no. 7 (2003): 1233.


177 David A. Steere, "Anton Boisen: Figure of the Future?", *Journal of Religion and Health* 8, no. 4 (1969): 363.

178 Hall, "Some Considerations of Anton T. Boisen (1876-1965) to Understanding Psychiatry and Religion," 46.
refused to forget it and settle for a period of adjustment. If the price of sanity is the lack of creativity, he wanted none of it.”\textsuperscript{179} While still in care at Westboro, Boisen writes on February 14, 1921, to one of his seminary friends, Fred Eastman, with whom he had completed a sociological and religious study after graduation from seminary. Eastman would later become a distinguished professor of Biography and Drama at Chicago Theological Seminary and it was Eastman, Boisen reveals in his autobiography, who suggested that he should make mental illness his “special problem.”\textsuperscript{180} Boisen wrote:

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 of people now suffering from mental ailments but also because of its religious and psychological and philosophical aspects. I am very sure that if I can make any contribution whatsoever it will well be worth the cost.\textsuperscript{181}

Ten months later, still in hospital care, Boisen writes a letter outlining a plan and future study goals, goals which he would later pursue at Harvard, to Dr. Elwood Worcester of the Emmanuel Church in Boston. The letter offers early and central insights about Boisen’s interest in certain kinds of mental illness he wanted to study, the promise he believed these mental illnesses held for the pastoral practice of the Church, and the important role for medicine in the study of pathology of actual religious experience. Boisen writes,

I am therefore hoping for the day when cases of mental trouble which are not primarily organic in origin will be recognized and treated as spiritual problems and that the church will develop physicians of the soul of a type whose work will be based upon sound and systematic study of spiritual pathology.\textsuperscript{182}

Boisen’s particular interest was in the transformative potential of non-organic, or what historically was called in Kraepelin’s terms “functional” cases of mental illness, most

\textsuperscript{179} Ibid., 46.
\textsuperscript{180} Boisen, \textit{Out of the Depths}, 96.
\textsuperscript{181} Boisen, \textit{The Exploration of the Inner World}, 7.
\textsuperscript{182} Boisen, \textit{Out of the Depths}, 139-149.
particularly those of the catatonic schizophrenic kind. This transformative or dynamic approach to mental illness would set Boisen apart from the dominant psychiatric approaches which were not yet committed to the treatment of such illness but to their codification and clarification “through observation [of] the categories of mental disturbance.”

Boisen was not entirely alone, however, in his insight that this population sometimes had “constructive” or “purposive” outcomes following intensely pathological and acute emotional turmoil. Harry Stack Sullivan, a “colleague and confidante [of Boisen], had come to much the same conclusion with the young male schizophrenic patients he treated at the Sheppard and Enoch Pratt Hospital in Baltimore in the 1920s.” In fact, Sullivan referenced Boisen’s work in his *Conceptions of Modern Psychiatry* and supported several of Boisen’s articles by publishing them in the journal he founded, *Psychiatry*.

This purposive outcome, Boisen would later say, gave him a task in which he found “the meaning and purpose of my life.” Near the end of his autobiography, he summarises:

I am profoundly convinced of the purposive nature of the searching experiences through which I have passed. I am equally convinced that there is involved something more than blind striving, or *élan vitale*. For these beliefs my own experience furnishes evidence to me. I can hardly expect it to do so for others.

In fact, Boisen did more than expect his own life to prove this. He spent his entire life trying to find evidence that his own experience was not in fact unique. In Hall’s assessment Boisen’s contribution to understanding psychiatry and religion was “both because of and in spite of his

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183 Ibid., 201.
184 Hart: 425.
185 Ibid., 424.
own personal experience of illness.”\textsuperscript{189} Indeed, this research, originating in his own experience, would form the core of his central thesis, and his central vision for the clinical psychiatric chaplain.

\textit{Boisen’s Central Thesis and the Distinctive Role of the Minister}

In 1936, sixteen years after his initial hospitalisation, Boisen published the first fruits of this inquiry in his seminal work, \textit{The Exploration of the Inner World: A Study of Mental Disorder and Religious Experience}.\textsuperscript{190} Boisen articulated there that the work proceeds from the hypothesis that there is an important relationship between acute mental illness of the functional type and those sudden transformations of character so prominent in the history of the Christian Church since the days of Saul of Tarsus.\textsuperscript{191}

His central idea being that in “personal struggle elevated to cosmic proportions; [that includes] the ideas of self-importance, [and] a heightened sense of personal responsibility,”\textsuperscript{192} there was sometimes a religious and therapeutic breakthrough, just as in the cases of certain religious leaders, such as Paul, George Fox, John Bunyan, and others. For Boisen, “the conclusion follows that certain types of mental disorder and certain types of religious experience are alike attempts at reorganization.”\textsuperscript{193}

In this approach some severe mental disturbance of the functional kind, including those with pathological psychosis, are sourced in the “disorganization of the patient’s world.”\textsuperscript{194} These are of the kinds of disturbances which threaten what Boisen called the “little-known wilderness of the inner life”\textsuperscript{195} which he himself experienced. Boisen makes the autobiographical link citing

\begin{itemize}
  \item \textsuperscript{189} Hall, “Some Considerations of Anton T. Boisen (1876-1965) to Understanding Psychiatry and Religion,” 52.
  \item \textsuperscript{190} Boisen, \textit{The Exploration of the Inner World}.
  \item \textsuperscript{191} Ibid., viii.
  \item \textsuperscript{192} Steere: 365.
  \item \textsuperscript{193} Boisen, \textit{The Exploration of the Inner World}, viii.
  \item \textsuperscript{194} Ibid., 11.
  \item \textsuperscript{195} Ibid., 11.
\end{itemize}
that the correspondence he wrote one month after his acute episode in 1922 “may be taken as the thesis of this book”:

Something has happened which has upset the foundations on upon which [a person’s] ordinary reasoning is based. Death or disappointment or sense of failure may have compelled a reorganization of the patient’s world view from the bottom up, and the mind becomes dominated by the one idea which he has been trying to put in its proper place. That, I think has been my trouble and I think it is the trouble with many others also.196

Boisen’s thesis is that in this kind of disorganization, there is sometimes the possibility of growth, a re-organization based on the person lifting their own values to the level “of the cosmic and universal, to establish and maintain a right relationship with all that is represented in the idea of God.”197 This is what achieves that “proper place.”198

This notion of “right relationship with all that is represented by the idea of God,” sometimes referred to as “fellowship of the best,”199 forms a central concept in what is essentially a “social” and developmental framework approach to Boisen’s religious meaning of some mental illness. Influenced especially by George Herbert Mead’s Mind, Self, and Society,200 Boisen’s foundational “hypothesis [is] that human nature is basically social”201 and that a person’s identity is built through a constructive social reference to that which is ultimate to the person. He hypothesized that certain mental health experiences, such as the ones he went through, reveal a significant brokenness in a person’s most important or ultimate of these social relationships.

For Boisen, the ultimate relationship, the “best,” is fellowship with God; and this basic social structure of human life is something shared by all people whether explicitly religious or

196 Ibid., 10-11. The letter, which Boisen started to write on thanksgiving in 1920, is produced in its entirety in his autobiography. Boisen, Out of the Depths, 97.

197 Steere: 365.


199 Boisen, Out of the Depths, 197.


201 Boisen, Religion in Crisis and Custom: A Sociological and Psychological Study, 86.
not. In fact, for Boisen religion is understood very broadly, and functionally. It is “understood as an attempt to face and grapple with the realities of life, not to escape from them.”202 It is “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.” 203 According to Boisen, the “idea of God stands for an abiding social fact. It represents the love, the fellowship, which has the capacity for universality and without which the individual cannot live.”204

Therefore, it is impossible to understand Boisen’s approach to the crisis of mental illness without Boisen’s fundamental commitment to this social or fellowship framework. This framework also included an ethical dynamic. “Boisen claimed that mental health is not an individual matter, but has to do with our consciousness of right or wrong relationship to those we count most worthy of love and honour.”205 When a person breaks from these things most worthy of love and honour, he or she experiences severe emotional disturbance, evidence Boisen concluded points to that person’s realisation that he or she was cut off or isolated from the very relationship that brings life and growth in their identity.

Boisen used theological terms to describe the “breach of ultimate loyalties”206 and its recovery, calling the breach sin or guilt, terms he used synonymously. He understood the effect of this disloyalty to be that the person would find him or herself to be unforgivable. The breach, “a rupture of the interpersonal relationships as inwardly conceived,”207 was often marked, he suggested, by a person’s effort to conceal that breach. Boisen studied in great detail the variety of


204 Ibid., 285.


206 Steere: 368.

ways that people practice this concealment. Boisen, The Exploration of the Inner World, 154-156.

208 Boisen, The Exploration of the Inner World, 154-156.

209 Ibid., 268.

210 Ibid., 210-211, 307. See also Steere: 369.


212 Ibid., 244.

213 Ibid., 268.

214 Ibid., 161.
professional, save for one thing: the distinctive work of the minister is to “help the soul in jeopardy to a solution on the level of the abiding and universal,”\textsuperscript{215} that is to find “forgiveness and restoration to the fellowship of that social something we call God.”\textsuperscript{216} This means that the minister embodies and

recognizes the fundamental need for love, the dark despair of guilt and estrangement from those we love, and the meaning of forgiveness through faith in the Love that rules the universe, and in whose eyes no one is condemned who is in the process of becoming better.\textsuperscript{217}

For Boisen, this is where “the domain of the medical worker leaves off and that of the religious worker begins.”\textsuperscript{218}

Boisen admits the possibility that other clinical team members, “regardless of [their] vocation” might also have this central insight and may help the mental health patient find this ultimate fellowship.\textsuperscript{219} But his core intent was to identify the minister’s unique interest and competency in religious experience. For Boisen the minister is the one

who has devoted himself to a certain realm or aspect of human experience. The priest or minister at his best brings to the task of helping the distressed in mind certain insights. He is versed in the utterances of the great and noble of the race, has traced the adventures of the human spirit both individually and collectively in its quest of the more abundant life. He understands the deep longings of the human heart and significance of the constructive forces which are manifest alike in the religious conversion experience and in acute mental illness.\textsuperscript{220}

In Boisen’s effort to delineate the distinctive task of the minister he does not appeal to the traditional role of the minister of religion which, as he writes elsewhere, “has always been looked upon as a representative of the superpersonal. He is a servant or agent of God.”\textsuperscript{221} While

\textsuperscript{215} Ibid., 281.
\textsuperscript{216} Ibid., 268.
\textsuperscript{217} Ibid., 285.
\textsuperscript{218} Steere: 363.
\textsuperscript{219} Boisen, \textit{The Exploration of the Inner World}, 285.
\textsuperscript{220} Ibid., 285.
\textsuperscript{221} Ibid., 265.
this can be meaningful according to Boisen, his interest in understanding the minister is not “about the traditional views,” but with what the minister can bring to those struggling with the kinds of mental health problems with which Boisen struggled and which he found in his research. Nor does Boisen seek to remove the minister’s traditional offer of “comfort” and the giving of “hope and courage,” but his outline of the distinctive task of the psychiatric chaplain is to attend to those whose mental health experiences might be potential religious experiences in the making.

Of particular interest are patients with catatonic schizophrenic mental illness of the functional type, people whom Boisen suggests can be helped “in the process of finding themselves [in] ... those eruptive solutions of inner conflicts which are known as religious experiences.” Significantly, Boisen reveals what is distinctive about the minister of religion using the first person.

What matters most is that I with my particular training and background may be able to see the true meaning of the experience and the fact that my objective is always to assist the better self in its efforts to win out in the face of the odds.

The distinctive task of the psychiatric chaplain therefore is intimately linked to attending to and assisting those cases of isolated and fearful patients, those whose experience of functional mental illness Boisen considers to be of religious experience potential. The minister offers a way to see what is a purposive experience and transformative promise, so that the patient may move away from the evils of isolation and estrangement towards the possibility of a right relationship with what is abiding and universal, in Boisen’s terminology, fellowship with God.

*Problems with Boisen’s Central Thesis*

Later pastoral historians, theologians, and medical scholars have correctly noted “serious inadequacies” in Boisen’s central thesis. David Steere summarises:

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222 Ibid., 265.
223 Ibid., 266.
224 Ibid., 267.
225 Steere: 365.
For one thing, Boisen comfortably divided mental illnesses into distinct groups of organic and functional disorder, remaining oblivious to the emerging holistic understandings of the organism even in his own day. The simple equation of constructive resolutions of the catatonic state with mystical experience is open to quarrel from both medical and religious perspectives. From the standpoint of the theologian, to make mysticism the paradigm for all religious experience is a dubious assumption at best.226

On the basis of these problematic grounds, Thornton asks “whether Boisen’s whole system of thought and his whole research enterprise is no more than a rationalization of a psychotic way of coping with life.” 227 Thornton’s important question points to a more serious concern: “If we accept his ideas as having validity in themselves, on what basis may such a judgement stand secure?”228 And if secure, is this the kind of foundation upon which the clinical pastoral education movement is built? What Steere and other scholars seem to suggest is that it is important “not to let the limitations of Boisen’s own particular findings blur the significance of what he was undertaking.”229 Part two of this chapter will argue that Boisen’s value lies, according to Pruyser, in his contribution being selectively qualified.

In summary then, this presentation of Boisen’s central thesis in the developing context of the early history of CPE was to make clear the link between Boisen’s relentless effort to make sense of his own mental illness experience, the experiences of others, and how this shaped his ideas for the distinctive role of the psychiatric chaplain. With this work done, it is possible now to return to the early history of the CPE because Boisen’s effort to make sense of his 1920 diagnosis of schizophrenia of the catatonic type as a functional kind of mental illness would eventually both unite him and eventually place him on a collision course with his future collaborator, Richard C. Cabot.

226 Ibid., 365.
227 Thornton, 55.
228 Ibid., 55.
229 Steere: 365.
Seminal Beginnings, Divisive Endings: 1922-1942

In 1922, shortly after being discharged from Westboro, Boisen began as planned his studies at an affiliate of Harvard Divinity School, The Andover Theological Seminary. In addition to courses in the area of abnormal psychology, the psychology of belief, and some Church history courses, he took a course in Social Ethics from Dr. Richard C. Cabot, professor of medicine and founder of medical social work.230 The next year, he took another course by Dr. Cabot, “the preparation of case records for teaching purposes” which Boisen considered to be one of the best courses he ever took.231

Cabot’s case method would remain hugely important for the rest of Boisen’s life and work. It would frame his fundamentally theological approach to the clinical study of living human documents,232 feature prominently in his teaching style, and would even structure his autobiography. The case method would also become the focus of significant research about Boisen in the late 60s and 70s and into his role in the history of clinical pastoral care.233 For Boisen, the case method offered a comprehensive and structured clinical map of inquiry into the presenting life and problems of the sick patient. Cabot’s approach was undergirded by a penetrating diagnostic hermeneutic: the idea of ‘differential diagnosis.’ This was a concept Cabot described initially in his 1912 published work by same name, a popular text that saw many editions.234 Its central idea documented his revolutionary clinical pathological conferences. An effort to “study medicine from the point of view of the presenting symptom,”235 these conferences sought to show the student in medicine the real struggle in correctly diagnosing

230 Hall, Head and Heart, 6.
231 Boisen, Out of the Depths, 195.
232 Hall, Head and Heart, 7.
illness. The method creatively engaged expert doctors in case analysis, literally putting them on a stage right in front of medical students. A patient’s presenting symptoms were introduced, the expert doctors would try to diagnose, and then the post mortem findings would be introduced, showing almost always how incorrect the doctors were. Cabot’s point was primarily to expose young students to the creative but failure filled and humbling process of diagnostics.236

Of all of Cabot’s works, Nouwen concludes that Boisen found this title to be the most influential.237 This was primarily because Cabot captured at once an important question in all diagnostic work, “how can I go beyond symptoms and find the actual cause?” 238 Nouwen writes:

It is exactly this emphasis which we find in all of Boisen's later writing. After two years of study under Cabot, Boisen wrote his article "The Challenge to our Seminaries," in which he defends the case-approach in theology. The focus is clear: a case-approach. Boisen calls this "investigation of living human documents." His vocabulary explains this: Careful scrutiny, seeking patiently and systematically and reverently, discovery, laying foundations, and building. It is primarily a scientific task. Cabot says to the physicians: “...we must reason and inquire our way back into the deeper process and more obscure causes…” Like an echo Boisen says to the theologian: "(We must) discover the motive forces and the machinery which are involved and ... formulate the laws which govern them. " In both formulations the focus is on Differential Diagnosis.239

While there would later be a major disagreement between Cabot and Boisen which would eventually lead to a split in the movement, this split would not primarily be about method.

Over all the years of their relationship, Cabot never agreed with Boisen’s psychogenic interpretation of mental illness, something which is not historically surprising. Cabot was very representative of the psychiatric world of his time. Boisen’s “interpretation of mental illness as psychogenic came at a time when most physicians thought it was due to organic causes.”240 This

236 Powell, CPE: Fifty Years of Learning through Supervised Encounter with Living Human Documents, 7.
238 Ibid., 59.
239 Ibid., 58.
is not to say that Cabot did not support Boisen in the early years of the movement. Boisen documents in his autobiography that as early as 1929 Cabot disagreed with his psychogenic theory about mental health, but “this conviction of his did not change his attitude toward our undertaking.” 241 In fact Cabot willingly used his considerable influence to make Boisen’s entry into mental health work possible. Cabot was the person who informed Boisen that Dr. William A Bryan, superintendent of the Worcester State Hospital in Massachusetts, was willing to try a chaplain.

Boisen appreciated the influence and assistance his relationship with Cabot offered him and his project for clinical training at his hospital.

As far as I am concerned, that was the first suggestion of the idea of clinical pastoral training in its stricter sense. It came I believe from Dr. Cabot. As the inaugurator of hospital social work and the case method in medical education, he was much interested in my undertaking at Worcester and he had on several occasions talked about it and about the need of a clinical year for students in theology. It was his article in the Survey Graphic for September, 1925, which called national attention to the plan.242

That article was “A plea for a Clinical Year in the Course of Theological Study”243 and was instrumental in focusing national attention on the importance of practical experience in theological education. It is however interesting to note here that already in Boisen’s own history of the movement there is a displacement of the name of the founding individual. Hall summarizes it this way: “Although Boisen is credited by some pastoral historians as being the ‘Father of Clinical Pastoral Training,’ he gives Richard C. Cabot credit for the idea.”244

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242 Ibid., 152.
243 Cabot, "A Plea for a Clinical Year in the Course of Theological Study," 9-11.
This is certainly Thornton’s point: Cabot is the organizational driver and Boisen an “instrumental” one.245 One aspect of this instrumentality is that Boisen actually recruited those who will become the key players in the movement that would develop. Between 1925 and 1930, Boisen’s summer training programs at his psychiatric hospital not only experienced growth in terms of numbers but included many of the future leaders of CPE. In 1925, Boisen recruited a Union Theological Seminary student and doctor by the name of Helen Dunbar and four other students for the first clinical pastoral training group. In 1926, four more students came. In the spring of 1927, Boisen adjusted the placement schedule, sharing one attendant position between two students, thus structuring more time for both clinical service and study. In 1928, Boisen had twelve students for the summer, including Don Beatty and Philip Guiles. Both would influence the organizational developments of CPE profoundly. Of Guiles, Boisen writes, he “stayed on with us and had a leading part in the organization of the movement. He was a charming person of farseeing vision and contagious enthusiasm who had much to give.”246 The summer of 1929, Boisen’s program grew again, now with 16 students. At the same time, Beatty left to establish a new training centre in Pittsburgh City Home and Hospital at Mayview.

The year 1930 saw the initial efforts at institutionalizing or structuring the clinical education movement. According to Seward Hiltner, another influential student of Boisen’s who would later work to reclaim aspects of Boisen’s work, the establishment of the “Council for the Clinical Training of Theological Students” was when the movement got a “constitution and by-laws, officers, minutes, and some very strong and not entirely compatible personalities.”247 But it is here, and most likely because of those personalities, that one finds a clear indicator of Boisen’s diminishing influence and place in the movement. The 1930s organizational choices for leadership place Boisen not as president, but as secretary. Cabot took on the presidency and Philip Guiles, field secretary. Helen Dunbar became the first medical director of the council.248

245 Thornton, 60.
246 Boisen, Out of the Depths, 163.
248 Boisen, Out of the Depths, 167-168; Hall, Head and Heart, 18.
Boisen’s presence on the executive was short lived. In November, just six months after the council was established, Boisen had another acute episode of mental illness. This one Boisen claims was caused by “some complications in my relationship with Alice” Batchelder.\footnote{Boisen, \textit{Out of the Depths}, 169. Asquith interprets Boisen’s mother’s death, which happened five months prior, as possibly being a “contributing factor.” Asquith Jr, “The Clinical Method of Theological Inquiry of Anton T. Boisen”, 23.} Sensing the onset of emotional difficulties, Boisen proactively handed over his program responsibilities to Philip Guiles as his behaviour had become ever more erratic. Following psychotic “promptings” he travelled to Exeter New Hampshire to visit a cousin, and then back to New York. He then took a train to Boston, and visited Dr. Cabot, speaking about himself in the third person. Cabot, Boisen writes, “was much alarmed and saw to it that I was at once hospitalized.”\footnote{Boisen, \textit{Out of the Depths}, 170.} Hospitalization would last less than three weeks.

When Boisen returned to active ministry he already knew that his breakdown had caused disastrous social effects that, in turn, also caused “damage to the project.”\footnote{Ibid., 171.} By this Boisen meant that Cabot’s reaction to this mental breakdown only made explicit Cabot’s longstanding disagreement with Boisen’s core thesis.

Dr. Cabot, the president of the new “council” was particularly aroused. He had throughout been opposed to the psychogenic interpretation of mental illness. My views now became abhorrent to him. He decreed that I must have nothing to do with the program of instruction. Phil Guiles supported him in this. Dr. Dunbar stood by me and saved the day as far as I was concerned.\footnote{Ibid., 171.}

Thus it was not only Boisen’s ideas that were now being unambiguously marginalised; Boisen was too. He writes, “Phil Guiles, naturally enough, felt it important to have me out of the way, and he started to raise money among my friends in order to send me to Europe.”\footnote{Ibid., 171.} Boisen however managed to stay in America, and taught one more summer session at Worcester in 1931, this time with 20 students; but the substantial growth in CPE was now with the work of
Guiles who established three new training programs. The distance between these camps continued to grow, culminating in a formal Cabot/Boisen split in 1932. Dr. Dunbar who was initially supportive of Boisen, moved the Council for Clinical Training to New York. Boisen left for Chicago to be a chaplain and run a clinical training program at the psychiatric Elgin Hospital. Cabot and Guiles remained in New England. Later, in 1944, this New England group incorporated as the Institute of Pastoral Care.254 Raymond Lawrence suggests this change marked the beginning of the development of “two centers of power in the clinical pastoral world, New York and Boston. They each had a different philosophy and they were competitive with each other.” 255 The split would last till the late 1960s.

More than just an issue of Boisen’s breakdown and Boisen’s commitment to a functional and psychogenic approach to mental illness, the split also reveals a key difference in therapeutic philosophy. While Cabot supported Boisen’s early entrance and work into mental hospitals, Boisen reveals “it is very clear that he [Cabot] did not believe that a religious worker could do anything beyond giving comfort and consolation.”256 Cabot’s primary “emphasis was on the application of theology in a clinical situation,”257 a “theology brought to the bedside.”258 Boisen understood that there could be theology via the living human document living with mental illness, and that some mental illness was potentially an adaptive religious experience. As Ciampa states in his analysis

the fact that the progenitors of the Clinical Pastoral Education, Boisen and Cabot, came down on opposite sides of this fence was, perhaps, to blame for a lot of the major division which characterized the first three decades of the movement.259

254 Thornton, 82.
256 Boisen, Out of the Depths, 149.
257 Hall, Head and Heart, 8.
259 Frank Ciampa, "Who We Were: A Survey of the History of the Pastoral Care, Counseling and Education Movement" http://www.pastoralreport.com/the_archives/2005/04/who_we_were_a_s.html [accessed June 10, 2011].
One effect of this was the waning commitment to Boisen’s original mental health focus. While some training in mental hospitals continued, the primary education goals were shifting beyond the mental health environment. Evidence of this is captured in the 1948 minutes documenting permission for the very first mental health hospital training program under the auspices of the New England based Institute of Pastoral Care reveal “that members of the Board were anxious this led to a shift away from the study of ‘normal people.’”260 Ironically this permission was being granted for the very hospital where Boisen began his work, the Worcester State hospital. In other words, the Institute saw its core work not among study and care of the mentally ill which were Boisen’s priority, but in the development of more mainstream care.

The Council for the Clinical Training of Theological Students also had its own challenges. Seward Hiltner, whom Boisen appreciated, advocated as director of this council from 1935-1938 for “theological reflection about human experience.” But Robert Brinkman, who followed him as director from 1938 to 1946, “emphasized science and psychology and subsumed the importance of pastoral theology.”261 In the summer of 1945, Boisen was given a formal responsibility as an educational consultant for the Council for the Clinical Training of Theological Students. This involved visiting fourteen training programs, “giving them such help as they might be ready to accept.” But Boisen writes, “It was a challenging opportunity, one which gave me a chance to take another look at the movement which I had helped to start some twenty years before.”262

What Boisen found troubled him.

I discovered quickly that the other centers had been developing along lines different from those which Beatty and I had followed. Most of them at that time were still using my case records as a basis for some of their case discussions, but increasing attention was being given to the techniques of interviewing and to verbatim transcripts of interviews rather that to case histories.263

260 Minutes of the Board, June 1948, Institute of Pastoral Care. Cited by Thornton, 204.
262 Boisen, Out of the Depths, 185.
263 Ibid., 185.
The move to the “verbatim” is also reflective of the Boisen/Cabot split. The innovation can be traced to Russell Dicks, who differed from Boisen in two ways: first he believed that the clinical training program should also take place in general hospitals “since most of the patients to which pastors would be exposed to in their ministry would be in general hospitals;”264 Second, Dicks created the verbatim, one that would endear him to Cabot and substantially challenge Boisen’s interest in case histories. Historian Hall writes that Dicks invented one of the most ubiquitous teaching tools in clinical learning: the verbatim. In searching for a way to document his work and reflect on it, he began writing down everything he and the patients said to one another. This impressed Richard Cabot. After his first summer there in 1933, Cabot said of him: “Here is a man that writes down the conversation and prayers he has with a dying man. That’s the craziest thing I’ve ever heard of. We’d better ask him to stay on. We might learn something.”265

Boisen saw verbatim accounts as much less than detailed case histories which he understood as a way of engaging the real material of the patient’s life in detail, of getting to the bottom of the experience and the cause of the symptoms the crisis revealed. For Boisen, the verbatim emphasized the techniques of interviewing at the expense of real research. Boisen phrases his worry this way: “My only question had to do with a lessened interest in case histories. Might it not mean a lessening of interest in the basic understanding of the experiences involved?”266

Boisen responded explicitly to these trends in his own list of goals for the clinical training he was offering in 1946. His mimeographed book to students began with a clear and concise description, the context of which betrays the contemporary trends of which he disproved:

This course is far less concerned with the consideration of techniques and skills than with the effort to discover the forces involved in the spiritual life and the laws by which they operate. It seeks to lay a foundation for the co-operative attempt to organize and test religious experience and to build a theology on the basis of a careful scrutiny of religious beliefs.267

264 Ciampa.
265 Hall, Head and Heart, 22.
266 Boisen, Out of the Depths, 185.
267 Anton T. Boisen, "Types of Mental Illness: A Beginning Course for Use in the Training Centres of the Council for Clinical Training of Theological Students (Mimeographed)," The Henri J.M. Nouwen Archives and
Boisen’s autobiographical summary of this period also captures his concerns about other influences characterising clinical pastoral education. Along with the lessening of interest in case histories, Boisen describes how his work as an educational consultant revealed an increase in “genetic emphasis” in understanding patient lives such that genetic determinism, along with an interest in oral and genital stages of development became, in his own words, “gospel in most of the centres.” Coupled with a preponderance of theories about childhood trauma, Boisen laments that:

The significance of the experience which has brought the patient to the hospital, the frustration out of which it grew, and the type of reaction it represented were sometimes practically ignored or treated as matters of secondary concern, while the dynamic factors with which religion is primarily concerned were being left in some of the centres for a three hundred question barrage at the end of the course.268

Boisen’s concern was that psychoanalytic approaches were being accepted uncritically and applied in a way that challenged his fundamentally empirical method. Note his use of the word “doctrine” as he writes:

This meant that there was a tendency to accept Freudian doctrine on authority without scrutinizing it closely, and a failure to ask the questions which are of first importance to the student of religion.269

To make his point even clearer, Boisen laments the retreat from cooperative enquiry and sees in the current training and practice a tendency to accept psychoanalysis as “solutions to some of the perennial problems of sin and salvation.”270 In his 1943 article, “The present Status of William James’s Psychology of Religion,” Boisen criticized these reductionist approaches which had their origins with certain aspects of Freud who considered religion as “a neurotic

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268 Boisen, Out of the Depths, 186.
269 Ibid., 186.
270 Ibid., 186.
Boisen criticised those followers who pursued Freud’s idea to the point of eliminating any therapeutic value to religion. Boisen saw his origins in the clinical pastoral training as a return to James. “As originally formulated, this movement saw in mental illness a problem which concerned the student of religion and minister of religion quite as much as it did the medical man.”

Boisen’s biography also reveals concern about teaching styles, including CPE’s turn to the student. Boisen comments on the rise in “prevailing concepts of group dynamics” and how, “according to the current views, good teaching must be student centered and never content centered;” and how “the teacher himself should be an umpire rather than an explorer and guide. I had,” Boisen adds in what gives a real glimpse into his personality and teaching style, “difficulty adapting myself to the view that the teacher should remain passive.” Certainly Boisen’s personality could be abrasive. Nouwen identifies how even those students who admired him, “were often strongly irritated by his rigidity of thought and sometimes even experienced him as a hindrance in their own professional development.”

Boisen never adapted to nor endorsed these changes. He remained singular and had repetitive preoccupations. While he bemoaned the lack of content in these new innovations, he never successfully achieved a return to his methods by the movement.

Boisen’s final grievance lamented a failure to better embed clinical practice in theological schools. Its place in his critique bears consideration. Boisen’s discussion re-centres the conversation and critique on the importance of his theological approach. In a very pointed address, he notes how the theology schools saw clinical training as adding another course, and when it got added, it usually got added as “personal counseling.” This privatised psychotherapeutic focus clearly missed the point for Boisen. He believed that the movement was

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272 Ibid., 157.
274 Nouwen, ”Anton T. Boisen and Theology through Living Human Documents,” 49.
275 Boisen, Out of the Depths, 187.
never about establishing a pastoral counselling technique but rather a radical method for theological training for seminaries that was linked to the mental health centre. He believed he was still trying to call attention back to the age old problems of sin, salvation, of prophetic inspiration. What was new was the approach. In a time when students of religion were making little use of the methods of science, and scientists were failing to carry their inquiries to the level of the religious, we were seeking to make empirical studies of living human documents, particularly those in which men were breaking or had broken under the stress of a moral crisis. We were proposing to alter the basic structure of theological education.276

Thornton’s own history underscores this problem. In his concluding considerations on the place of professional competence in the field of personal ministries, Thornton identifies how the integration of CPE into the theological schools, while increasingly commonplace, was in fact, quite inadequate when it came to achieving the goals of CPE. By 1970

CPE is being required by more and more seminaries. But ordinarily, the requirement is for one quarter or less..... Clearly, one quarter of clinical pastoral education grafted into standard theological education is not the answer.277

**Boisen’s Lonely but Productive Retirement 1942-1965**

There is value in returning to Thornton’s historical assessment of Boisen as one who is “essentially alone,” as a man who “stands in history, as in life, somewhat apart, a problem to others as well as to himself.” 278 Indeed, Boisen faded progressively to a certain and real historical isolation from the clinical pastoral education movement. His final five years were marked by fragile mental health including occasional suicidal ideas, moments of paranoid fears. While he died with profound appreciation for the Elgin mental hospital which he called home for all these years, his death was barely noted in the pastoral literature.279 Thomas Klink’s

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276 Ibid., 187.

277 Thornton, 234.

278 Ibid., 54, 55.

observations about the burial of his ashes on October 6, 1965, symbolises just how alone Boisen was at his end.

The Elgin State Hospital cemetery lies half-way between the "back hospital" and the Farm Colony. It is reached by a gravel track around the water tower, past rusting piles of old-issue hospital beds, and two raw gravel pits. On the low hillside a bulldozer labored without pause; over the ridge a pile of burning refuse billowed dark smoke. The burying ground itself is neat, almost inconspicuous. There is a low, pleasant carpet of native grass. There is a fence, a hedgerow to the north, a gentle slope and rows of plain grave markers. The filled space occupies only a bit more than half of the enclosed plot. This is unspectacular waste ground and the hospital seems to use it as repository for that which has lived out its usefulness.

The scene was not spectacular, today. The weather was modestly autumnal and the sky just ordinarily overcast. Except for the cluster of awkward mourners—forty or fifty persons including Chaplain Charles Sullivan, Professor Victor Obenhaus (who, respectively, read the requested service and the obituary), a few patients, a handful of friends, a few hospital staff, a little group of ex-students—it was an unremarkable state hospital burial.

There were no tears.

There was little conversation, little drama.

But, because he lived and suffered and imposed his always-distant urgency on others, some of the living seem less likely to be scattered as burned-out ashes "back of the hospital," over the fallow waste ground.280

These final years were, however, anything but unproductive for Boisen. In fact, his return to Elgin psychiatric hospital was part of his retirement plan, not as a patient but at the invitation of the administrator. From 1942 Boisen dedicated himself almost exclusively281 to research. During these years, Boisen published many articles and three major works, a period of incredible productivity and creativity. As Nouwen notes:

In 1946 his book, Problems in Religion and Life, appeared; in 1955 his work, Religion in Crisis and Custom, found a publisher and, finally, in 1960 his autobiography, Out of the Depths was completed. There is no doubt that Boisen

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281 Except for 3 years, between 1951-54 where he filled in as chaplain until a replacement for Chaplain Eichorn could be found. But even there, Boisen writes, “I did, however, find time to do some writing.” Boisen, Out of the Depths, 193.
shows an astonishing vitality and creativity in the last twenty-five years of his life.\textsuperscript{282}

Boisen himself saw his major contribution at this stage of his life to be his writing;\textsuperscript{283} the essential content of which Nouwen summarises as the consolidation of his case studies, a kind of effort to “safeguard his basic idea …. in the hope that the case method would remain central in the training centers.”\textsuperscript{284}

This section has argued Boisen’s basic form of the case method with his focus of using it for the detailed presentation and understanding of a patient’s mental health issues as potential religious experience never did survive implementation in CPE in the way Boisen intended. In fact, the movement changed its focus from patient to student and from religious experience to interpersonal development. “Without a doubt, there occurred a refocusing of CPE during the 40s away from the patient and toward the student, with due regard for the problems involved.”\textsuperscript{285} By the 50s and 60s, the developing paradigm of attending to living human documents essentially moved to one of supervision of students, their “problems of personhood, and the associated problem of interpersonal relationships.”\textsuperscript{286} Those changes brought with them vital dialogue in CPE circles about two main things: the place of theology in the pastoral task and a developing awareness that the movement was becoming a profession; the latter issue bringing with it new concerns about the meaning of professional identity.

It was not until 1967, two years after Boisen’s death, that the two branches of CPE merged, taking on the new name, Association for Clinical Pastoral Education; but this did not resolve the underlying and very much still percolating issues. Thornton’s own conclusions in his 1970 study reflected the future implications and choices required for resolving these tensions. In language remarkably similar to Boisen’s own language of “loyalties,” Thornton suggested that

\textsuperscript{282} Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 62.
\textsuperscript{283} Boisen, \textit{Out of the Depths}, 188.
\textsuperscript{284} Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 62.
\textsuperscript{285} Powell, \textit{CPE: Fifty Years of Learning through Supervised Encounter with Living Human Documents}, 19.
\textsuperscript{286} Ibid., 29.
the future of CPE would ultimately test the maturity of the profession’s capacity to choose its “ultimate loyalties.” He asked:

Which was higher on the clinical pastoral educator’s hierarchy of values: To protect the hard-won gains of professional identity in a unified association, or to risk losing those gains by joining whole heartedly in the fast-breaking, revolutionary remaking of theological education?  

Thornton predicted that “theological education was expected to be the major preoccupation of the new profession as it moved beyond unification.” In this he was partly right. These issues continued to be debated well into the 80s and 90s with special emphasis being placed on the role of theology, either as rediscovered, reclaimed or re-interpreted in the pastoral care task. A survey of the literature points to this concern: For example, in 1981, Alastair Campbell called for a “rediscovery” of pastoral care because of “a contemporary confusion about the true nature of Christian caring and by a feeling of alienation from traditional understandings of the pastoral task.” Around this time, Thomas Oden called for a return to classical theological language and practice. He took issue, among other things, with “an anti-theological style of pastoral care.” In 1984, Charles V. Gerkin looked for a middle way through this tension seeing both aspects of the debate as “tools of interpretation.” Calling this a “re-visioning” in a “hermeneutic model,” he proposed a “process of interpretation and re-interpretation of human experience within the framework of a primary orientation towards the Christian mode of interpretation in dialogue with contemporary psychological modes of interpretation.”

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287 Thornton, 196.
288 Ibid., 195.
A Future Marginalisation: CPE and Corporate Religious Mission

Prophetically however, Thornton’s analysis identified a more important foundational concern: that the question about clinical pastoral education’s commitment to theological education

assumes that clinical pastoral educators are less ultimately concerned about self-development and self perpetuation as a group than about a corporate mission [emphasis added]. It assumes that the mission has to do with being educators for the leadership of religious communities.292

With this insight, Thornton simultaneously returns to the historic religious grounding vision of clinical chaplaincy and raises the possibility of its vulnerability: CPE’s commitment to theological education rests on a primary assumption about a corporate religious mission.

Thornton’s work does not explicitly reveal if he ever considered that clinical pastoral education could or would abandon this basic assumption just that CPE naturally grows from it. Thornton does reveal that his own bias about the relationship between clinical pastoral education and theological education changed in the writing of his thesis.

Ten years ago [1960] when I first began writing a history of clinical pastoral education, my hidden agenda was to prove that clinical pastoral education really ought to be domesticated by affiliation with theological education. Today, my now open agenda is to fan the fires of adventuresomeness, to encourage mavericks, to tend the radical spirit in those seminarians who may read a history of clinical pastoral education only because they are required to take a course in “clinical.” We may affiliate with theological education for our own security, to enjoy the privileges of the establishment, or we may affiliate in order to accomplish the revolution that fired the imagination of the founding fathers.293

It is my suggestion that Thornton’s articulation of the basic assumption represents an early and critical insight into where that revolution could lead; that CPE’s faith based corporate mission can no longer to be taken for granted.

In this new century’s conversations, as developed in the introduction of the dissertation, there is evidence that the new discipline now often called spiritual care is progressively

292 Thornton, 231.
293 Ibid., 232.
abandoning its core theological reference and religious commitment. In its contemporary turn to what it means to be human, strictly within the paradigm of a scientific, secular and medical model, its *existential* turn to an immanent understanding of being human threatens to further remove it from theological education, per se. As argued by Elaine Graham, “pastoral theology may in part be an enquiry into what it means to be human, but its traditions also insist upon a Divine or transcendent dimension to human affairs and Christian practice.”

Thornton’s comments on the necessary and basic assumptions of the movement, when viewed in light of this contemporary history, indicate prophetic insight on his part.

**Preliminary Conclusions**

By way of preliminary conclusions, it is important to return in particular to Boisen’s own place in the early organizational developments of clinical pastoral education. Thornton is partially correct to suggest he was essentially left behind, primarily because Boisen never was able to turn the corner from movement to profession, to enlarge his concerns, and to enter the mainstream of the seminary task of educating men both for personal authenticity and for functional competence. Boisen resisted the professionalising trends.

Indeed Boisen “never did turn the corner” from his own concerns. His own critique, as evidenced in his biography, is detailed proof that his passion for the study of religious experience, its relationship to mental disorder, his ideas about the complexity of the mentally ill person’s ultimate loyalties, and the role of the Church’s ministers alongside the other medical professionals never gained primacy of place in the way he hoped.

Boisen’s journey to the periphery is not however the entire story. Around this very time, new scholarship was emerging that attempted to re-interpret Boisen precisely because his original ideas might have within them corrective value to some of the ways the professionalised movement was developing. The work of Pruyser and Nouwen tell this story. Their observations suggest that the contemporary situation of chaplains called for a different reading of Boisen’s

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294 Graham, 88.
295 Thornton.
work: that some of Boisen’s foundationally innovative ideas were a casualty of his move to the periphery.\(^{296}\) In this next section, I will present Pruyser’s observations and recommendations on the role of the clinical psychiatric chaplain, in the 1960s and mid 1970s, as his attempt to explore and adapt the life and work of Boisen in light of these issues.

**Paul Pruyser: Reclaiming Anton T. Boisen’s Innovation of the Psychiatric Chaplain**

Originally from Amsterdam, Holland, Pruyser immigrated to the United States to pursue doctoral work. He graduated with his PhD in psychology from Boston University in 1953. From 1956 and for the rest of his life, Pruyser was employed at the Menninger Clinic, Topeka, Kansas. He held various roles, first hired as a clinical psychologist, then assistant to Dr. Karl Menninger, and at the time of his death in 1987, director of its Interdisciplinary Studies Program. Honoured by many academic appointments in medical schools, intellectual and professional societies, and a consultant to psychological as well theological schools, Pruyser was prolific, authoring “five books, 27 book chapters, and more than 80 journal articles.”\(^{297}\)

Pruyser’s interest in the innovative value and promise of Boisen’s historical creation of the mental health chaplain reflect Pruyser’s own commitment to developments in the psychology of religion and psychoanalytic discourse. For this he was well placed. The Menninger Clinic, since its founding in 1925, attempted to lead a revolutionary approach to “a better kind of medicine and a better kind of world.” America’s first group psychiatry practice, founders C.F, Karl, and Will Menninger “believed that persons with mental illness could be treated and helped at a time when custodial care or lifetime exile were the only alternatives.”\(^{298}\) As early as 1954, the Menninger centre established training programs “for scholars in theology and psychiatry and for clergy in pastoral care and counseling.”\(^{299}\) Pruyser played an important role in the

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\(^{296}\) See also Seward Hiltner, "Debt of Clinical Pastoral Education to Anton T. Boisen," *Journal of Pastoral Care* 20, no. 3 (1966): 129-135; Steere.


\(^{298}\) Menninger Clinic, "The Menninger Website " http://www.menningerclinic.com/about/Menninger-history.htm [accessed May 2, 2011].

\(^{299}\) Ibid.
development of this program, and his supervision of such clergy was central to his contribution to the field of pastoral care.

Contextually Pruysers is separated by a full generation from Boisen and never worked with him. They did meet once for several days when Boisen was 83 years old at a lecture Pruysers gave in Chicago that included reference to the innovative quality of Boisen’s work, especially his creation of the psychiatric chaplain. By the time Pruysers began his clinical work in America in 1953, the clinical pastoral education movement had already essentially lost any direct control and influence from Boisen. But especially because of Pruysers’s close relationship with Seward Hiltner, a student of Boisen’s and one of the theological and pastoral care scholars invited to consult at the Menninger’s, Pruysers was privy to both the internal strife of the clinical education movement and Hiltner’s own efforts to bridge the gaps. They co-taught concerning clinical training issues in the 60s, 70s and early 80s. The core of Pruysers’s writings that refer to Boisen cover the 1960s to the mid 70s, with some reference in the 80s.

Pruysers’s Essential Writings in Regard to Boisen


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300 Pruysers, in personal correspondence to Henri Nouwen dated August 15, 1967 reports that Boisen was in the audience when Pruysers presented his paper “Some Trends in the Psychology of Religion” for the Society for the Scientific Study of Religion, in Chicago, in the spring of 1959. Pruysers reports that “Boisen attended the meeting, and after I had given my presentation, in which I had praised his work highly, he came to see me, to shake my hands, and to engage in conversation. I drove with him late that evening in a taxi to one of the downtown hotels where he stayed. For the next several days he arranged for me to go with him by car to Elgin State Hospital where he lived, and where he asked me to make a few presentations to the staff, to the chaplains in training, and to the Psychology department. On all these occasions he served as my official host.” Paul W. Pruysers, "Letter to Rev. Dr. Henri Nouwen," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives, (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1967). The lecture Pruysers gave was latter published as Pruysers, "Some Trends in the Psychology of Religion," 113-129.

301 Pruysers, "Some Trends in the Psychology of Religion."

302 Pruysers, A Dynamic Psychology of Religion.

in the psychology of religion, and religion in psychiatric settings refer to the creative work of Boisen. In 1971, Pruyser wrote, “Assessment of the patient’s religious attitudes on the psychiatric case study.”304 In 1972 he wrote, “The Use and Neglect of Pastoral Resources.”305 Four years later, after substantial contact with and observation of the many chaplains who were among his professional students (psychiatrists, social workers, psychologists, etc.) at Menninger’s, Pruyser wrote the book *The Minister as Diagnostician: Personal Problems in Pastoral Perspective*, a text intended to speak directly to the problematic of the place and importance of a pastoral perspective in mental health work. In 1984, almost 60 years after Boisen’s debut in mental health care, Pruyser wrote an article titled, “Religion in the Psychiatric Hospital: a Reassessment.”307 He noted there that this anniversary of Boisen’s provided an important opportunity to revisit “how little attention has been given to ways of dealing with religion in the mental health hospital.”308

This listing of the relevant writings reveals two important contextual points. When Pruyser engages Boisen, it is primarily directed at how best to manage the interface of religion in the new psychiatric hospital. In one respect therefore, his approach is contextually clinical and practical. But given Pruyser’s intellectual breadth, his use of Boisen is also philosophically analytic in terms of developments in psychiatry as a discipline. It should not be forgotten that Pruyser was co-author with Karl Menninger and Martin Mayman in their 1963 seminal work, *The Vital Balance*.309 This work attempted to shift psychiatry’s interface with mental health from a static approach to a more dynamic one where “balance” was key. This is what Menninger et al.

305 Pruyser, "The Use and Neglect of Pastoral Resources," 5-17.
308 Ibid., 5.
called “homeostasis,” an idea characterised by an approach which saw recovery from some mental illnesses as possible. This approach underscored the complexity of relationships (intrapsychic, familial, social, cultural etc.) at play in the mental illness experience. It placed little emphasis on the rigid application of static psychiatric labels. Their interest was on the vital process of better understanding “personality dysfunction and living impairment.” Mental illness, from this perspective, was not so much “a thing at all but an aspect or quality of life at a particular time under particular circumstances.”

It is legitimate to ask if Boisen’s ideas do not reflect a historical kind of prophetic synchronicity with Pruysers’s work at the Menninger’s. In 1968, Lefevre certainly suggests this “contemporary ring” when he writes that

Boisen conceived of mental illness as a problem solving experience. It was fundamentally a purposive and adaptive effort at reorganization. At the root of functional mental illness lay the disorganization of the patient’s world. Psychosis is one of the ways in which an individual struggles ... to cope, to restore or create equilibrium. Here Boisen’s own views clearly foreshadow those current in such discussions as Menninger’s Vital Balance, and R.D. Laing’s comment in his brilliant book, The Politics of Experience, “Madness need not be all breakdown. It may also be breakthrough.”

Pruysers however cautions the researcher from seeing too much of a direct link between Boisen’s ideas and those in The Vital Balance. In a documented but unpublished interview from 1967, Pruysers states that “Boisen did not reach that level of thinking in his days at all and was still very much a victim of those old concepts, that is, the Kraepelian ones.” In fact, Pruysers’s assessment is that Boisen often used other thinkers superficially and only in such a way as they advanced his working out his own story. Bluntly put Pruysers considers Boisen’s explanations

310 Ibid., 81.
311 Ibid., 5.
312 Ibid., 4.
314 Henri J. M. Nouwen and Dwight Norwood, "Paul Pruysers Interview," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1967), 7.
about mental illness to be “entirely too simplistic,” but that does not suggest Boisen’s efforts were without value.

**Pruyser’s View of Boisen’s Breakthrough as “Perspectival”**

What Pruysers portrait of Boisen does underscore, however, is Boisen’s fascination with his own case and how in it, one finds the seeds of new ways of looking at things, a new perspective. In this sense, Pruyser does not provide a systematic presentation of Boisen’s ideas per se. Rather Pruyser situates his analysis by focusing on Boisen’s fascination with his own case. What is original is Pruyser’s conclusion that in Boisen’s desperate search to work out his own case, a critical perspectival breakthrough about the role of religion in mental health care occurred. This included, because of Boisen, a new clinical role for the psychiatric chaplain as the clinical member primarily responsible for that perspective on the clinical team.

Perspective is an entirely critical thing to Pruyser. To follow Pruyser’s intellectual approach means embracing a definitely perspectival view of human experience, in its totality and its expressions. Near the end of his own life and during a time of illness, Pruyser wrote that “reality as a whole cannot be fully defined and is always individually edited.” This perspectival focus was not only true autobiographically, but is also key to understanding Pruyser’s approach to psychology, religion and Boisen. The term “perspectival” is self applied. In his major work, *A Dynamic Psychology of Religion*, he writes that his approach

has been perspectival, not only for the psychology we practice, but for the subject matter we have dealt with in this book, religion. We regard religion as a perspective on things, a certain way of looking at the world and all reality, including ourselves.

In other words, each discipline, each science, has its own perspective. For this reason, Pruyser considered his own work on religion to be one of a psychologist who offers a “perspective of a

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315 Ibid., 5.
perspective" and consistently called for perspectival integrity when religion is studied by other disciplines.

Pruyser’s application of this idea in the clinic is very practical. Pruynser deems it important that different health care disciplines find ways to identify with the perspectives of other disciplines, but not to confuse them. In his work The Minister as Diagnostician, Pruynser develops this idea most explicitly, delving specifically into the practice of ministers of religion: “I shall make a modest endeavour, not quite to integrate two different perspectives, but to bring them into thoughtful apposition to each other.” In this work, Pruynser considers theology as a kind of basic science necessary for the religious perspective. In his 1984 article, “Religion in the Psychiatric Hospital: A Reassessment,” Pruynser clarifies that this engagement is not about fusion of perspectives.

I espouse a perspectival view in which each of the arts, sciences, religion, professions, and disciplines adopt its own thought pattern and language game in order to make reality, and especially the human condition, a bit less chaotic and more understandable.

Pruynser’s position is one of respecting the legitimacy of each discipline, each perspective, all in the service of the patient. But that is not to say there is not some legitimate overlap.

Pruynser also argues for the perspectival view from the existential experience of the patient who knows that his or her suffering does not find exhaustive treatment in any one way.

Only an organized multiplicity of organized disciplines is fit to do justice to human suffering, which is always multifaceted. It is my conviction that all patients know deep down in their bones or bowels that their plight has more than one side, that it cannot be caught in one phrase, that it cannot be exhaustively labelled by a uniform system, and that each chosen approach to the alleviation of their plight can be complemented by another approach, and still another one after

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318 Ibid., 330.
320 Pruynser, The Minister as Diagnostician, 17.
that, almost *ad infinitum*. For human suffering is mysterious and cannot be reduced to a single system of explanations.322

Pruyser therefore argues that the patient requires a “thorough hearing”323 in the psychiatric clinical milieu. His approach argues for collaborative mental health care where every discipline does its equal part in the diagnostic process such that it is able to define clearly particular problems for which its help is asked.324

And let us be frank about the crucial point that not a single one of the collaborating disciplines and professions has a corner on holistic thought or action—all team members have been trained to be specialists and to identify themselves with what they think a nurse, a psychiatrist, a social worker, an occupational therapist, a music therapist, a psychologist, or a chaplain should and can do, with loyalty to their own discipline. But they also proceed with fidelity to the team whose main task is to bring about transformations in the patients' presenting conditions, in the direction of betterment.325

Striking such a balance on a multi-disciplinary team is, Pruyser admits, not easy for at least two temptations work against it: the first is to sharpen the differences between disciplines, and the second is to level them. Sharpening of differences essentially reduces any sense of unity among the diversity of disciplines. This approach “leads some to put religion exclusively to the chaplain as the acknowledged and appointed expert in that perspective on humanity.”326 In this way, all others avoid religion as if there is no legitimate overlap in the presentations of the patients. Levelling does just the opposite. In this approach every one “gets busy with religion”327 but the lack of particular specificity and expertise is lost.

322 Ibid., 6-7.
324 Ibid., 448.
326 Ibid., 7.
327 Ibid., 8.
What Pruyser is trying to do is protect the integrity of a perspective. Pruyser’s article “Some Trends in the Psychology of Religion” documents about 50 years of the history of psychology’s relationship to religion ending in 1960. Here he cites Allport who proposed that “a narrowly conceived science can never do business with a narrowly conceived religion. Only when both parties broaden their perspective will the way to understanding and cooperation open.” Pruyser’s point about the necessary integration of all clinical perspectives, including the religious and theological, challenges by implication the notion the contextual challenge that people living with severe mental illness only need psychological or psychiatric help. In his 1976 text, *The Minister as Diagnostician*, Pruyser addresses this directly wondering whether this “triumphalent” [sic] idea does not “proceed from a peculiar tacit assumption, namely that theological ideas become inoperative in the face of serious mental turmoil?” On this issue, he explicitly targets his criticism toward pastors who fail to make theological diagnosis but make referral to psychiatric services when there is a perceived “seriousness of the disturbance.” Pruyser’s point is not that he is anti-referral but that it is possible to assess the same “complex personal problems” from “several different perspectives at once.”

This perspectival emphasis is remarkably prophetic, given the current challenges outlined in the introduction related to the funding of explicitly theological and religious chaplains as full time members of clinical teams. Pruyser warns against the temptation by some hospital systems to bring ministers and priests on board as “religious officers” or on a fee-for-service kind of basis. Pruyser is referring to the practice of hiring them “part time, to hold religious services for...”

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328 Pruyser’s insight here is reflected in contemporary times in the work of Kenneth I. Pargament (b.1950), psychologist and researcher on religion, spirituality and mental health. In his book, *Spiritually Integrated Psychotherapy*, he writes, “I have warned against attempts to “explain spirituality away” by reducing it to seemingly more basic psychological, social or physical processes. Instead I have insisted that spirituality be understood and addressed as a legitimate dimension of human experience in itself.” Pargament, *Spiritually Integrated Psychotherapy*, xi.


331 Pruyser, "The Minister as Diagnostician,” 3.
the patients, to serve some public relations purposes.”

Pruyser’s underlying point about some hospital systems historically bracketing off the religious perspective is prophetically accurate today. Pruysr’s argument is that “Boisen changed all that by insisting on special clinical training for such dignitaries and by turning the chaplaincy into a functional direction and a specialized career choice.”

**Pruyser’s Portrait of Boisen as a Diagnosing and Organizing Minister**

In Pruysr’s view, Boisen had two major tasks for his trained chaplains: “[1] To make diagnostic investigations about the patients’ religious histories, ideas, feelings and practices, and [2] to make the patients’ otherwise dull lives in the hospital stimulating and rewarding.”

Pruyser’s reclamation of the historical Boisen reveals two things: on the one hand, specific attention by the minister to diagnose the patient’s religious history and, specific attention by the minister to help organize the mentally ill persons’ lives. But what are the roots of this twofold task of the minister and how does Pruysr develop these tasks?

To answer this, Pruysr argues that one must first probe deeper into Boisen’s fascination with his own case which characterise virtually all his writings and the changes taking place in his historical context. The way that Boisen interpreted his own case cannot be understood, Pruysr argues, outside of these revolutionary psychological developments. They profoundly shaped Boisen’s own approach. Pruysr’s critical analysis provides helpful context because he is “a prime spokesperson for understanding religion through sympathetic psychoanalytic eyes.”

A noted expert and critic of the groundbreaking work of James, Pruysr understood that, after the subsequent developments of R. Mueller-Freienfels, Freud, and Jones,

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333 Ibid., 9.
334 Ibid., 9.
337 Pruysr did have critical concerns though about some early trends in the first psychiatric revolution. Beginning with William James, whom Pruysr deeply admired, Pruysr concluded that while James’ legacy is of
perhaps the most significant contribution of psychoanalysis to the psychology of religion is its insistence upon the role of conflict in religion, and of religion in conflict, personal as well as social. Religion can now no longer be seen as an isolated item or parcel of experience but as a quality of an individual’s experiencing the world and himself; it can be defined as a way of problem solving.338

This approach essentially saw religious experience not as a static state but as a social process involving interpersonal relationships. These ideas brought a significant engagement with personality issues, including adjustment issues and opened the clinic’s doors to existential concerns and considerations. Like Pruys, pastoral historian Holifield notes these ideas characterised Boisen.

Implicit in [Boisen’s] outlook and in that of his successors was an ethical and theological vision, which defined the self with metaphors of struggle, conflict, impulse, non-rational feeling, and inner chaos.339

Pruys identifies how from as early as Boisen’s hospitalization in 1920 and as late as Boisen’s autobiography, there is evidence that Boisen was trying to understand his mental illness in the midst of the first psychiatric revolution, namely the “discovery and application of psychoanalysis.” Boisen was introduced to Freud’s *Introductory Lectures* through his friend Fred Eastman who sent them to him during this first hospitalization. Thanking Eastman in a letter dated December 11, 1920, Boisen makes the synchronicity clear:

Freud’s conclusions are so strikingly in line with those which I had already formed that it makes me believe in myself a little bit once more. I refer in particular to two propositions: He stated in the first place that neuroses – i.e., abnormal, or insane conditions have a purpose. They are due to deep seated conflict between great subconscious forces and the cure is to be found not in the

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339 Holifield, 245.
suppression of the symptoms but in the solution of the conflict. That is just what I tried to say in my last letter.341

What Pruyser underscores here is that it is not difficult to see how a “problem solving” approach would have been of interest to Boisen and how psychoanalytic concepts were, for his case, full of potential.342

However, Pruyser is careful not to over exaggerate Boisen’s understanding of the primary authors responsible for the psychoanalytic revolution. Although Boisen read these authors, Pruyser draws attention to Boisen’s highly selective approach and the way he would often repeat the same excerpts.343 Pruyser maintains that links to these authors are best understood as reflective of Boisen’s determination to find whatever he could to help make sense of his own case. In fact, Pruyser cautions against “the great temptation to try and research the influence of the writings of Freud, Jung, Sullivan, Mead, Dewey, and of others on the writings and thinking of Anton Boisen.”344 Pruyser concludes that Boisen was likely attracted specifically to psychoanalytic thought for three “ideological premises.”345 Firstly, Freud’s open study of sexual behaviour was welcomed by Boisen, especially for his own history of sexual maladjustment, well documented in his autobiography.346 Secondly the psychoanalytic theory of a “developmental and dynamic continuity between child and adult, healthy and sick, normal and

341 Boisen, Out of the Depths, 103.
342 Contemporary pastoral theologian and writer Pamela Cooper-White is among those who are retrieving and redefining elements of psychoanalysis from the modern pastoral care and counselling period, especially the concepts of transference and counter-transference, for the postmodern period. Reaching back into the history of pastoral care to highlight this element, she argues that Boisen “believed in the existential value of psychoanalytic self-exploration.” Pamela Cooper-White, Shared Wisdom: Use of the Self in Pastoral Care and Counseling (Minneapolis: Fortress Press, 2004), 27.
344 Nouwen and Norwood, "Paul Pruyser Interview."
346 For development of this idea, see Raymond J. Lawrence, Sexual Liberation: The Scandal of Christendom, Psychology, Religion, and Spirituality, (Westport, Conn.: Praeger Publishers, 2007), 96-104, 153. Raymond Lawrence documents ten biographical references to argue that Boisen’s life story can be read both as a history of sexual maladjustment and as a contributing factor to sexual liberation and revolution in American Protestantism. Ibid., 96-104, 153.
deranged,” paved the way to a certain blurring of the questions about what is normal and abnormal. Thirdly, for Boisen, psychoanalytic thought gave rise to a more psychodynamic idea that “the mentally ill are not hopelessly fixed in their miserable condition,” an idea to which Boisen was very committed in his effort to understand his own case.

Boisen’s use of this psychodynamic context reveals a very strategic move in his obsessive effort to understand what was happening to him. This shift was to re-evaluate the meaning of pathology. Boisen reappraised psychopathology and religious experience as essentially integrating phenomena. Pruyser writes that in Boisen’s groundbreaking book, *The Exploration of the Inner World*, Boisen put a new stamp on psychopathology and religion by placing both in the framework of the life-crisis. Religious experience can best be understood if it is seen in the same order of intensity and depth that attaches to severe mental illness. Both are processes of disorganization and reorganisation of personality, of transformation, dealing with man’s potentialities and ultimate loyalties.

This central existential idea here cannot be overemphasized. Rather than treating psychopathology itself, and any religious sounding expressions of it as some kind of denial of existential reality, Boisen reframes the problematic. Boisen’s approach “places religious experience functionally and experientially most clearly at the nexus of holistic, integrating tendencies of the organism.” Religious expression is understood here as reality.

Nevertheless, Pruyser has concerns with how Boisen develops this strategic breakthrough. The central problem that Pruyser identifies is that Boisen’s division of the mentally ill into “organic” and “functional” illnesses is too strict. Boisen was unable to break out of the categorical definitions and labels of the Kraepelin system which were already under attack for their rigidness in Boisen’s day. And so, while Boisen’s thought appears very progressive in some areas, Pruyser reminds the reader that in this area Boisen’s actual understanding is very

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347 Pruyser, "Anton T. Boisen and the Psychology of Religion," 211. This line of argumentation is also pursued by Steere: 360.


349 Ibid., 11-12.

350 Ibid., 12.
limited and ultimately self serving. One reason Boisen may have wanted to maintain Kraepelin’s system is that it offered a diagnostic label, namely the catatonic type for schizophrenia that made sense to Boisen’s experience because this diagnostic presentation offered the possibility of a certain kind of recovery. As noted by Steere, “Pruyser has pointed to Boisen’s lasting preoccupation, if not obsession, with his typology of schizophrenia.”\textsuperscript{351} But in terms of historically analyzing developments in the psychology of religion and the creation of the mental health chaplain, Pruysers point is to underscore how Boisen’s approach to religion and its problem solving capacities creates opportunities for clinicians. Boisen’s argument is that “religion is not an adjuvant to integration; it is integration. It is one way of solving problems, sometimes successfully.”\textsuperscript{352} As such, the way is opened to clinically consider that “religion and mental illness, and of course by implication mental health …be approached as existential conditions.”\textsuperscript{353} In this way, problem solving experiences become those kinds of crisis experiences that are essential to religion, which are in fact expressive of religion. In Boisen’s central thesis, the psychiatric chaplain on the psychiatric team is meant to interact “with persons who have met with utter failure in problem solving, with or without religion or pseudo religion, and at times with failure in earlier attempts.”\textsuperscript{354}

What Pruysers is trying to show is that Boisen birthed the promise of a new clinical perspective. It opens wide the data of inquiry. It is for this reason that Boisen wanted his chaplains in training to begin where he did, at the psychiatric frontlines of concrete human experience. As he explains, “I have sought to begin not with the ready-made formulations contained in books but with the living human documents and with actual social conditions in all their complexity.”\textsuperscript{355} Snyder affirms how profoundly revolutionary this approach is: Boisen’s practice calls for “a firsthand study of religious experience, contemporary man’s experience.”

\textsuperscript{351} Steere: 365.
\textsuperscript{352} Pruysers, \textit{A Dynamic Psychology of Religion}, 12.
\textsuperscript{353} Ibid., 12.
\textsuperscript{354} Ibid., 12.
\textsuperscript{355} Boisen, \textit{The Exploration of the Inner World}, 185.
His analysis underscores Pruyser’s central idea about holistic clinical care. Snyder writes that this openness extends to formation in theology too since the “critical point here is that in theological education, theology itself must be an interdisciplinary effort.”

For Pruyser, this approach accomplishes two things: it establishes a scope of practice for the chaplain and considerably broadens the discipline of the psychology of religion. In finding “religion in psychopathology” that may be full of pathological religious content or none at all, Boisen has essentially changed the question of religion’s relationship to psychology in his assertion that religion is potentially to be found “sometimes in seemingly non-religious processes, and at other times nowhere.” This point is especially important. Boisen’s idea of having people look for religion in experiences that may be explicitly religious with exaggerated, apparently unhealthy, content and in those places where there is no explicit religious content at all, puts all experience on the clinical table as potentially significant to religious interpretation.

This practical shift changes a central clinical question which Pruyser expresses this way: “The old question was: Which are the significant data of religious experience? The new question is: Which data of experience are of religious significance?” This shift means plumbing all experience for data of religious significance. It means that this data fits into the new approaches to holistic mental health. Pruyser’s approach to this wider horizon of data that may be of religious significance is anything but facile. The practical assessment “of the religious dimension of a patient is an extremely difficult business,” is often clinically missed, and is one made

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358 Snyder offers an interpretation that develops this further: “Boisen believed that in the study of religious experience, you were discovering what enabled man to be human. What enables man to live in the midst of a precarious and broken world is disclosed in religious experience.” And “Boisen was determinedly convinced that the religious was the indestructible core, integrating spine, originating genes of *human* life.” Snyder: 11.


all the more challenging by Boisen’s thesis that no one can expect religious data to appear in predictable ways. It must rather be expertly and carefully sought after and diagnosed.

Pruyser’s insight into Boisen underscores the important historical development of an interdisciplinary psychiatric team which itself was characterized by an emerging psychiatric model of medicine as distinct from custodial care. The team’s goal was one of healing, and involved sometimes overlapping but still distinct professionals, (social workers, psychologists, etc) all under the direction of the psychiatrist. While no one perspective, in Pruyser’s eyes, was the sole domain of any one discipline, the chaplain did have a particular expertise. The chaplain was the expert in religion and assessed the patient, asking about the meaning of the patient’s presentation in religious terms. Thus the team would be able to understand “the role of religion in life, the nature of an individual’s faith, and the possible distortions thereof.”362 In Pruyser’s view, Boisen contributed to the creation of one profession that had an “obvious and direct concern with the religious welfare of the hospitalized patient before, during, and after his temporary isolation.”

CPE’s Early Complications with Boisen’s Diagnostic Perspective

In spite of Boisen’s creative innovation of the mental health chaplain on the psychiatric team, the greatest complication came from within. In Pruyser’s understanding, it was the chaplains themselves who substituted psychological perspectives for theological ones, especially when it came to providing a diagnostic interpretation of the presenting problem.

Writing from his vantage point as an educator especially attuned to multi-disciplinary team functions, Pruyser noted how in these contexts, it was often asked by other members of the team

in what way the pastor’s work is different from any one else’s on the team? Such explicitly religious acts as worship leadership, administering sacraments, convening religious study groups, or acting as liaison between the institution and the patient’s home Church are clearly his responsibility. But what special basic or

363 Ibid., 121.
applied science or art does the chaplain bring to bear on the diagnostic and therapeutic processes in such institutions?\textsuperscript{364}

What Pruyser notes is that chaplains “felt greatly at sea,”\textsuperscript{365} either unwilling or unable to frame their work in a way that offered a different perspective than their colleagues. In other words, chaplains chose to define the presenting clinical problems in ways that did not seem dissimilar to their colleagues’ approaches. Pruyser considered this practice disconcerting, an outright abandonment of this profession’s unique perspective, which ignored their patients’ “desire to look at themselves in a theological perspective.”\textsuperscript{366}

Pruyser identified a few contributing elements to this problematic. First, it is not uncommon in multi-disciplinary settings for “identity confusion” to set in.\textsuperscript{367} Secondly, it is true that in pastoral care’s movement to integration into the clinical setting, much learning needed to occur. Pruyser argues that the learning ought to have been, and should still be, both ways,\textsuperscript{368} but his experience was that most pastors and chaplains were “eager to absorb as much psychological knowledge and skill as they could, without even thinking about instructional reciprocity.”\textsuperscript{369} In addition, much of the learning that these ministers undertook was, to a high degree, skill based. Indeed, the “applied science and skill aspects” from psychological methods and insights that pastors learned were welcome additions to their pastoral work. However these aspects did “tend to take over in daily work and to become a substantive area of concentration.”\textsuperscript{370} Pruyser’s concern was that adding “clinical insight and skills to pastoral work” was in fact shaking the authenticity of the “pastoral outlook and performance.”\textsuperscript{371} Pruyser notes that a preference for

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  \item \textsuperscript{364} Pruyser, \textit{The Minister as Diagnostician}, 41.
  \item \textsuperscript{365} Ibid., 27.
  \item \textsuperscript{366} Ibid., 43.
  \item \textsuperscript{367} Ibid., 19.
  \item \textsuperscript{368} Pruyser, "Where Do We Go from Here? Scenarios for the Psychology of Religion," 177.
  \item \textsuperscript{369} Pruyser, \textit{The Minister as Diagnostician}, 24.
  \item \textsuperscript{370} Ibid., 28.
  \item \textsuperscript{371} Ibid., 10. In terms of a more general overview, William Clebsch and Charles R. Jackle affirm that the history of pastoral care has always sought the use of each epoch’s psychology or psychologies while protecting
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“skills” was supplanting the substantial theological work, and that this was Boisen’s concern too. Other historians would agree.\textsuperscript{372}

According to Pruyser, Boisen’s “relative disease with later developments in the clinical pastoral education movement is best described, though cryptically, in his autobiography.”\textsuperscript{373} Pruyser’s assessment of this part of CPE’s history includes Boisen’s worry that his case approach was being supplanted by a trend that saw “increasing attention was being given to the techniques of interviewing and to verbatim transcripts of interviews rather than to case histories.”\textsuperscript{374} Boisen’s case histories, as previously shown, were extensive documents that covered in great detail the crisis experience and history of his patients, and are not primarily about skills or techniques brought to the therapeutic encounter. They are rather about research and analysis of the problem that is seeking to be solved. Pruyser maintains that

I think that Anton Boisen ... shared my concern with pastoral theological diagnosis not that he was able to evolve a diagnostic system, but he wrote case studies in which he tried to keep psychiatric language at a minimum while maximizing the use of categories and observations that spring from a theological and pastoral framework.\textsuperscript{375}

In the clinic, Pruyser saw firsthand how chaplains often spoke uniquely in “psychiatric categories and psychiatric language.”\textsuperscript{376} What Pruyser concludes is that the new learning actually

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\textsuperscript{372} For a similar critique see R. A. Lambourne who noted that in the American CPE experience there was an “almost lack of theological thrust displayed in their so-called dialogue with psychoanalysis.” R. A. Lambourne, “With Love to the U.S.A,” \textit{Journal of Religion and Health} 8, no. 4 (1969): 312.

\textsuperscript{373} Pruyser, \textit{The Minister as Diagnostician}, 136, FN#14. See also Henry Meserve’s “Anton Boisen and the Cure of Souls” in which he states that Boisen’s purpose in studying “living human documents” through case studies and in the manner used by James was “for the purpose of deepening our general understanding of religious values, beliefs, and behavior. The clinical training movement, Boisen felt, had concentrated too much on psychological theories and counseling skills, not enough on basic religious issues.” Meserve: 4.

\textsuperscript{374} Boisen, \textit{Out of the Depths}, 185.

\textsuperscript{375} Pruyser, ”The Minister as Diagnostician,” 6.

\textsuperscript{376} Pruyser, \textit{The Minister as Diagnostician}, 39.
supplanted the theological framework unique to the minister; and a medical model was taking the place of a theological basis.377

Pruyser provides a most illuminating example, a consequence related to the neglect of pastoral resources. He describes how many pastors engaged in clinical work were unwilling to provide blessings for their patients. He writes that “well trained pastoral counselors, after having absorbed the psychological literature, may be unwilling to reveal any practices of blessing for fear that this may indicate psychological naiveté or an unresolved countertransference problem.”378 Pruysrer saw this as a critical misstep and was amazed that members of this profession would “relinquish or play down their great heritage of pastoral symbols, gestures and formulas in favour of some kind of quasi sophistication in psychology.”379

Pruyser saw this neglect to be most evident in terms of diagnostic practice. The thesis of his book, Minister as Diagnostician, argues that “Pastors like all professional workers, possess a body of theoretical and practical knowledge that is uniquely their own, evolved over years of practice by themselves and their forebears.”380 Consistent with his perspectival approach, Pruysrer’s argument has been for the importance of identifying the “anchorage points” for pastoral care so that this may “provide a base of identity and a source of replenishment.” The irony here is that Pruysrer is writing this particular conclusion more than 40 years after CPE began and is arguing that clinical pastoral education has “come of age and reached the time to be thinking of its roots.”381

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380 Pruysrer, The Minister as Diagnostician, 10.

381 Ibid., 28.
Boisen's Religiously Corporate Perspective at Risk

Pruyser sees another aspect of the Boisen heritage that needs to be reclaimed in addition to arguing that a distinctively theological and pastoral diagnostic heritage belongs in the clinical setting. Pruyser also suggests that what is at risk is a religiously corporate perspective; this is something he develops from Boisen’s historical interest in organizing the collective lives of the mentally ill. He contrasts this with the contextual trend of early CPE’s primary emphasis on the private sphere. Pruyser describes it this way:

Seen from this historical angle, the modern clinical pastoral training movement was grafted ambiguously on the corporate as well as the private care tradition. Its founder, Anton Boisen stressed the corporate tradition by approaching his hospital patients as a special congregation, to be engaged in worship, mutual encouragement, and wholesome recreation. He wrote a special hymnbook for use in psychiatric hospitals. Most of his followers, however, modeled their approach on the exquisitely private care of psychotherapy and secular counselling, which led to the modern forms of pastoral counselling.  

Pruyser recalls that one of Boisen’s reasons to introduce the chaplain to the clinical and hospital setting was for corporate religious reasons. To justify this interpretation, Pruyser sources it in the great depth and promise in Boisen’s explicitly pastoral works, particularly his *Hymns of Hope and Courage*—a text Pruyser considers “representative in its content of some of Boisen’s finer work.” Pruyser cites Boisen’s explicitly pastoral introduction from the hymnbook, a text designed to “deepen the aspiration for a better life, to strengthen faith in the love and healing power of God and to foster attitudes of hope and courage.”

Pruyser also identifies another corporate priority, this time in Boisen’s hope that his own life would be “exemplary and inspiring to others as well.” This self offering adds an even

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382 Ibid., 38.
deeper meaning to the idea of corporate religious life in that Boisen felt that his own experience could not remain a private matter. Pruyser suggests that Boisen’s uniqueness lies first in his ability to “communicate his own experience of such a ‘mutation’ to others and to capitalize in his studies on introspection and retrospection.” Secondly, Boisen’s commitment to working out his own experience was so that he could be a consummate helper to others, a fact revealed in his vocational choice. Pruyser writes:

Because he has chosen to become a clergyman, he was not content with merely describing what he saw in the members of his odd flock. He added the pastoral perspective, which means that he tried to understand the process of this patient’s cataclysmic episodes with a view to helping them come to a good ending. Recording and reporting is not the same thing as aiding and helping them come to a good ending.

Boisen articulated this ministerial hope as one of the reasons he worked to integrate his clinical training into the theological schools and seminaries. He stated that he hoped the Church would produce “physicians of the soul of the type whose work will be based upon sound and systematic study of spiritual pathology.”

This ministry focus is also developed by other Boisen experts. Synder wrote:

Boisen studied religious experience not only as a participant, but as one ministering to those who were in the midst of such experience. His was not the role of the spectator; he was within the healing process. And what that is, is what we must discover.

Steere too affirms this writing:

Boisen was convinced that the Church must give attention to a ministry in the personal crisis of life. Here we encounter the two central thrusts of his thought. First, there was a conviction that empirical study of certain types of mental illness would yield new understandings of the nature of religious experience and open avenues to an informed ministry of pastoral care. Second there was a belief that

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387 Ibid., 214.
388 Ibid., 214.
389 Boisen, Out of the Depths, 139-40.
390 Snyder: 11.
such studies would inevitably reinforce the fundamental structures of traditional theology as bearing an authoritative message for the sin-sick soul.  

Thus, Pruyser’s insight into Boisen’s own life and practices suggest that it was always Boisen’s intention to develop and use corporate religious resources to the fullest. On this point, Pruyser identifies another contextual irony in his own clinical observations: namely that chaplains were abandoning resources from the religious and theological heritage at the very time when members of the modern psychiatric community were taking “some clues for their own work, consciously or unconsciously, from traditional activities of ministers, and from certain operations of the institutional Church.” And so, the very moment that ministers are trying to look less like ministers, mental health professionals are beginning to “resemble ministers in the multiplicity of their roles.” For example, with the radical move of psychiatric services to the community at that time he notes how community practitioners were integrating the ideas of ritualisation in all areas, an expertise and practice central to religion. He also notes how mental health professionals were broadening their ideas about when and where clinical interventions could take place including for example on Sundays and in the community. In comparison he notes how chaplains were beginning to abandon their “right of association and access,” a historic practice of pastoral initiative not open to other disciplines.

Pruyser’s singling out the loss of Boisen’s ministry focus finds additional support as well. In his 1972 article, “Major Issues Currently Impeding Clinical Pastoral Education,” Ernest E. Bruder identifies “the lack of real commitment to the ministry among many engaged in clinical training.” At the time, Bruder was a clinical pastoral supervisor with over 20 years of

391 Steere: 362.
392 Pruyser, "The Minister as Diagnostician," 1. See also Pruyser, "The Use and Neglect of Pastoral Resources."
393 Pruyser, "The Use and Neglect of Pastoral Resources," 8.
394 Ibid., 8.
experience at executive levels with the Council of Clinical training and the *Journal of Pastoral Care*. He was also professor of Clinical Pastoral Care at the Wesley Theological Seminary and director of Protestant Chaplain Activities at St. Elizabeth’s Hospital, National Institute of Mental Health, Washington D.C. He adds that “The central professional identity with which we are dealing is that of the minister, and the ministry can never be separated from the Church it serves and of which it is an integral part.”

He asks: “Is clinical pastoral training truly committed to the ministry?” Bruder’s own analysis ends with what he understands as the most critical issue having to do with differentiation among clinical multi-disciplinary team members:

For the only distinction between what a clinically trained pastor can offer a troubled person and what a psychologist or social worker can offer is the pastor’s relationship and commitment to God and his understanding of the *living* Church.

The critical question that Pruyser is asking in this reclamation of Boisen’s religiously corporate perspective is this: Who is the minister or chaplain on the multi-disciplinary psychiatric team? In other words, what is her identity in differentiation to the other clinicians and does a corporately religious worldview belong in the clinic? This section has argued that the core differentiation is to be sourced in Pruyser’s idea of perspectives. Pruyser appealed to Boisen’s own life, his own case study, as evidence that Boisen’s original conceptualisation of the mental health chaplain is the result of discovering the clinical pastoral perspective. Boisen’s critical effort to understand his own life story of mental illness offered a fundamentally new way to engage or view the data of human experience, even the apparently pathological, as potentially religious in import. In addition, it created a role for the trained chaplain as the representative of religion—in its obvious and not so obvious presentations—in the clinic.

Pruyser explores and adapts Boisen, critically selecting from some but not all of his life and work. Crediting Boisen as the chief source of the innovation of the clinical psychiatric chaplain, Pruyser calls upon psychiatric chaplains to be diagnosticians who are not afraid to use

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396 Bruder: 301.
397 Ibid., 310.
398 Ibid., 311.
the pastoral resources which have historically made them ministers of the Church. He wants chaplains to benefit from psychoanalytic approaches but also push forward and engage social and contextual elements by bringing a theological perspective to healing. He suggests that chaplains should be equal but distinct members on the clinical multi-disciplinary team. And he certainly wants them to stop comparing themselves to other helping professions. He makes this assessment against the backdrop of what he sees as the real and contemporary problems in pastoral identity of his day. In this Pruyser has essentially called for an adaptive albeit selective faithfulness to Boisen’s original innovation.

**Pruyser’s Portrait of Boisen in Pastoral Care’s Search for its Own Identity**

The purpose of this final section is to critically contextualise Pruyser’s adaptive portrait of Boisen in pastoral care’s historical search for its own identity. Richard Dykstra’s work is an excellent resource for this kind of inquiry. His 2005 book *Images of Pastoral Care: Classic Readings* captures the identity problematic very succinctly by documenting its historical variability. The text brings together a total of nineteen pastoral identity images starting with Boisen’s seminal “living human documents” image and includes an entry for Pruyser. Dykstra presents each image with an edited and abbreviated primary text by each of the authors. In this way, the collection provides an important snapshot of the varied ways ministers have tried to understand who they are and what they are doing. Dykstra organizes these nineteen sources into three classifications: classical images of care, paradoxical images of care, and contemporary and contextual images of care. This threefold structure is an effort to bring some order and coherence to these otherwise varied sources, contexts, questions, and philosophies, facing the individual writers and the discipline collectively. With the exception of the first image in his book, Boisen’s 1930 phrase, the “living human document” and a representative citation for it from Boisen’s *Exploration of the Inner World*, Dykstra does not classify these images and their representative texts chronologically. As an alternative, I will consider them in chronological order to provide a critique of an aspect of Dykstra’s interpretation of Pruyser’s place in the history of these images.

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399 Dykstra, *Images of Pastoral Care*. 
Before doing that, it is important to affirm Dykstra’s historical accuracy and academic insight. Dykstra is right to claim Boisen’s place as foundational to the clinical pastoral enterprise and to directly affirm Boisen’s mental illness experience. Dykstra writes:

Contemporary pastoral theology serves as a key resource for understanding the tasks of pastoral care and counselling today. It is therefore not without significance that the origins of pastoral theology in mainline Protestantism may be traced in large measure to the psychotic delusions of a particular Presbyterian minister some eight decades ago.  

As mentioned in the introduction of this dissertation, Dykstra’s direct question pursuing the possible meaning of Boisen’s mental health issues is critical. Dykstra asks whether contemporary chaplaincy’s long search for its own identity is not itself reflective of a kind of “essential insecurity” that is traceable to its mental illness’ origins in Boisen.

Is this relentless pastoral self-scrutiny, I began to wonder, in part an unfortunate legacy of our inauspicious origins in that Boston Psychiatric hospital so many decades ago? Are ministers somehow constitutionally endowed with madness?  

Unfortunately, Dykstra answers this question by avoiding the literal mental health issue. He does this in two ways, referencing first pastoral theologian Alastair V. Campbell’s image of the “wise fool,” which Dykstra places in his book’s paradoxical category. Dykstra also identifies how pastoral theologian Donald Capps reframes this image. For Capps, the “madness” is this: anyone, especially a chaplain, who “claims to speak for God cannot know what he is talking about.”  

Secondly, Dykstra appeals to the work of pastoral theologian James Dittes, whom he places in the book’s third category: contemporary and contextual images. He suggests that Dittes affirms a necessarily unstable pastoral identity, less a birthright than an unspoken yearning or desire. To know with great certainty just who we are or what we are

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400 Ibid., 1.
401 Ibid., 3.
403 Donald Capps, Reframing: A New Method in Pastoral Care (Minneapolis: Fortress Press, 1990), 178. Cited by Dykstra, Images of Pastoral Care, 3.
to do in relation to God or others is almost certainly to have gotten it wrong. There is no accumulation of knowledge. Everyone starts afresh.\footnote{Dykstra, \textit{Images of Pastoral Care}, 5. See also Dittes: 13.}

Given that the context is always changing (individually, experientially, socially, environmentally, etc.), Dykstra gleams from Dittes that a certain identity crisis lies at the very heart of the pastoral task. In other words, the essential instability of pastoral identity is not related to Boisen’s mental illness or his effort to understand it, but to a deepening awareness over the history of pastoral care that contextuality removes stability and replaces it with tentativeness. As Dittes says, “This tentativeness, this everyone-needs-to-start-fresh custom, reflects the way things are.”\footnote{Dittes: 13. Cited by Dykstra, \textit{Images of Pastoral Care}, 4.}

Dykstra places Pruyser’s work, which he titles “The Diagnostician,” first among those in this third category, the contemporary and contextual images of care. This is mostly because Dykstra considers him to be at the “crossroads of this shift from the intrapsychic to the social and contextual in pastoral theology.”\footnote{Dykstra, \textit{Images of Pastoral Care}, 152.} Such a pivotal placement is essential to Dykstra because he understands that Pruyser “hints at an emerging postmodern perspective, in which theology, while reclaiming its rightful place at the table, is considered to offer only one among many informed points of view.”\footnote{Ibid., 154.} There can be no doubt that postmodernity has radically challenged and transformed scholarly and practical conceptualisations of the pastoral task, a point convincingly argued by Elaine Graham in \textit{Transforming Practice: Pastoral Theology in an Age of Uncertainty}.\footnote{Graham.}

However, Dykstra’s placement of Pruyser in this category because his work “hints” at postmodernism is anachronistic. Weighting Pruyser’s perspectival bias in a way that pushes beyond Pruyser’s original intent, Dykstra conflates Pruyser’s historical intention to reclaim a theological perspective or world view in the clinic with postmodernity’s critique about whether
there is definitive authority in any perspective, be it religious, theological or otherwise.409 It is not that Pruyser’s work cannot offer something important to this postmodern discourse, but contextually, Pruyser’s concern addressed role confusion by clinical chaplains with their peers and with the challenge of integrating diagnostic competency about the complexity of religious disclosure into the clinical process. Simply put, Pruyser feared that the abandonment of a theological or religious viewpoint by clinical chaplains was a betrayal of ministry, quite possibly an unfortunate consequence of the historical ascendancy of strictly scientifically and medically framed diagnostic approaches. This chapter has argued that Pruyser rehabilitated the classical Boisen in a very specific way, corresponding to Pruyser’s concerns regarding these contextual problems in the development of pastoral care in the clinic.

Dykstra certainly captures elements of the essential twofold thrust of Pruyser’s intention. In his entry for the third category of pastoral images, he writes, “Let ministers be ministers, Pruyser seems to be saying. Let them be theologians.”410 Indeed, here Dykstra reflects that Pruyser is underscoring at once an emphasis on the theological aspect of diagnosis and the minister’s corporate connection as central to his or her place on the clinical team. However, Dykstra is also critical of Pruyser and suggests that he “tends to accept at face value the conceptualisations of contemporary pastoral theology as laid out by Boisen, Hiltner, and other early theorists, with whom he was personally well acquainted.”411 By “face value,” it appears that Dykstra implies that Pruyser does not so much attempt to define pastoral care himself but tries to get clinical chaplains to apply current conceptualisations.

This is where it is valuable to consider Pruyser’s image in the chronological placement of images. It is true that Pruyser cites only a few early theologians but at the time of Pruyser’s early

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409 Postmodernity is an admittedly difficult and ambiguous term to summarize. David Tracy’s work recognizes this, but his definition is helpful in this context: “Postmodern thought at its best is an ethics of resistance-resistance, above all, to more of the same, the same unquestioned sameness of the modern turn to the subject, the modern over-belief in the search for the perfect method, the modern social evolutionary narrative whereby all is finally and endlessly more of the self-same.” David Tracy, "Theology and the Many Faces of Postmodernity," Theology Today 51, no. 1 (1994): 108.

410 Dykstra, Images of Pastoral Care, 153.

411 Ibid., 153.
seminal writing about Boisen, there were few contemporary images of and academics writing about pastoral care. Constructing a chronological list from Dykstra’s compilation confirms this. Of the 18 other images in the book, only four are dated before Pruyser’s 1976 image. In addition to Boisen’s, there is Hiltner’s 1959 image of “The Solicitous Shepherd,” then Heiji Faber’s 1971 image of “The Clown,” and Henri Nouwen’s 1972 image of “The Wounded Healer.” The point is, in addition to Boisen, Pruyser really only had Hiltner, Faber and to a lesser degree Nouwen, to draw on. And this is what he in fact does. It is interesting to note that after Pruyser, the variety of interpretative images explodes. By Dykstra’s own counting, only these four images and authors hold sway over CPE’s first 40 years. But after Pruyser in 1976, an incredible 14 images fill the almost 20 years of pastoral reflection beginning with Campbell in 1981 and ending in 1999. Dykstra himself comes to a similar conclusion:

The image of the solicitous shepherd, which came into ascendency in the 1960s, gives way to the wounded healer in the 1970s, which in turn is displaced by the wise fool of the 1980s, while a host of alternative images arrives on the scene from the 1990s to the present.

Dykstra’s critique of Pruyser’s “face value” acceptance of the theological opinions around him is overstated. It is more accurate to argue that Pruyser, a psychologist, sits on the boundary of an important early bifurcation in pastoral identity: whether chaplains would find a way to meaningfully explore and represent religion in the clinic or to abandon theology and religion altogether in favour of a primarily psychological and psychiatric identity. The assertion, central to the historical perspective presented in this chapter, is, as Pruyser asserts, that

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413 Dykstra’s citation for Pruyser’s image comes from the 1976 publication, see Pruyser, The Minister as Diagnostician. The earliest published reference by Pruyser on this image is in a 1973 article by the same name. Pruyser, "The Minister as Diagnostician," 1-10.

414 Dykstra, Images of Pastoral Care, 11.
the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation. His is a unique function: he represents religion in all its aspects on the psychiatric team and to the patients.415

At its core, Pruyser’s emphasis on the importance of diagnostics for the religious perspective is not primarily about ushering in the relativity of the postmodern view, but of the insight that no single perspective can be the sole perspective or paradigm in holistic care, in the multifaceted experience of illness. It is for this reason that Pruyser explores and adapts Boisen’s own much personalised investigation into the religious meaning of mental illness.

More than a simple issue of “face value” correspondence, Pruyser was actively in critical dialogue with many of these early theologians. Hiltner and Pruyser were friends, working together at the Menninger Centre where Hiltner was a consultant, and Nouwen was a student. There is also literary evidence that Pruyser engaged Hiltner and he also read Faber. Pruyser documents that “Hiltner is in basic agreement with my perspectival view of disciplines and professions.”416 He also references him in numerous works, including several of his prefaces where he thanks Hiltner for his incisive critiques of earlier drafts. Hiltner, like Pruyser, also had concerns that Boisen’s innovations were being forgotten. Already in 1958, Hiltner thought that Boisen was the one “who had done more than any other in our century to prepare the soil for a new pastoral theology,”417 but that his contribution was at risk of being forgotten in the development of clinical pastoral education and practice. About Boisen, he writes:

In studying “living human documents,” even those in deep disturbance, one was not, [Boisen] held, merely studying psychology or psychiatry but theology. For it is out of just such experiences, he contended, that great religious insights have emerged in prophets and mystics of the past. Boisen’s radical thesis is gradually gaining the recognition it deserves. Behind the particular form of his thesis, we should note, is the assertion that the study of actual and concrete forms of human experience, especially where ultimate issues are at stake, is theological if we bring theological questions to it. It is not merely psychological or psychiatry


incorporated by theologians. It is a point in theological method. Boisen has not himself been concerned to work out a systematic pastoral theology, but the basic clue to the systematic construction of this author [Hiltner] has come from Boisen.\footnote{Ibid., 51. [emphasis added]}

Although later pastoral theologians would criticise Hiltner’s systematic pastoral theology as too operational and functional,\footnote{Graham Buxton, “The Failure of Functional Theologies of Ministry and the Promise of a Relational Alternative,” Ecclesiology 1, no. (2005); Graham, 72-73.} Hiltner’s work, like Pruyser’s, essentially called for creative dialogue between, and not the disappearance of, clinical perspectives. Hiltner prophetically pushed for dialogue with the clinical pastoral encounter itself, thus reclaiming Boisen’s importance of pastoral engagement with real human experiences and the necessary engagement with the social sciences. In this way, Hiltner’s model has some affinity with Paul Tillich’s methodological concept of “correlation” which sought to engage concretely the theologian in matters of culture and life. For Tillich, “the method of correlation explains the content of the Christian faith through existential questions and theological answers in mutual dependence.”\footnote{Paul Tillich, Systematic Theology, 3 vols., vol. 1 (Chicago: University of Chicago Press, 1951), 60.} Thus it can be said that Tillich strove to make “Christianity coherent,”\footnote{T. F. O'Meara, “Paul Tillich in Catholic Thought: The Past and the Future,” in Paul Tillich: A New Catholic Assessment, ed. Monika Hellwig, Raymond F. Bulman, and Frederick J. Parrella (Collegeville, Minn.: Liturgical Press, 1994), 10.} explicitly acknowledging that “there must be a link between the Christian message and the situation in which it is proclaimed.”\footnote{Anthony A. Akinwale, “Tillich’s Method of Correlation and the Concerns of African Theologians,” in Paul Tillich: A New Catholic Assessment, ed. Monika Hellwig, Raymond F. Bulman, and Frederick J. Parrella (Collegeville, Minn.: Liturgical Press, 1994), 190.} But Hiltner argued that Tillich’s work needed expansion in order for it to more properly become a “two way method.”\footnote{Hiltner, Preface to Pastoral Theology, 223 FN#19.} It is for this reason that contemporary pastoral theologian Elaine Graham suggests that Hiltner anticipated David Tracy’s and others’ ideas about “revised critical correlation.” For Hiltner, “Christian truth is never complete in itself, but remains to be informed by the revelation of God within the immanence of the present
situation.”424 The central point here is that Dykstra’s assessment that Pruyser treats these works at face value is reductionist. Both Hiltner and Pruyser were grappling with real tensions in the actual contemporary practice of pastoral care of their day. Hiltner was indeed an important dialogue partner in Pruyser’s considerations on Boisen as a diagnostician and a minister.

Faber for his part occupies a much smaller but nevertheless indicative place in the work and ideas of Pruyser. Well published, Faber is best known in the North American history of pastoral care for his work, Pastoral Care in the Modern Hospital,425 which he wrote when he was professor of Psychology of Religion and Pastoral Psychology at the University of Tilburg, the Netherlands. Three years after its Dutch publication, it was translated into English in 1971. This relatively small book seeks clarity about the “role of the minister in the hospital,”426 which was a problem Faber found virtually unaddressed in the extant literature and practice of the period. He was also convinced this was an institutional problem, citing one hospital director’s opinion as representative of the collective estimation of most hospital staff at the time: that ministers were “an alien body.”427 He also asked “in the progressive secularization of society, which affects the hospital deeply, how long can [the minister] count on the place he has at present?”428

Faber’s work surfaces in Pruyser’s 1972 article “The Use and Neglect of Pastoral Resources,” partly because of Faber’s interest in intentional pastoral conversations,429 but mostly because of his creatively paradoxical contribution to the problem of pastoral identity.430 In this latter case, Pruyser refers to Faber’s proposal of minister as clown. For the source of this clown

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424 Graham, 71.
425 Faber, Pastoral Care in the Modern Hospital.
426 Ibid., vii.
427 Ibid., vii.
428 Ibid., viii.
image, Faber turned at once to Paul’s First Letter to the Corinthians 1:25 which has to do with God’s use of foolishness and to existential analysis. Concerning the latter, Faber analyzed the minister’s inward experience of being in the hospital with a medical staff and concluded that there were three basic tensions.

First, the tension between being a member of a team and being in isolation: secondly, the tension of appearing to be and feeling like an amateur among acknowledged experts; and finally, the tension between the need for study and training on the one hand and the necessity to be original and creative on the other.431

The clown, Faber argues, lives these tensions all the time. His “number” in the circus is to be alone, as the apparently clumsy fool who comes on stage in between all the expert artists. His skills are visibly paltry compared with the specialists, such as those on the trapeze for example. And his piece looks unskilled and spontaneous. But Faber warns that some things are not as they appear. The clown is an accomplished artist whose work is the result of years of training and performance experience, as the great clowns have shown.

What is important about Pruyser’s citation of Faber is this insight: the temptation for the chaplain to be like the other clinical team members. What Pruyser identified as a betrayal of the corporate ministerial vocation, Faber considers a temptation to be a virtuoso. Faber’s point is that even from the perspective of the patient, all that virtuosity, those highly specialised people that the patient meets, it is very easy for the patient to lose heart, to feel somehow objectified to the point of not even feeling human anymore. Pruyser’s use of Faber’s insight is to remind the chaplain to do the opposite and not to desire to be like the other professionals. Pruyser uses the clown image because the clown “gives people through his bumbling acts some freedom from the need to empathize with virtuosity.”432 In this dynamic, there is a special role and tool for the chaplain: empathy. This gets to the heart of the clown image: it is through this often vulnerable character that “the audience gets from the clown a new sense of its humanity.”433

431 Faber, *Pastoral Care in the Modern Hospital*, 81-82.
432 Pruyser, "The Use and Neglect of Pastoral Resources," 16.
433 Ibid., 16.
This idea is consistent with Pruyser’s perspectival bias, only here he suggests that the chaplain as clown can potentially be representative of an “authentic human being”\textsuperscript{434} in the hospital. The central position here is that the clown’s and chaplain’s perspective point to and access a fundamental perspective that often gets lost in the human tragedy of health care. Faber is used here as another way of capturing Pruyser’s fundamental perspectival idea about theological clinical work and the particular role of the chaplain in the clinical interaction. In Faber’s words, the minister “represents another wavelength, another order in which man is no longer only an object of treatment, but a person, who struggles in his suffering to remain man, perhaps man with a relationship with God.”\textsuperscript{435}

In a 1979 article titled, “Second Thoughts on the Minister as a Clown,” Faber addresses the potential of missing this human and divine mystery by using Ian T. Ramsey’s work on disclosure, \textit{Models and Mystery}.\textsuperscript{436} Ramsey’s thought, which is close to Pruyser’s observation about perspectival reality, suggests that the different sciences disclose different mysteries. Ramsey’s insight is that distinct models are necessary for this disclosure. Faber writes:

> One cannot disclose or reveal the mystery of a human being or of a relation to God in the sense that one can examine them with scientific instruments. What one can do is to get a certain view of them with the help of a model, so that the mystery can be discussed and articulated and in doing so to a certain extent disclosed.\textsuperscript{437}

In calling the chaplain a clown, Faber introduces a model by which we get a perspective on the depth of the ministry which we can never show completely, but which in this way becomes transparent, as it were, so that we can make clear to ourselves and to others our view of the minister, our belief in him.\textsuperscript{438}

\textsuperscript{434} Ibid., 16.

\textsuperscript{435} Faber, \textit{Pastoral Care in the Modern Hospital}, 91.


\textsuperscript{437} Faber, "Second Thoughts on the Minister as a Clown," 132.

\textsuperscript{438} Ibid., 133.
Pruyser, by engaging Faber, is underscoring his fundamental belief that the clinical role of the chaplain is perspectival and representative of religion. That the chaplain must be a theological diagnostician and a minister discloses the possibility that a human being’s relation with God can, at minimum for some patients, be relevant in the clinical milieu.

**Conclusion**

Finding its focus in psychologist Paul Pruyser’s insight that “the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation,” this chapter has sought to bring greater specificity to and document what became of the unique contribution of Anton T. Boisen. This chapter began by tracing Boisen’s move, along with his central thesis and its focus on the potential religious meaning of mental illness and the distinctive role of the chaplain in mental health care, to the periphery in the early history of clinical pastoral education. In terms of a critical historical reading, this inquiry has provided evidence that Boisen’s mental illness and determined effort to make religious sense of it contributed to his marginalisation. This chapter has argued that one outcome of this shift in CPE direction was a substantial altering of Boisen’s priorities about and conception of the identity and role of the psychiatric clinical chaplain. This section concluded with a consideration on Thornton’s prophetic reflections on the future of CPE’s corporate religious mission.

Part two of this chapter presented Pruyser’s explorative and adaptive portrait of Boisen. It presented how Pruyser’s approach started uniquely with attention to Boisen’s own case, a life of severe mental illness turned into ministry. It suggested that Pruyser found in Boisen’s life and work the seeds of a necessary and invaluable religious perspective for the psychiatric team and for the innovative value of the clinical chaplain. The central point of this part of the chapter traced how Pruyser’s historical portrait of Boisen as a theological diagnostician and as a religious corporate minister was Pruyser’s corrective to what he considered to be disturbing trends in the development of CPE.

This chapter concluded by contextualising Pruyser’s portrait of Boisen in pastoral care’s larger search for its own identity. It presented Pruyser’s use of the contemporary pastoral theologians of his day, including Hiltner and Faber. I argued that Dykstra is incorrect when he
suggests that Pruyser’s use of them was to take these authors merely at face value. This inquiry revealed that, while written from the perspective of a psychologist and expert in the psychology of religion, Pruyser’s fundamental question was essentially the same as Hiltner’s and was probably best articulated by Faber: “what is the essence of pastoral ministry? What is irrereplaceable about it? And what, in the light of this, are the potentialities open to us of realizing this essential ministry?”

What this chapter did not engage was the influence Henri Nouwen, the final theologian Dykstra identified as having important sway during clinical chaplaincy’s early search for an identity, had on Pruyser. This is primarily because Nouwen was a student of Pruyser’s at the Menninger’s from 1964-1966, and the influence went essentially the other way. By the time Nouwen arrived at the Menninger Clinic, he was a doctoral student with an incomplete thesis on the subject of Boisen. Nouwen would never complete his doctoral work on Boisen, and most of his writings on Boisen would remain unpublished. Nevertheless, under Pruyser’s supervision and influence, Nouwen would develop an explorative and adaptive portrait of Boisen of his own. In fact, much like Pruyser, Nouwen would make his own contribution and critique of pastoral ministry by appealing to Boisen. Chapter Two presents that untold story.

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439 Faber, *Pastoral Care in the Modern Hospital*, 89.
CHAPTER TWO:

ANTON T. BOISEN AND HENRI J.M. NOUWEN

With Chapter One’s critical historical contextualisation and analysis of Boisen’s innovation of the clinical psychiatric chaplain along with Pruyser’s explorative and adaptive portrait of Boisen now complete, the primary purpose of Chapter Two is to consider the legacy of Boisen’s innovation using the insights of Nouwen. It is little known and studied that Nouwen chose Boisen as a subject of exploration and adaptation in two incomplete doctoral efforts in his native Holland \[440\] including extensive consultation with Pruyser during and after Nouwen’s two years at the Menninger Clinic, Topeka, Kansas. While some fruits of these efforts eventually found a place in a few of Nouwen’s early published works, most of his research material and writing on Boisen remains unpublished, but archived. Furthermore, the existing biographical literature concerning Nouwen lacks depth and analysis of any relevance that this Nouwen-Boisen connection might have, both in terms of its importance in Nouwen’s early formation and in regards to its contribution to his ideas about pastoral ministry.

This chapter therefore is particularly important in terms of what it adds to contemporary scholarship: It proposes the first detailed and intentional study of the Nouwen-Boisen connection, thus filling a lacuna in the extant literature about both historical figures. Second, it underscores the influence of Pruyser in Nouwen’s creative conceptualisation of Boisen, something hitherto not appreciated in the existing biographical work about Nouwen even though it is critical to the way Nouwen reads Boisen. This conclusion will also serve as a basis for the remainder of this thesis, providing a foundation for two credible options [to be explored in Chapters Three and Four] for rendering a contemporary and theologically relevant clinical model for psychiatric chaplaincy.

\[440\] Although the Netherlands and Holland are often used interchangeably, in this thesis Holland will refer to the country whose official name is Kingdom of the Netherlands.
In four parts, this chapter first situates the Boisen-Nouwen connection as it is known in the extant literature; part two critically analyses Nouwen’s core published texts on Boisen; and part three turns especially to the unpublished archival material, an important source which includes some documentation from his incomplete doctoral efforts as well as his record of personally meeting Boisen in 1964. These first three parts will be expository and exploratory in nature, the goal being to describe and analyse Nouwen’s study of Boisen in order to determine the influence of that study on Nouwen’s early conceptions of ministry and spirituality. This research will show that Nouwen’s last published citation of Boisen was in 1977.

Part four is interpretive. It will suggest that the relative silence about Boisen in Nouwen’s public professorial life, his publications, including the scant attention in the extant studies of Nouwen, should not be interpreted to mean that Boisen was unimportant to Nouwen. I will argue that Nouwen’s use of Boisen in his published material, along with the depth and breadth of the archival material, paints a portrait of Boisen which suggests a theological and methodological corrective to what Nouwen considered problematic contextual trends in the development of Clinical Pastoral Education. Nouwen’s Boisen is primarily pastoral, having to do with how God is made present and attended to in the clinical presentation as the primary task of the chaplain. In summary, Nouwen’s writings about Boisen in the context of training models of his time represent a contextual critique, suggesting that there has been a misappropriation of Boisen’s “living human document” at the expense of the “living human God.”

**Boisen in Existing Studies of Nouwen**

Nouwen’s study of Boisen is either ignored or underdeveloped in the four unofficial biographies and studies published about his life. In chronological order of publishing dates, the biographers are Jurjen Beumer (1996), Michael Ford (1999), Deirdre LaNoue (2000), and

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441 Henri J. M. Nouwen, “Pastoral Supervision in Historical Perspective (Unpublished Manuscript),” The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly at the University of St. Michael's College, University of Toronto, 1965), 68.

442 During his life time, Nouwen never officially authorized any biographies nor did he undertake to write his own autobiography.
Michael O’Laughlin (2004). In 2009, the Henri Nouwen Legacy Trust\textsuperscript{443} contracted Catholic scholar Michael Higgins to write an authorized biography, which he is currently doing.\textsuperscript{444}

Much is written about Nouwen and his spirituality in these published works, but only the briefest of biographical sketches of his early years. In fact, most studies methodically build on his published writings. Since only one of these biographies references any of his publications before 1969, and briefly at that, the portraits of Nouwen’s early years are thin with greater focus on the more public period of Nouwen’s life.\textsuperscript{445} Finally, while all the authors reference that archival material by Nouwen about Boisen exists, none seriously engages in any systematic study of it.

This section indicates the degree of inclusion or exclusion of Boisen in these works by using four basic criteria: (1) Evidence of any awareness that Boisen was an influence on Nouwen; (2) Evidence of Nouwen’s study of Boisen; (3) Documented reference to Nouwen’s two published articles on Boisen,\textsuperscript{446} and (4) any documented evidence that the author used and read any of Boisen’s work.

Originally written in Dutch, Jurjen Beumer’s book appeared in 1996 as \textit{Omrustig Zoeken naar God: De Spiritualiteit van Henri Nouwen}. It was translated into an English edition: \textit{Henri Nouwen: A Restless Seeking for God} in 1997.\textsuperscript{447} Beumer is a Dutch protestant minister who first met Nouwen in 1984 in the United States at a meeting sponsored by Sojourners. He describes

\begin{footnotes}
\item[445] Michael Higgins and Kevin Burns were hired in 2007 by the CBC Radio to prepare a documentary for IDEAS on the life and legacy of Nouwen. On February 19, 2010, they interviewed me about the Boisen-Nouwen connection and its place in my doctoral work. This suggests that there is new interest in this historical period. The series is scheduled to air in September, 2012 followed by the release of a book version of the documentary, \textit{Genius Born of Anguish: The Life and Legacy of Henri Nouwen}, published by Paulist Press and Novalis.
\end{footnotes}
himself as a friend of Nouwen’s but claims that while Nouwen was aware of this biography, Nouwen is in no way was responsible for the shape, contents, or text of it.448

The author attempts to offer a “portrait”449 of Nouwen using “restlessness” as its frame. For Beumer, Nouwen is the quintessential searcher, a remarkably lonely man, whose constant question is “where does God want me to be?”450 This restlessness Beumer maintains is central to his spirituality.451

Beumer is aware that Boisen was an influence on Nouwen. In a section describing his two years at Notre Dame University (1966-1968), Beumer writes: “The three people who influenced him the most during this time were Anton T. Boisen, Seward Hiltner, and Thomas Merton.”452 A footnote reveals his source in the Henri Nouwen Archives where one “can peruse Nouwen’s lecture notes and other unpublished materials dealing with these three people: Boisen, Hiltner, Merton.”453 Neither here nor in the rest of the text does Beumer offer any development or analysis concerning the influence of Boisen.

Beumer’s book is important to this inquiry in that it identifies the historical connection between the person of Boisen and Nouwen, but it provides no meaningful analysis. Beumer’s work does not identify Boisen as the topic of Nouwen’s doctoral work, nor does he cite or even list Nouwen’s published articles on Boisen. Finally there is no referenced evidence that Beumer has used or read any of Boisen’s own work.

The second biographical work, best known for its sensational disclosure of Henri Nouwen’s homosexuality is also noteworthy for its open descriptions of Henri Nouwen’s bouts

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448 Ibid., 9.
449 Ibid., 8.
450 Ibid., 54.
451 Ibid., 166.
452 Ibid., 30.
453 Ibid., FN 12, 178. The footnote develops the link only in terms of a biographical citation about Boisen and uses another author’s work, W. Zijlstra’s Klinische Pastorale Vorming, on the general history of the clinical pastoral care movement to describe Boisen. See W. Zijlstra, Klinische Pastorale Vorming (Nijmegen: Dekker & van de Vegt, 1973).
with “depression.” Journalist Michael Ford’s 1999 work, *Wounded Prophet: a Portrait of Henri Nouwen*, was not meant as a “full scale biography” but rather as “an exploration of the person of Henri Nouwen as a wounded prophet for our time.”

Structured in three themes (heart, mind, and body) and not chronologically, the book reflects Ford’s idea that “much of [Nouwen’s] genius was shaped by an ongoing loneliness and anguish, of the sort that also afflicted Van Gogh.” It is a link that Nouwen himself provides and Ford seizes. In the introduction of Cliff Edwards’ book on the painter, Nouwen wrote in 1989: “I experienced connections between Vincent’s struggle and my own and realized more and more that Vincent was becoming my wounded healer.” This term of “wounded healer” was made popular in 1972 when Nouwen published his fifth and very popular book by the same name. The term becomes seminal for Ford who titled his biography with it and then dedicated a chapter to it in his first section concerning the theme of the heart. According to Ford, what made Nouwen so effective was his insight to encourage ministers to do what he himself did: “to make their own wounds into an important source of healing” for others. Ford suggests the wounds “he often spoke of were those of alienation, separation, isolation, and loneliness, the ones he shared himself.”

Important for this chapter is Ford’s documentation that Nouwen was already studying Boisen in his first doctoral effort in Psychology at the University of Nijmegen. From 1957 to 1964 (the year of his departure for the Menninger Clinic in Topeka, Kansas), Nouwen “undertook research on Anton Boisen, the father of the clinical Pastoral Education Movement

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455 Ibid., xxi.
456 Ibid., xi.
458 Ibid., x. Cited by Ford, xi.
459 Ford, 45.
460 Ibid., 45.
(whom he was later to meet).”\textsuperscript{461} Ford reveals that Nouwen ran into difficulties in this endeavour. His academic advisors wanted “more statistical evidence and scientific evaluation” in his thesis work. Ford describes a “furious” Nouwen, who felt as if he were being “forced into a straightjacket.”\textsuperscript{462} Ford states that Nouwen did not complete the doctorate, but that on account of the existing research he had completed he was entitled to “the degree of \textit{doctorandus}, meaning, ‘someone who has to become a doctor.’”\textsuperscript{463}

Ford’s reference to Boisen ends with a description of Nouwen’s visit to Boisen, in 1964.

Nouwen was grateful to have met this man whose suffering had become a source of creativity: “Seeing a man so closely and being able to experience how a deep wound can become a source of beauty in which even the weaknesses seem to give light is a reason for thankfulness.”\textsuperscript{464}

Nowhere in Ford’s text does he identify Boisen as a “wounded healer,” nor does he offer any further reflection on how Boisen influenced him. A reason for this might be that the book’s argument is more singular if this wounded relationship is reserved only for Van Gogh.

Ford, while his work is not a biography in the strict sense, better situates the Boisen-Nouwen relationship than Beumer’s. Although his analysis of the meaning of the influence is not developed, he captures Nouwen’s admiration of Boisen, documents his incomplete doctoral work, and most importantly situates a seminal event, Nouwen’s visit to Boisen. Ford’s inclusion of Nouwen’s unpublished notes on his meeting with Boisen shows evidence that he had access to and made use of some early archival records. Finally, Ford’s work, reference pages, and bibliography make no reference to Nouwen’s published articles on Boisen, nor is there any evidence that Ford read or referred to any of Boisen’s writings.

\textsuperscript{461} Ibid., 89.
\textsuperscript{462} Ibid., 89.
\textsuperscript{463} Ibid., 89. This Dutch degree is the contemporary equivalent of a Masters in most English speaking countries. A significant academic achievement, it also indicates that the student is “all but dissertation.”
\textsuperscript{464} Henri J. M. Nouwen, "Boisen," \textit{The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives} (Toronto: John M. Kelly Library at University of St. Michael's College, University of Toronto, 1964), 3. Cited by Ford, 92.
Generally regarded as the most academic study so far on Nouwen, Baptist historian Deirdre LaNoue’s *The Spiritual Legacy of Henri Nouwen* is the book version of LaNoue’s 1999 doctoral dissertation. The author describes her work as an exploration of “the spirituality of Henri Nouwen within the context of American Spirituality in the late twentieth century.” She contends that Nouwen’s work captures an historical shift in American spirituality from a “dwelling-oriented spirituality” to a “seeking-oriented spirituality.” For Lanoue, Nouwen’s spiritual legacy is that he was able to act as a guide for others who were searching, “and the value of a guide is found in his or her ability to meet you where you are, to understand how you got there, and to lead you where you want to be.”

Lanoue defines Nouwen’s spirituality in terms of thirteen characteristics, the primary one being “relational”, that he “described the spiritual life as encompassing three primary relationships – the relationship to self, to others, and to God.” It is a definition she borrows from Nouwen scholar, Robert Durback. Lanoue is also in agreement with Durback’s insight that this relational dynamic, which was first expressed in 1975 in *Reaching Out*, “would become the foundational framework for much of the rest of ... [Nouwen’s] life work.”

LaNoue considers Nouwen through his “literary biography.” She reviews “all of Nouwen’s major writings ... in the context of the major phases of his life.” This provides a literary foundation for her thematic analysis. Lanoue only has one reference to Boisen. This is found in her section on Notre Dame and the Netherlands (1964-1970) which describes Nouwen’s

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466 Deirdre LaNoue, “Henri Nouwen and Modern American Spirituality” (Baylor University, 1999).
468 Ibid., 150.
469 Ibid., 153.
470 Ibid., 25.
first American teaching experience, his interest in the formation of priests, and his desire to put the connection between psychology and religion in the service of ministry. Lanoue notes that he was “strongly influenced by the work of Carl Jung ... and Anton T. Boisen, the founder of the clinical pastoral education movement.” The rest of her book has no further reference to Boisen and his influence, nor to Jung’s for that matter.

Like Beumer and Ford, Lanoue is aware of the large amount of material in Nouwen’s Yale archives about Boisen. Her only other reference to Nouwen’s archived materials on Boisen is in a footnote along with her source for her brief biographical description of Boisen, the *Baker Encyclopedia of Psychology*. She writes:

> An extensive amount of material regarding Anton Boisen can be found among Nouwen’s papers in the Archives of Yale Divinity School Library. Nouwen also collected materials regarding Seward Hiltner and Thomas Merton.

Lanoue makes reference to but uses none of this material in her book.

Finally, while her bibliography is by far the most developed to date including a listing of Nouwen’s articles, it is worth noting that her list begins in 1969. This is a significant omission. Nouwen’s first article on Boisen was published in 1968, and he published other articles in Holland as early as 1957. Lanoue’s list also does not include Nouwen’s 1977 article on Boisen. To conclude, since there are no citations about Boisen other than the encyclopaedic one, it would appear that she did not refer directly to Boisen’s primary work when preparing her publication.

The fourth and final study is Michael O’Laughlin’s *God’s Beloved: A Spiritual Biography of Henri Nouwen*, published in 2004. O’Laughlin, a former student and then friend of Nouwen’s, considers his task to be a kind of portraiture that asks “what does [Nouwen’s]
life mean in spiritual terms? What should I or anyone else do to continue Henri Nouwen’s spiritual legacy? This book is “in part a reaction” to Ford’s work, “mostly because of its negative assessment of Nouwen’s psychological health.” O’Laughlin’s self confessed concerns with Ford’s analysis are always in the background. He maintains that “knowing that [Nouwen] had psychological problems is not the key to understanding Henri Nouwen.” A portrait of Nouwen framed uniquely around his psychology misses the point because “we must remember that much good came from Henri’s troubles.”

O’Laughlin’s work is overly ambitious and borders at times on being too simplistic an analysis in its effort to be corrective of Ford’s work. One example is how he argues that “simply by being himself, [Nouwen] changed the way Christianity is practiced in the Western world.” However, in fairness to O’Laughlin, he is trying to draw attention to Nouwen’s decision to use his autobiography. For O’Laughlin, it was Nouwen’s capacity to integrate and unmask Nouwen’s own struggles that makes Nouwen’s way of writing from a spiritual perspective unique.

O’Laughlin has the most references to Boisen of all the biographers, and he references Nouwen’s 1968 article on Boisen but not his 1977 article. In terms of Nouwen’s incomplete doctoral studies of Boisen, he cites and follows Ford’s conclusions. O’Laughlin’s work is most significant in that he ventures an interpretation, beyond just admiration, of Boisen’s influence on Nouwen. O’Laughlin’s ideas here are not developed deeply, but he moves beyond the mere fact that Nouwen studied Boisen.

There are two components to the way O’Laughlin understands Boisen’s influence on Nouwen: First as a model of who Nouwen would be in later life, and secondly as a kind of visionary Nouwen would follow. The first idea suggests that Boisen was himself “a wounded

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481 Ibid., 15.
482 Ibid., 11.
483 Ibid., 12.
484 Ibid., 84.
485 Ibid., 12.
healer” who sourced in his own suffering seminal insights. In this conceptual presentation, O’Laughlin makes the point that:

Boisen … did not strive to be other than he was. He was a tragic figure, a creative genius and a wounded healer whose mine of insights was his own suffering, much like Vincent Van Gogh, and much like Henri Nouwen himself would become later in life.486

O’Laughlin continues along these lines when he presents in detail how one of Nouwen’s early sufferings may have shaped his future path. O’Laughlin suggests that Nouwen’s two incomplete doctorate bids in both psychology and theology were “great disappointments.” But that his reaction to them allowed him to chart a new and creative path. O’Laughlin concludes that “Nouwen had learned by studying Boisen that adversity and even disaster could be decisive in leading a person into his or her most significant work.”487 Later on in the text, O’Laughlin returns to this analysis, this time biblically. Explicitly referencing St. Paul, he writes, “Long ago Henri learned from Anton Boisen that weakness could become one’s strength and inspiration.”488

O’Laughlin’s second idea about Boisen’s connection to Nouwen is that he is a visionary witness to a new way of combining psychology and religion. In reference to Nouwen’s time at the Menninger Clinic, O’Laughlin writes that Nouwen “was able to connect to the world he had glimpsed through Boisen’s writings – a world where religion and psychology could be combined and the human dimension was not lost from view.”489 This unitive feature, applied to Nouwen and sourced in Boisen is a critical insight into both men.

These two ideas, of mining insights from one’s own suffering and the combination of religion and psychology without losing the human dimension, fit into O’Laughlin’s larger project of seeing in Nouwen someone who returns to the ordinary things of life for his theology. He calls this Nouwen’s “artistic temperament or consciousness,”490 a way of seeing and “seeking God’s

486 Ibid., 47.
487 Ibid., 56.
488 Ibid., 152.
489 Ibid., 50.
490 Ibid., 88.
presence in the world around us.”491 This point is very important for O’Laughlin’s portrait of Nouwen. O’Laughlin credits Boisen among others for this vision: “Henri had those who taught him how to see, such as Rembrandt, or van Gogh, or Boisen, or Merton.”492 The learning here is that in “order to find God, we must return to what is simple and ordinary, because that is where God is unexpectedly to be found.”493

In conclusion, this final biography adds important references to Nouwen’s work on Boisen and presents a basic but intentional effort to consider the influence of Boisen. For this O’Laughlin is to be credited. He is the only biographer to have sourced out at least one of Nouwen’s published writings on Boisen, is aware and presents in the greatest detail so far his having studied him, and has tried to connect them within an interpretive framework. While there is no evidence in the text or in his bibliography that he read or used any of Boisen’s writings, he has captured something of the creative genius of Boisen operating out of his own suffering, the important unitive efforts of both authors in regards to psychology and religion, and of Nouwen’s commitment, time after time, to use his own life for an inquiry into God presence in the ordinary.

Each of these unofficial biographies and academic studies of Nouwen’s life and legacy was presented to determine how extant scholarship on Nouwen considers the Nouwen-Boisen connection. While every author without exception makes the point that Nouwen dedicated considerable time to the study of Boisen and that this is evidenced by his considerable archival holdings on the same, overall there is little consideration and effort given to meaning of this relationship. Except for O’Laughlin, no effort was made to develop even the most basic of theories on Boisen’s influence on Nouwen.

**Boisen in Material Published by Nouwen (1968 to 1977)**

From 1968 to 1977, Nouwen wrote 10 books and was prolific in his article output. Among them, there are only two articles in which Boisen is the core subject matter. The first, a

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491 Ibid., 108.
492 Ibid., 109.
493 Ibid., 124.
work of 24 pages, “Anton T. Boisen and Theology through Living Human Documents”\textsuperscript{494} came out in 1968 when Nouwen was teaching at Notre Dame. The second, “Boisen and the Case Method,”\textsuperscript{495} was published in 1977 while Nouwen was a professor at Yale Divinity School. This publication was occasioned as part of centennial year celebrations for the birth of Boisen. The editorial inside cover for the journal indicates that Nouwen’s is among three collated “papers dealing with aspects of Boisen’s contribution which are less well known.”\textsuperscript{496} It also indicates that Nouwen’s article “was drawn from a longer manuscript by the author. [Nouwen’s] paper deals with Boisen’s development and use of the case method.”\textsuperscript{497}

Beyond these two publications in which Boisen is the primary subject matter, Boisen appears to drop out of sight as Nouwen moved onto other subject matters. The historical period under review in this chapter is determined by the two aforementioned articles and four explicit references to Boisen in three published works. Two appear in his first book, \textit{Intimacy}\textsuperscript{498} in 1969, and the other two follow with \textit{Creative Ministry}\textsuperscript{499} in 1971 and with \textit{The Living Reminder: Service and Prayer in Memory of Jesus Christ}\textsuperscript{500} in 1977. As the titles suggest, these references appear in Nouwen’s early reflections on ministry and spirituality.

These texts are important for two reasons: first of all, they are the only explicit references to Boisen in all of Nouwen’s considerable published works. Second, they point to how Boisen was being understood and used by Nouwen in his \textit{published} works. In this sense, this literary testimony reveals the way Nouwen referred to this person he had spent so much time studying.

\textsuperscript{494} Nouwen, "Anton T. Boisen and Theology through Living Human Documents."
\textsuperscript{495} Nouwen, "Boisen and the Case Method."
\textsuperscript{497} Ibid., inside cover. This original “longer manuscript” will be critically reviewed in part three of this chapter.
\textsuperscript{499} Henri J. M. Nouwen, \textit{Creative Ministry} (Garden City, N.Y.: Doubleday, 1971).
In his article “Anton T. Boisen and Theology Through Living Human Documents,” Nouwen’s thesis is that it is impossible to understand Anton Boisen’s innovation of the clinical case method in theological education and practice without consideration of “Boisen’s own case,” specifically his “intensely autobiographic” use of it.\textsuperscript{501} Both aspects are important.

The central idea in this article is Nouwen’s presentation of the place autobiographical issues play in Boisen’s work. Nouwen presents Boisen’s innovation, the case method, as a new approach to theoretically diagnosing “living human documents,” as emerging from another, more personal issue. Nouwen suggests that “Boisen himself is the core document for understanding and illustration”\textsuperscript{502} of the case method. To illustrate this, Nouwen cleverly structures his article as a “case study” of its own, beginning with the following headings about Boisen: The man, the central experience, the input, the outcome, growth through conflicts, and the last years.

Under these headings, Nouwen presents the innovation of Boisen’s approach by essentially arguing that Boisen’s work was really about working out his own mental health experience. “His own case forms the core inspiration”\textsuperscript{503} and his question was: “What does this [these mental health disturbances] mean for me, a minister who is trained in the psychology of religion?”\textsuperscript{504}

Nouwen carefully constructs his argument. He begins by citing how this sourcing of his illness is something that Boisen himself readily attested to in his credo statement: “central convictions have grown out of my efforts to deal with the problem of mental disorder in myself and others.”\textsuperscript{505} The full import of this Nouwen finds in the following articulation of belief: “I

\textsuperscript{501} Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 50.

\textsuperscript{502} Ibid., 49.

\textsuperscript{503} Ibid., 50.

\textsuperscript{504} Ibid., 52.

believe,” writes Boisen, “that the paramount human need is for that love that there is a law within which forbids us to be satisfied with any fellowship save that of the best.” 506

In Chapter One’s analysis of Boisen’s central thesis, I described how essential the “fellowship of the best” concept is in Boisen’s heritage. By way of summary here, the concept has to do with the transferring the loyalties of love from the finite to infinite. Nouwen finds this to be of great importance to Boisen’s autobiographical use of his own case: In Nouwen’s analysis, it makes sense of Boisen’s concrete life and it undergirds his approach to religion which for him represents the best in our social relationships. Both of these aspects, a lonely life and a social constructed approach to religion, come together in Boisen’s experience of mental illness. So if the primary evil of mental illness, as Boisen thought, was in the realm of social relationships, 507 then special attention needs to be paid to those lonely experiences which alienate us.

For Nouwen, the autobiographical story of Boisen is a life “long search for this fellowship of the best.” 508 It is “his lifelong task,” and it is a story of what Nouwen terms “transference.” 509 While there is evidence that Nouwen was not using this term within the psychoanalytic tradition, his central idea was that Boisen transferred to God his unrequited human love for Alice Batchelder, a woman he loved all his life, and the love he had for his father who died when Boisen was seven. This searching for love, writes Nouwen, was:

Boisen’s life work: discovering ways in which man can overcome the sense of alienation. This was the motive for the exploration of his inner world, this brought him through the wilderness of the lost, which he calls “a little known country,” and led him to the final discovery that “love between man and woman can be truly happy only when each is a free and autonomous being, dependent not upon the other, but upon God.” 510


508 Ibid., 62.

509 Ibid., 63.

Nouwen astutely notices that Boisen’s major intellectual output, beginning with The Exploration of the Inner World starts in 1936, the year after Alice died. Thus Nouwen concludes his “unreachable love was not only the main motive for his suffering but also the main motive for his creative work.”\textsuperscript{511} God becomes the ultimate best fellowship for which Alice prepared him. Nouwen’s portrait of Boisen is that of a man “whose whole life was a long terrible struggle to overcome the sense of alienation,”\textsuperscript{512} an alienation which Nouwen categorises as having an effect on Boisen’s personal and theological relationships. For Nouwen, Boisen is an alienated lonely man in search of a lasting and transcendent relationship with God, a search which passes through the upward movement of social loyalties, including for Boisen his love for his remembered father, his unrequited love of Alice and ending with God.

The book Intimacy\textsuperscript{513} endeavours to answer the following question: “How can I find a creative and fulfilling intimacy in my relationship with God and my fellowmen?”\textsuperscript{514} While the question arose originally from a group of priests at Notre Dame University campus who were reflecting on their ministry, Nouwen expands the question to be everyone’s: “The struggle for intimacy is no longer limited to one age group, but has become the struggle of modern man beyond the borders of a university campus.”\textsuperscript{515} Nouwen’s exploration of intimacy is therefore “primarily concerned about the inner life of man.”\textsuperscript{516} His book explores the problem of how to access and cultivate that inner life. Nouwen uses psychological terms in the book to describe this inner world. However, he clearly intends his approach to be pastoral, meaning it is written from “the concern of a priest who wonders how to understand what he sees in light of God’s work with man.”\textsuperscript{517}

\textsuperscript{511} Nouwen, “Anton T. Boisen and Theology through Living Human Documents,” 56.
\textsuperscript{512} Ibid., 58.
\textsuperscript{513} Nouwen, Intimacy.
\textsuperscript{514} Ibid., 1. Henri Nouwen wrote before the sensitivity to inclusivity was operative, and all citations of his work reflect this. Please see my statement regarding inclusive/unbiased language in the thesis’ front matter.
\textsuperscript{515} Ibid., 2.
\textsuperscript{516} Ibid., 163.
\textsuperscript{517} Ibid., 1.
This book has two explicit references to Boisen. The first appears in the chapter on student prayers as revelatory of confusion and hope. Nouwen, in his consideration of a particular student’s comment that prayer served a clarifying function in terms of “further action and further thought,” makes the link to Boisen:

The student’s post script is a beautiful echo of Anton’s Boisen’s conviction: “I do believe in prayer. I believe that its chief function is [....] to find out what is wanted out of us and to enable us to draw upon sources of strength which will make it possible for us to accomplish our task whatever it may be.”

In this section, Nouwen provides no contextualisation about who Boisen is, but I suggest his purpose in using this interpolation is clear. This citation from Boisen’s autobiography presents his ideas about religion as a way to problem solving. When Nouwen does his analysis, his emphasis is on how one particular student’s prayer reveals a “clarifying God,” that is, a means whereby the student in question was able to conceptualise who God is and what God does. In the rest of the chapter he identifies six other interpretations of “Gods” from the inner workings of other student prayers. The key point for Nouwen is accessing the workings of the inner world, something Boisen did as a way of doing theology.

The second citation, in a chapter titled “the priest and his mental health,” makes Boisen’s way of sourcing out theology from ministry explicit. The idea Nouwen wants to communicate, following Boisen, is that students are “living human documents”:

Are there pastors who realize that the people they are working with every day form one of the main sources for their theological understanding? Since God became man, man became the main source for the understanding of God. The parish is just as much a field of research for the priest as the hospital is for the doctor. Perhaps nobody made us so much aware of the need of this empirical theology as the Protestant mental-health chaplain Anton Boisen, who wrote: “Just as no historian worthy of the name is content to accept on authority the simplified statement of some other historian regarding the problem under investigation, so I have sought to begin, not with readymade formulations contained in books, but

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[518] Boisen, 111. Cited by Nouwen, Intimacy, 60. N.B. Nouwen slightly edits this citation removing the text “not to help us attain what we want but” where the brackets are placed.
Nouwen’s emphasis here is on the task and identity of the priest as one who is called to “remain responsible for God, to keep God alive always changing and always the same, as man himself.” 520 What is central about the way he uses Boisen is his appeal to Boisen’s method of sourcing this intimacy in the living human documents and their social relationships. This, he suggests, is the locus of a ministry responsible for keeping God alive.

Two years later, in Creative Ministry, 521 Nouwen cites Boisen to support his growing concerns about professionalization in ministry. The tension at the heart of Creative Ministry is that the elevation of psycho-social skills and their concentration on interpersonal dynamics is moving ministry away from its primary pastoral task. Nouwen is concerned with losing ministry’s “careful and critical contemplation of man” where “every pastoral contact is a challenge to understand in a new way God’s work with man and to distinguish with a growing sensitivity the light and darkness in the human heart.” 522 Nouwen invokes Boisen to make the point that Boisen too was not writing about skill acquisition alone. Rather than ask “how to do it well,” (a question of skill or technique) Nouwen suggests that Boisen’s question was “What can I learn from this person I meet as a pastor?” And to support his point, he cites the same seminal text he used in Intimacy, a citation from The Exploration of the Inner World. Boisen rejects what he calls “readymade formulations contained in books” and opts instead to work “with living human documents and with actual social conditions in all their complexities.” 523 Nouwen’s point is to refocus the minister’s task: while skills are important, the pastoral task involves unveiling human experience to discover the current expression of the fundamental religious view point.

520 Nouwen, Intimacy, 138.
521 Nouwen, Creative Ministry.
522 Ibid., 63.
This Nouwen calls contemplation, “the continuing search for God in the life of the people we [pastors] want to serve.”

_The Living Reminder_ is the book version of three lectures Nouwen gave at the 1976 International Conference of the Association for Clinical Pastoral Education and the Canadian Association for Pastoral Education in Detroit, Michigan. In many ways, references to Boisen would be appropriate and certainly expected here. Boisen only comes up once but in a critical way. In this text Nouwen’s overall task is the exploration of the risk of separating a central connection between ministry and spirituality, and prayer and service. He defines ministry as a “service in the name of the Lord” and spirituality as “attention to the life of the spirit in us.”

His central point is that the two, like prayer and service, are indivisible.

One particular metaphor frames Nouwen’s exploration of this connection: “remembrance.” This approach to ministry Nouwen explicitly roots in Abraham Heschel’s work, _Man is not Alone_ and in Nihls Dahl’s article, “Anamnesis: Memory and Commemoration in Early Christianity.” Both texts underscore the importance of remembrance. Heschel believes “much of what the Bible demands can be comprised in one word: Remember” and Dahl makes the point that the task of the first apostles was to “make the faithful remember what they have received and already know – or should know.” Nouwen concludes: “I felt that the best

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524 Nouwen, _Creative Ministry_, 63.
525 Nouwen, _The Living Reminder_.
526 The Canadian organization was subsequently renamed The Canadian Association of Pastoral Practice and Education (CAPPE). The name changed again at CAPPE’s AGM in April 2010. CAPPE is now known as “The Canadian Association of Spiritual Care.” This name change, and how it may reflect contemporary issues in clinical chaplaincy, was presented in detail in the contextual introduction of the dissertation.
527 Nouwen, _The Living Reminder_, 12.
528 Ibid., 12.
way to set about this exploration would be to look at ministry as ‘remembrance’ and the minister as the living reminder of Jesus Christ.”

Nouwen’s sources are also scientifically contemporary to his period. The importance of remembrance, Nouwen proposes, is evidenced in the “new insights into interpersonal relationships that we have received from the social sciences” which the minister must integrate into pastoral work. Nouwen cites Max Scheler’s *On the Eternal in Man*, “remembering is the beginning of freedom from the covert power of the remembered thing or occurrence.” Ministers must learn to “offer the space in which the wounding memories of the past can be reached and brought back in the light without fear.”

Herein lies the significance of the Boisen reference. Boisen is invoked at this point as the historical originator of “a dynamic understanding of the lives and behaviours” of those in care. While Boisen “pleaded” for chaplains to attend to the psychic forces at play, Nouwen says that after Boisen, much work focused on psychodynamics, to the extent that some are asking if we have not “created a situation in which ministers have become more interested in the receiver of the message than in the message itself.” Nouwen’s argument: ministers who get stuck learning the “technical specialty” about human dynamics risk getting “in the way of the experience of God.”

Nouwen directly challenges what he sees to be a shift in focus for ministry. In his view ministry certainly has something to do with the life story of the patient but it is primarily concerned with its relation with the life story of God. “The great vocation of the minister is to

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534 Ibid., 14.
537 Ibid., 23.
538 Ibid., 24.
539 Ibid., 27.
540 Ibid., 29.
continuously make connections between the human story and the divine story.”\(^5\) In other words, the minister helps people remember or reveal the forgotten connection because “all of ministry rests on the conviction that nothing, absolutely nothing, in our lives is outside the realm of God’s judgement and mercy.”\(^6\) In this sense, the minister’s challenge is to help people see their experience differently, not as excluded from, but as “as part of God’s ongoing redemptive work in the world.”\(^7\)

To be clear, Nouwen’s work is not anti-psychological. It is rather an attempt to clarify the limits and interrelated contexts of different disciplines. What was important to Nouwen during this time was to clarify what we might today call a scope of practice. John Mogabgab, who assisted Nouwen in the redaction of the *The Living Reminder* describes it as Nouwen’s “attempt to affirm the value of psychological insights for ministry while distinguishing clearly between psychology and spirituality.”\(^8\) Practical theologian Yolanda Dreyer underscores this distinctiveness in her assessment of Nouwen’s larger body of work. She writes that “in order to explain and enhance spirituality, Nouwen finds it imperative that the pastoral caregiver should move beyond psychology,”\(^9\) and find ways to relate the presenting experience with God’s presence in the world. Pastoral psychologist Kevin Gillespie, SJ, a foundational source for Dreyer’s assessment, suggests that this distinction is related to the fact that “Nouwen wanted more than psychological answers to the real questions of the day.”\(^10\) In his analysis of Nouwen’s work, he cites Todd Brennan’s 1978 interview with Nouwen on this issue in which Nouwen said “I, however, feel that if you simply remain in the psychological world, if you raise only psychological questions, you will get only psychological answers.”\(^11\) In this text of *The

\(^5\) Ibid., 24.
\(^6\) Ibid., 26.
\(^7\) Ibid.
Living Reminder, Nouwen himself makes this point very clearly as he argues for a different kind of ministry, a remembering one, that facilitates the disclosure of God where “the insights of the behavioural sciences should be seen as aids in this process.”\textsuperscript{548} The central point in reference to this citation of Boisen is that Nouwen uses Boisen to support theological priority and human/divine disclosure in the actual scope of practice for chaplaincy. (I will return to the importance of this metaphor of remembering and its link to the sciences in Chapter Four.)

In addition to his 1968 article, “Boisen and the Case Method” was published in 1977.\textsuperscript{549} This is Nouwen’s second and only other article with Boisen as the primary subject matter. It is also his last public and published work on Boisen. Where the former article stressed Nouwen’s own case and his autobiographic use of his “case,” this 1977 article explores in greater detail the roots of Boisen’s case method in the work of Richard Clarke Cabot\textsuperscript{550} as well as the way Boisen developed it theologically. This 1977 article includes many repeated paragraphs from his 1968 earlier article, but Nouwen does not directly indicate these are previously published citations.

The 1977 article addresses the approach to the case study method as practised by Cabot and Boisen. The first half of it centers on Cabot’s “case-approach in medical education,”\textsuperscript{551} including his clinicopathological conferences, and his teaching at Harvard. The second focuses on Boisen’s use of the case method in the context of the mental hospital where he worked and trained students, and how this core idea influenced Boisen’s “theology through living human documents.”\textsuperscript{552} Noteworthy in this article is that Nouwen reproduces in detail one of Boisen’s many cases. Nouwen has a detailed presentation of the case of Benjamin Mickle, something only briefly referred to in his 1968 article.\textsuperscript{553}

\textsuperscript{548} Nouwen, The Living Reminder, 34.
\textsuperscript{549} Nouwen, "Boisen and the Case Method."
\textsuperscript{550} Medical Doctor and one of the founders of contemporary Social Work, Cabot is treated in detail in Chapter One of this dissertation.
\textsuperscript{551} Nouwen, "Boisen and the Case Method," 13.
\textsuperscript{552} Ibid., 13.
\textsuperscript{553} Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 60.
In the first half of this 1977 article, Nouwen presents a very detailed portrait of Cabot, his sources, personality, and important role in the advancement of medical education. Although live cases were for a long time part of medical training, Nouwen identifies how it was Cabot’s use of the “discrepancy between diagnosis made during life and what the autopsy reveals only after death” that made all the difference because it necessitated going beyond the symptoms to the actual cause of the problem. Cabot later published these cases in a two volume work titled, *Differential Diagnosis*, a text Nouwen notes Boisen believed was the “most important” work by Cabot. For Nouwen, Cabot’s imprint and the influence of his case method on Boisen are clear. Nouwen evidences this with a directive that Cabot gave to the physicians: "We must reason and inquire our way back into the deeper process and more obscure causes." Nouwen then sees an echo in Boisen’s directive to theologians: "(We must) discover the motive forces and the machinery which are involved and formulate the laws which govern them." Nouwen explains that the focus of both approaches is on Differential Diagnosis.

In the second half of the article, Nouwen provides a compelling portrait of Boisen who took this idea and put it into practice theologically. More than just a tactician, Boisen was committed “that theology should derive its authority not from books, but as in every science worth its name, from observable and controllable data.” And it is out of this idea Nouwen suggests that the contemporary chaplaincy of Nouwen’s day owes both its place on the clinical team and its gratitude.

[Boisen] established the invaluable tradition of the minister as fully recognized member of the therapeutic team and claimed a due place for the minister in the

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555 Ibid., 16. This text, in a shorter form also appears in Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 58.
558 Nouwen, "Boisen and the Case Method," 17. This text also appears, in slightly altered form, in Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 59.
circle of helping professions. If today in hospitals and institutions where clinical training programs are established the chaplain-supervisor and his students from an integral part of the hospital staff and can participate in the staff discussions and are free to consult all the files, they are indebted in large part to the strong conviction of Boisen that the chaplain is also a scientist, specialized in the religious aspect of the case under consideration.\(^{560}\)

It should be mentioned here that this text bears a deep resemblance but no official citation to those ideas by Pruyser which were explored in Chapter One of this thesis.

Also in this section, Nouwen’s Boisen is both chaplain and researcher,\(^{561}\) trying to offer “service to the suffering patients and research to come to a better understanding of the nature of mental illness and its religious implications.”\(^{562}\) With reference to Boisen’s own course and case material which Nouwen sought out from Boisen’s own archives in Chicago and then mimeographed, Nouwen highlights that Boisen is a man who first believed and then taught his first students that

"service and understanding go hand in hand. Without true understanding there can be no effective service in that which concerns the spiritual life, and only as we come to know the attitude of service will the doors open in the secret places of the heart."\(^{563}\)

Nouwen draws attention to the insight that observation comes through direct service and contact. In Boisen’s case, the first students served as attendants in mental hospitals. In the first clinical student conferences Boisen organized, he preferred to base the cases on “the daily contact and experiences of the students with the patients” in such a way that these, and many other cases from Boisen’s own work, became “living human documents, the new source for Boisen’s theological training.”\(^{564}\) Thus, “the point of departure was not any longer an idea, concept, or

\(^{560}\) Ibid., 20.

\(^{561}\) Ibid., 20-21.

\(^{562}\) Ibid., 21.


\(^{564}\) Nouwen, "Boisen and the Case Method," 22.
theory, but a living person, with a unique history and a unique problem.”

Case-studies were of value to Boisen for research and training, even if, Nouwen admits, those cases were often like Boisen’s own.

In this article Nouwen points out the extent to which Boisen’s approach to case method is derived from the work of the influential Cabot. Boisen took Cabot’s approach and adapted it in the venue he thought best, mental hospitals, and used it to structure his chaplaincy, his research, and his training of students. He did this in a way that permitted the asking of “some very crucial theological questions,” especially the ones dealing with why voices heard by patients in mental health centres are “immediately regarded with suspicion.”

In a way that very much celebrates the innovative genius of Boisen, Nouwen underscores that Boisen’s “new clinical approach to this age old question gave it a new and fresh articulation, replaced it in a relevant context, and brought theology back from the “brains-level” to the “guts-level.”

The overarching contextual issue in this study of the way Nouwen writes about Boisen in his published books is that Boisen is cited in Nouwen’s larger efforts to situate ministry in its primarily pastoral and theological context. Boisen is used sparingly, but strategically, to underscore that when ministers turn to the actual person, the living human document, the minister’s main task is to search for and support the development of the human/divine relationship.

This unique approach is rooted in Nouwen’s specific method of reading and presenting his portrait of Boisen. In his two articles, Boisen is a man whose personal story of mental illness reveals his effort to resolve his own alienation, a loneliness resolved only in God. Nouwen suggests that to understand Boisen, it is necessary to grasp his fundamental search for the fellowship of the best, a searching Boisen believed to be visible in some acute mental illness. His pursuit of this reality, expressed in his social relationships and evidenced in his own experience

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565 Ibid., 29.
566 Ibid., 23.
567 Ibid., 27.
568 Ibid., 27.
of mental illness, constitutes the core of Boisen’s use of the case method. Nouwen stresses that Boisen applied the case method, which he learned first from Cabot, innovatively to clinical chaplaincy, research and training.

There are also individual themes that support this specific conclusion: First, Nouwen uses Boisen to underscore a fundamental *relationality* between human beings and God and, second, ministry has something essential to do with “contemplating and connecting” those two elements so as to achieve *intimacy*. Nouwen’s use of Boisen also underscores the complementarity that psychology can bring to theology. In this approach, Nouwen, like Boisen, supports a *unitive* approach, combining the two disciplines. But his use of Boisen reminds the reader that the integration of the social sciences cannot be at the expense of the *pastoral* relationship. In these documents, and in this usage of Boisen, the emphasis is on the theological. Finally, Nouwen’s suggest that the metaphor of *remembrance* can be employed in a theologically corrective way to the practice of pastoral care.

**Boisen in the Henri J.M. Nouwen Archives and Research Collection**

Nouwen’s archived materials on Boisen are part of a larger collection comprising The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives in the John M. Kelly Library at the University of St. Michael’s College, University of Toronto. As referenced in the extant biographies, the Nouwen-Boisen related files are ample, constituting more than one linear meter of archived files. Nouwen’s material on Boisen is part of a larger collection on the North American pastoral care movement. For example, Nouwen collected over 50 different articles written by Boisen, many more about Boisen by such people as Hiltner and Pruyster, and even a photograph of Boisen. In many of the articles, one can see Nouwen’s annotations and marginalia. Nouwen also collected Boisen’s class material and handouts, including many of his case studies.

569 This collection includes the archived material referred to in the biographies. Previously at Yale, these documents were donated to Toronto in the year 2000, making this new collection the definitive archive site for Nouwen’s life and work. For an excellent overview publication about the entire collection by the archivist responsible for these holdings, see Gabrielle Earnshaw, “The Henri J. M. Nouwen Archives and Research Collection,” (Toronto: John M. Kelly Library, University of St. Michael's College, 2011). http://archive.org/stream/henrijmnouwenarc00earn#page/n0/mode/2up [accessed September 5, 2011].
Of particular significance in the archives are two doctoral outlines concerning Nouwen’s research on Boisen. These can be read as indicators of the kinds of questions Nouwen was exploring about Boisen, Nouwen’s intellectual influences, and the kinds of research material Nouwen was collecting in his doctoral efforts. My exposition of this material will suggest that one of these, or at least its seminal ideas, was discussed in detail with several staff from the Menninger Clinic, with the most explicit notes being from Pruyser.

The archives also include several manuscripts of original material Nouwen wrote on Boisen for his post-graduate work at the University of Nijmegen. These documents seem to have been written between 1964 and 1971, the outside dates of Nouwen’s degrees in psychology and theology. Some are clearly traceable to parts of the two theses outlines. Whereas there is no complete thesis these documents include research, study notes, as well as partial and complete manuscript sections, all likely from this period. There is also correspondence that reveals that two of these unpublished manuscripts assisted other students in their doctoral work on Boisen. One final document here is Nouwen’s record of his personal interview with Boisen.

There is other material in the archives which provides a more longitudinal view of the place that Boisen played in Nouwen’s non doctoral activities. The archives have teaching material that Nouwen collated while he was in the Psychology Department at Notre Dame and at The Yale Divinity School. In these teaching notes, Boisen appears primarily as a historical figure in the development of pastoral care, religion and the psychology of religion.

Much of the documentation written by Nouwen about Boisen was not dated by Nouwen, a challenge to both researcher and archivist. For this reason, the general outside dates assigned by the archives to most of the material are 1966-1977. This period is considered Nouwen’s active period of scholarship on Boisen. Nouwen’s last published references to Boisen date to 1977.570 The only notable exception to document dating concerns Nouwen’s notes from 1964-1966. These relate to Nouwen’s training at the Menninger Clinic, Topeka, Kansas, as a student in the Religion and Psychiatry program. These include dated documentation of lecture notes, and records of specific interviews Nouwen undertook to discuss ideas with people like Pruyser.

570 Nouwen, *The Living Reminder*; Nouwen, "Boisen and the Case Method."
Except in these instances then, for the purposes of this research, using the archived material required an “archaeological” approach where documents were at least dated to no earlier than the “in text” citations. Finally, while the archives have some material by Nouwen written before 1966, none of it has to do with Boisen.\textsuperscript{571}

Since there are challenges related to accurately dating these files and many are incomplete manuscripts, my critical reading method was to follow the data while attempting a meaningful critical literary review without interpolating or reconstructing his ideas. It is unfortunate that Nouwen was never interviewed about Boisen and his work, and its influence on him. As has been shown in part two of this chapter, other scholars have tended to be eisegetic in their limited analysis of this early period. My method in analysing scholarship and future studies recognises that we are dealing with incomplete records.

This next section presents my key findings, including a critical presentation of what I consider to be eleven core documents and fragments, organized under four main titles. The first section begins with a personal letter which identifies two unpublished documents which were helpful to other scholars. The second section presents and analyses these two documents. Section three critically presents Nouwen’s two doctoral outlines and some supporting documentation related to them, including interviews. Section four completes this inquiry with a description and critical review of Nouwen’s personal interview with Boisen.

\textit{A Revealing Letter}

In a letter to Nouwen dated September 2, 1975, then doctoral student Glenn Asquith Jr., promises to return unpublished manuscripts Nouwen had previously lent him for Asquith’s own work on Boisen.\textsuperscript{572} While Nouwen’s original letter requesting their return is not in the archives,

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{571} The earliest documents, from about 1963-64 include three manuscripts in Dutch, two of which are original writings by Nouwen. The first is on the pastoral formation of army chaplains, and the second on a pastoral approach to homosexuality, neither one having anything to do with Boisen. These documents are not dated by the author, but these “earliest possible dates” were determined by reference to the bibliographies. There is one other undated document, a Dutch translation of Paul Pruysers’s “A Dynamic Psychology of Religion.” Since that text came out in 1968, the translation is likely later.

\item \textsuperscript{572} Glenn. H. Asquith Jr, "Personal Correspondence with Henri Nouwen," \textit{The Henri J.M Nouwen Archives and Research Collection in the Special Collections and Archives} (Toronto: The John M. Kelly Library at the University of St. Michael’s College, University of Toronto, 1975).
\end{itemize}
\end{footnotesize}
Asquith’s letter is helpful in that it specifically identifies the documents that Nouwen lent to him. The letter also provides an external albeit brief assessment of Nouwen’s material by a scholar who would later become an important Boisen expert⁵⁷³ and Professor of Pastoral Theology at Moravian Theological Seminary. The three listed documents are: (1) a 151 page document titled *Anton T. Boisen and the Study of Theology through “Living Human Documents”*, (2) a 70-page report on *Pastoral Supervision in Historical Context* and, (3) some material from a former mental health patient named Lulu Wendel who had written to Boisen.

Asquith’s interest is with the first two texts, stating that they were important for his own doctoral work:

Your manuscript on Boisen has helped me greatly in terms of putting Boisen’s contribution to theological education in clearer perspective. I especially liked and agreed with your assessment at the end in which you stated that Boisen’s theological interest was coloured by a personal preoccupation and that it took persons like S. Hiltner to put Boisen’s ideas into effect in the theological schools….And I also liked your comment that “of all his work, Boisen’s autobiography will be his most lasting contribution because it is in fact the best representation of his method.”⁵⁷⁴

This valuation is evidenced in the use Asquith made of Nouwen’s material in parts of his 1976 doctoral thesis titled: “The Clinical Method of Theological Inquiry of Anton. T. Boisen.”⁵⁷⁵ In particular, in Asquith’s second chapter on the *personal “Sources of the Method,”* which includes 75 pages on “Boisen’s Early Years” and “His [Boisen’s] Search for Commitment,” Nouwen’s unpublished material in page count alone is one of the most voluble sources after Boisen’s

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⁵⁷⁴ Asquith Jr, "Personal Correspondence with Henri Nouwen."

Methodologically, Asquith justifies his use of such personal sources citing the “personal experiences of psychoanalyst Erik Erikson and theologian Paul Tillich” in order to “further validate the claim that the personal sources of one’s ideas merit attention.” However, Asquith’s citation pattern indicates Nouwen as his key Boisen biographical expert, outside of Boisen himself. Asquith chose Nouwen to give evidence that Boisen’s biography and especially his personal challenges in life were the source of his creativity.

**Two Key Unpublished Documents**

1. “Anton T. Boisen and the Study of Theology through ‘Living Human Documents’”

This 151-page manuscript appears in the same mimeographed draft form three times in the archives along with one much edited base document, but all copies are undated. One appears with “Yale Divinity School” on the title page. Since Nouwen was there between 1971 and 1981 this date range could be considered, but an earlier dating is likely. The latest chronological reference date using the text’s bibliography is August 15, 1967, and this date reflects a citation of a personal letter from Pruyser about Boisen, to Nouwen. This makes the fall of 1967 the earliest date discernible based on the document itself.
A comparison of the structure and text suggests that the 1968 article is a reduced version of this document. Some of the contents of the 151 page manuscript are also the source material for Nouwen’s second published article on Boisen from 1977. Dwight Norwood, the person named in the 1968 article as providing “invaluable help in the preparation of this article,” confirms that he assisted Nouwen in research on Boisen in the summer of 1967 at Notre Dame University. Norwood also spoke of a research trip that summer with Nouwen to the Menninger Clinic, which included several interviews. A seven page record of an interview with Pruysper, but none of the others, is on file in the archives. There is no discussion in the archives why Nouwen would have published this manuscript in two articles.

Nouwen introduces this text as a “book about new trends in theological education which have developed since Anton T. Boisen accepted four theological students at Worcester State Hospital,” in 1925. Nouwen describes the project in two parts.

In the first part of this book, we will discuss the person and work of Anton T. Boisen, who laid the foundation for many new trends in the field of theological education. In the second part we will describe and illustrate some of these new insights which seem to constitute the core of many current discussions. The focus

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582 Nouwen, "Anton T. Boisen and Theology through Living Human Documents."
584 Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 49.
585 Henri J. M. Nouwen and Dwight Norwood, "Paul Pruysper Interview," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at University of St. Michael's College, University of Toronto, 1967). Personal correspondence with Dwight Norwood confirms that this document, which in its original is without an author’s name on it, was scripted and then corrected by Norwood. It was likely typed by Nouwen’s secretary at the time.
586 Henri J. M. Nouwen, "Anton T. Boisen and the Study of Theology through 'Living Human Documents' (Draft #3)," 2.
will be on the study of theology through “living human documents,” which we will call the case method in theological education. 588

At the end of this manuscript, Nouwen signals the purpose of the second part: pastoral formation.

It is now our task to study more systematically this case approach in theological education in its many ramifications and to show the power of this approach for the formation of the future pastor. 589

But there is no “part two” in this manuscript which begins and ends with the case of Boisen. In terms of this 151 page document, it is Boisen’s “own case” and the “case method” that form its fundamental core. These two related ideas inform the core sections that Nouwen published, in many cases verbatim, in his 1968 and 1977 articles. In fact, the 1968 article’s “case” structure (that is with five titles of the central experience, the input, the outcome, growth through conflicts, and the last years) is exactly the same as in this larger manuscript, which titles its chapters the same way.

In terms of content, the 1968 document reproduces with some slight editing most of chapter one (the central experience) in about four pages, most of chapter two (the input) in another six pages, and most of chapter five in two pages. What is not covered in any detail is chapter three (the outcome) and four (growth through conflicts). This material in the 1968 published article is selectively summarised in three and half pages but represents 90 pages of manuscript text. The 1977 document begins with and maintains an almost verbatim citation of chapter three (the outcome) in its entirety. In other words, these two published documents present almost two thirds of the archived and unpublished document, or about 100 pages. Since these two published documents were described in detail in part two, there is no need to critically review the ideas of Boisen’s autobiographical case and the case method again here.

What does require attention in terms of a critical review of content is chapter four, titled “Growth through Conflicts.” As mentioned, the 1968 article gives this scant attention, but in the unpublished manuscript, it occupies one third of the text or fifty five pages. This manuscript

588 Ibid., 2-3.
589 Ibid., 154.
section is especially important for the portrait it offers of Boisen. It details not only the trends in pastoral care that followed Boisen’s move to the periphery of the clinical pastoral movement, but Boisen’s reactions to the same. Nouwen’s titles reveal his focus on Boisen’s shifting place in these changes: Boisen and the Verbatim Report, Boisen and Psychotherapeutic Trends, and Boisen and the Theological Schools. Nouwen carefully identifies the causes, the players, and benefits of these developments. He affirms that while Boisen’s preoccupation with cases like his own was in fact at least one of the reasons that some students moved in other directions, these developments in clinical pastoral education need to be seen as “more than just disturbing [to Boisen’s original vision]. In fact they helped to clarify the many key issues in training and broadened the possibilities of the case method.”

But Nouwen’s core critical point in this larger unpublished document is that the movement risked losing Boisen’s basic intention with the case method, that the work always be theological. Nouwen notes how Boisen felt for example, that the therapeutic shift in clinical training away from the patient towards the student-supervisor relationship obfuscated the medically inspired importance of being patient and content focused. Nouwen also describes in detail how this move, especially with the advent of Robert Brinkman as administrative assistant to “the council of clinical training of theological students” in 1936, meant that “the theological perspective [was] hardly present and what emerge[d was] a pastoral counsellor who [was] hardly different from a psychotherapist, with a psychiatric background.” Nouwen notes that Boisen protested when Brinkman moved to change the name of the council dropping any reference to theological students and opening up training to other disciplines. But Nouwen also underscores that one of the positives of the Brinkman tradition was the importance of attending to the “student’s own personality, his weaknesses and strengths, his problems and assets.”

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590 Ibid., 143. See also Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 61.
591 Nouwen, "Anton T. Boisen and the Study of Theology through 'Living Human Documents' (Draft #3)," 114.
592 Ibid., 121.
593 Ibid., 121.
594 Ibid., 123.
However, while Nouwen does identify some positives in these changes, his intention is to show that for Boisen, this change away from a theological priority meant “a rejection of the theological basis on which he had built his training and an undermining of his primary concern.”

Another central element in this chapter belongs to Nouwen’s description of Hiltner, specifically how “Hiltner never lost his view of Boisen’s basic insights and kept faithful to his main concepts about theological education.” Nouwen carefully describes how Hiltner was able to build on the case method innovations of Boisen’s followers in a way Boisen could never do, all the while maintaining the theological focus on the case. Nouwen’s argument being that Hiltner understood and practiced this in a more effective way than Boisen himself, whose “preoccupation with his own case, made it very difficult for him to elaborate his own ideas.” In Nouwen’s own words, “Hiltner realized more and more that the crux of the matter was exactly in the area of theology.” He writes Hiltner understood there will need to be psychological insight and understanding, but the goal is the enhancing, deepening, and widening of his theological insight. This means that a case method remains incomplete when it does not guide the student to the theological question, which is the question about God and His work with man.

This last quote highlights Nouwen’s interest in “guidance,” but it will take another unpublished work Asquith referred to, “Pastoral Supervision in Historical Perspective” from the archives, for Nouwen to fully develop this.

2. “Pastoral Supervision in Historical Perspective”

The document is dated in pen on the bottom of the first page as “Dec. 1965.” Although this is not Nouwen’s hand writing, the date is likely correct. There is a typewritten note on the title page indicating that this document is exclusively for the use of “members of the supervision

595 Ibid., 128.
596 Ibid., 129.
597 Ibid., 137.
598 Ibid., 139.
599 Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)."
seminar” and that Nouwen is waiting on corrections from Hiltner and Southard. If this 1965 date is correct, then this supervision seminar likely refers to the training Nouwen received during his second year, 1965-66, at the Menninger Clinic. Both Hiltner and Southard were on staff for this seminar during that time. Secondary resources confirm that a second year program in “supervised pastoral work and counselling” was offered at the clinic since 1963 and that Nouwen did a second year at this clinic.

The text does not have a bibliography. Two of its “in text” references confirm its dating to no earlier than May 1965. First, the latest of the in text references is May 1965. The second is a reference to Nouwen’s only visit with Boisen. Nouwen writes “Boisen told me last year when I visited him...” Nouwen recorded his visit to Boisen in a document which exists in the archives (and which will be analysed shortly) which dates that encounter to August of 1964. We can therefore confirm that “Pastoral Supervision in Historical context” is not earlier than May of 1965.

In this document, Nouwen sets out to look at “the history of the concept of supervision in reference to four models of pastoral supervision.” He begins by noting that while the central tool for supervision has been “written reports...seldom do we find an article or study which gives better understanding of this learning.” Nouwen compares clinical pastoral training’s lack of reflection with evidence of social work’s abundant interest in report writing. He concludes that critical reflection regarding supervision in clinical pastoral care is long overdue.

Nouwen’s analysis covers four models, three of which he terms strictly historical: the medical case model, the therapeutic model, and the theological school model. While he says that the spiritual guidance “as a model does not play a [historical] part” Nouwen does source it in

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601 Nouwen, “Pastoral Supervision in Historical Perspective (Unpublished Manuscript),” 44.
602 Nouwen, “Boisen.”
603 Nouwen, “Pastoral Supervision in Historical Perspective (Unpublished Manuscript),” 3.
604 Ibid., 1.
605 Ibid., 67.
clinical training’s earliest beginnings, with Cabot himself. As the text develops, Nouwen builds a case that the spiritual guidance model is his preferred corrective to certain trends in clinical pastoral training.

What, then, are the problems with these historical models? What does Nouwen’s treatment of them disclose? The first one, rooted primarily in the work of Richard Cabot, has to do with the idea that supervision should include students seeing and participating in their teachers’ struggles and failures in the diagnosis of complex medical presentations. Thanks to the influence of John Dewey’s ideas on education as well as historical efforts at the time to restructure medical education’s use of student interns, Cabot’s formative ideas changed medical training practice dramatically. His innovative “clinical pathological conferences”, which Nouwen describes in detail, permitted a doctor’s struggles and failures in diagnosis to be centre stage. No longer were teachers or supervisors seen as infallible and authoritarian, but they were transparent models of the very challenging process which is diagnosis.

Although Cabot was very influential in the life work of Boisen and even though Cabot captured this struggle dynamic in his own “Plea for a Clinical year in the course of theological studies” in 1925, Nouwen asks, “How much of this went into the concept of supervision?” Nouwen’s answer is very little. “This confronting the student with the struggles, pains, failures, and successes of the teacher never became so central as it was for Cabot. Even Boisen did not stress this point so much.” Herein lies Nouwen’s first criticism: the medical model of supervision as adopted by clinical training’s leaders—including Boisen—lost the transparency of the supervisor’s struggle.

This turn to supervision by “infallible” supervisors became even more pronounced in the next historical period. Supervision started to engage in therapy for students and thus became more student centered. The supervisor considered “it his obligation to help the student work through his personal problems related to his pastoral work or not.”

606 Ibid., 9.
607 Ibid.
608 Ibid., 47.
Meyer, Harry Stack Sullivan and Wilhelm Reich contributed to this therapeutic turn. This turn was also marked by a theological deficit. Supervisors and students began to “doubt the relevance of their theological education.”⁶₀⁹ Although Nouwen indicates that Hiltner worked against this trend, David Brinkman’s preference for psychology and science over pastoral theology brought isolation of clinical training from seminaries and theological schools. For Nouwen, this trend relegated the importance of theology and had serious consequences for formation.

Nouwen’s third model, the theological school model is, he admits, one that is very denominationally driven and specific. He presents the effort by Wayne Oates whom Nouwen introduces as “the father of clinical pastoral education for the Southern Baptists.”⁶¹⁰ He describes Oates’ model as integrating clinical training with the other disciplines of theology in such a way that it emerged as an “integral part ... of the theological curriculum.”⁶¹¹ Nouwen, however, has this concern: “supervision in the school shows all the marks of the predominant denominational emphasis”⁶¹² where the evangelistic focus is on immediate conversion and the role of the minister stops after the “static”⁶¹₃ conversion experience. What is not accounted for and what Nouwen saw as underrepresented is a more gradual or moderated conversion experience.

For Nouwen all three historical periods have negative outcomes in terms of supervision trends. The medical model quickly became professionalized and authoritarian losing any witness of professional struggle; the therapeutic model replaced theology with other social sciences; and the Baptist school model made no space for a more dynamic conversion processes, rendering it theologically bound to a certain static denominational outlook. In each of these models, supervision takes on an approach which diminishes dynamic and creative theological inquiry.

⁶₀⁹ Ibid., 49.
⁶₁⁰ Ibid., 57.
⁶₁¹ Ibid., 58.
⁶₁₂ Ibid., 65.
⁶₁₃ Ibid.
Nouwen frames his corrective proposal for a spiritual guidance model in a somewhat convoluted way. He says this is not meant to be “a better model or even an alternative model but to be able to see the history of the concept of supervision in a little different context and to evaluate certain trends, in a certain sense, from without.” I suggest that Nouwen’s word choice is intentionally indirect. His argument proceeds this way. Nouwen understands that clinical training is supposed to be about making theological education reality oriented; that Boisen’s intention was for “the creation of a body of concrete experience held in common by pupil and teacher, serving as a field for illustration, holding discussions down to reality and linking it in profitable union with the minds of those present.” However, for Nouwen, the turn to the actual human subject may be obfuscating another source of data and another purpose: the study and assistance to people living their relationship with God. Nouwen’s attention is particularly on the student’s relationship with God. He argues that clinical training is not using available resources, such as those from the great spiritual writers such as Theresa of Avila, Ignatius of Loyola, Thomas à Kempis and Cardinal Newman who:

wrote thousands of pages about the stormy development of their most intimate relationship with God, with all its ups and downs, times of pain and times of rest, lives of understanding and intensities of darkness and light.  

In this same section, Nouwen references his own “own experience” to suggest that “it has become very difficult in the circles of clinical pastoral training to speak long and realistic [sic] about God...[God] has become vague, undefined, distant... whereas man was concrete, defined and close.” This reference is very interesting contextually. It likely refers to his two units of clinical training which were part of his training at the Menninger Centre. From September 1964 to March 1965, Nouwen trained as a psychiatric chaplain at Topeka State Hospital, under the

614 Ibid., 67.
616 Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," 69.
617 Ibid., 68. In terms of grammar and spelling in these unpublished documents, please see the statement regarding inclusive/unbiased language in the front matter of this thesis.
supervision of Charles Hall. The archives have his written evaluation of his learning during this period. These include this comment which addresses a trend he was witnessing in his hospital. Chaplains were presenting their clinical work through immanent psychiatric categories without any theological vocabulary, concepts or discourse. He writes:

I do not think this approach is defensible by saying this is [an] adaptation to or translation for the psychiatric team. It shortcuts the most essential message of the ministry. If the ministry melts together completely with the prevailing philosophy of treatment it loses its meaning. The ministry can only be sufficiently described in theological terms because it is essentially a theological profession. I think this is an extremely important point because terminology is an expression of attitude. I have the impression that there is a hidden agenda which says that theological terms are not relevant enough for our daily concerns, and the layman feels more comfortable with terms borrowed from the psychological disciplines than with those available in theology. I think we are responsible for the language we develop. The language protects the profession and offers a frame for its development.\footnote{Henri J. M. Nouwen, "Evaluation of Six Months Clinical Pastoral Training 1964-65," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1964-65), 62; [emphasis added].}

The value of this contextual reflection is that it supports Nouwen’s fundamental criticism that clinical pastoral education is missing an essentially theological perspective in the clinical reality. He asks whether there is not another concrete reality which can function as a theological source? For Boisen the concrete reality is the living human document. The question is: Is there something like the experience of the living God or better the living human God?\footnote{Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," 68.}

Nouwen is pointing here to a systemic problem in the way education about living human documents developed. If the only data admissible emerges from the concrete human experience before the student, then this experience and only this experience “is the highest reality that provides the source of his theological education.”\footnote{Ibid., 68.} Nouwen maintains that experience, which can be constructive as well as destructive, is not enough on its own. Since the “spiritual life is a
dynamic encounter with God,” Nouwen argues that clinical training’s attention to human interpersonal dynamics needs to be also applied to “our understanding of the relationship between man and God.” Therefore, “the exploration of our relationship with God is a primary source of our theology,” writes Nouwen, and this demands yet another source, spiritual guidance.

Nouwen’s end purpose is to help a person “to ask the right question at the right moment with the right goal.” Such guidance requires awareness of the concrete reality but also an understanding and capacity to use the dynamics involved in the human/divine relationship. He finds a source for this understanding in the history and practice of mystical experience. Mysticism “is to be considered as a part of the life of every Christian and not as a performance on the trapeze of our spiritual household.” Nouwen is aware that the mystical tradition has not been part of the Protestant experience which was so formative in clinical training’s early development. Nouwen suggests it might benefit from it now. For Nouwen, mysticism is not to be considered something having to do with “abstractness, vagueness or cloudyness [sic]” but about God as the “only real object,” a territory that requires guidance. Appealing to the tradition of the mystics, Nouwen makes the point that the great saints’ main complaint was “the absence of people who could guide them on their difficult road.”

By way of summary, in these two documents, Nouwen presents the person and work of Boisen and then Nouwen develops his assessment of both Boisen’s and his own concerns with the development of pastoral education and supervision. Nouwen’s treatment concerns two missing pieces in the history of training: the first goes back to Boisen’s himself and the influence of Cabot. This has to do with Boisen’s theological intentions in the way he used Cabot’s case.

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621 Ibid., 70.
622 Ibid., 70.
623 Ibid., 70.
624 Ibid., 70.
625 Ibid., 70.
626 Ibid., 69.
627 Ibid., 69.
method. It includes the lack of transparency in the way pastoral education developed especially as it failed to make visible the supervisor’s struggle in the teaching of pastoral diagnosis. The second is the lack of attention given to the dynamics of the human/divine relationship. Supervision must help people ask the right questions to explore this reality. In other words, attention to living human documents must also give way to the “living human God.” Quite simply, Nouwen is concerned that clinical pastoral supervision, in its supervision on the concrete living human document has forgotten the need for skilled people in guiding students and patients through the human/divine encounter.

**Doctoral Outlines and Related Documentation**

1. Documentation referring to Doctoral Outline #1

The archives have a two and a half page thesis dissertation outline titled “The history use and value of the casemethod [sic] in American Pastoral Education.” Undated, it is certainly no earlier than 1960 because its latest reference is to Boisen’s autobiography which only came out in that year. Due to the incomplete files pertaining to the period, it is unclear whether this actual outline is an English version of the doctoral efforts Nouwen began in 1957 in Holland at the Katholieke Universiteit Nijmegen. It is known Nouwen was awarded the non thesis degree of doctorandus on Feb 3, 1964 with a primary specialisation in psychology as well as studies in sociology and social geography, just before he left for the United States to start at the Menninger Clinic.

What is however certain is that Nouwen discussed key ideas about Boisen and the case method in 1964 with people connected to Menninger Clinic. There is a note on file titled

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629 This university changed its name 2004 to the Radboud Universiteit Nijmegen.

“Conversation with S. Hiltner about Boisen. 24 April, 1964”, another titled “conversation with Klink: June 1964 about Cabot and the case method;” and two undated notes referring to conversations about Boisen with Caroll Wise and W. Sullivan. One note, undated but likely from this period, is explicitly titled “Conversation with Dr. Pruyser about Dissertation.” The content of these records are certainly reflected in the doctoral outline suggesting that this thesis document could be a topic or the result of these and other conversations in America.

Since a precise dating is not possible at this time, a range can however be determined. At the outside, Nouwen’s first published article on Boisen’s case method came out in 1968 and it uses many of the same ideas employed in this outline. On the inside, this thesis outline certainly reflects conversations as early as 1964. In the absence of any other corroborating data, this outline is best situated between these two dates, 1964-68.

Nouwen’s thesis title provides the basic description of its proposed structure. Nouwen envisaged a three part thesis that would outline the “history” of the “case method”, as well as its “use” and “value”, all in regards to American Pastoral Education. In part one Nouwen planned to place special emphasis on Boisen’s discovery of the method through Richard Cabot. Nouwen stressed the importance of Boisen’s own case “to show how the personal experience of Boisen started a movement” which he tended to replicate, and the way his students developed the method further, especially the move to supervision. Part two proposed a systematic description of the “uses” of the method including the idea to compare “casuistry as used in Moral Theology” with case method for the “catholic reader.” This section’s outline underscored how

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632 Henri J. M. Nouwen, "Gesprek Met Dr. Pruysers over Dissertatie." The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, n.d. [c.1964?]).

633 Nouwen, "Anton T. Boisen and Theology through Living Human Documents."


635 Ibid., 2.
The supervision of students took priority over case descriptions as a way to assist the student in developing a pastoral identity. The third part, the most undeveloped in the proposal, called for research on “the experimental way the influence of the case method [has] on the theology student, or on the minister, or priest.” Nouwen himself writes that these “ideas are still very vague.” What is significant about this first outline is the central topic: the case method. It confirms that by this stage, Nouwen’s had already framed his study of Boisen in terms of his own case and that he was interested in the developing trends related to supervision in clinical pastoral education.

Nouwen’s thesis interest in the case study and the role of supervision becomes clearer in light of his discussion notes about his dissertation with Dr. Pruyser. Nouwen’s handwritten and then typed notes are filed together with the thesis outline. These notes indicate that Pruyser said “Don’t overlook the influence of supervision on the way a case is written. The purpose of supervision effects [sic] the writing.” Pruyser, Nouwen reports, also added that the setting matters too: “A senior Pastor as supervisor of a junior pastor is different than the psychiatric trained pastor and his trainee in a hospital setting. Prison setting is different again.” Nouwen’s thesis outline lists the setting possibilities for cases in exactly the same order: “In the rectory room, in the hospital, the prison etc.”

More particularly in terms of influence, the central point here is that Nouwen took Pruyser very seriously. Several other inclusions in the archives reveal this as well, especially Nouwen’s careful notes dated March 20th, 1964 from a lecture by Pruyser titled, “Some Trends in the Psychology of Religion.” Likely taken during a conference at the Menninger, these

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636 Ibid., 3.
637 Nouwen, "Gesprek Met Dr. Pruyser over Dissertatie."
638 Ibid.
640 This lecture was likely based on Pruyser’s lecture notes for his earlier article by the same name. See Paul W. Pruyser, "Some Trends in the Psychology of Religion," The Journal of Religion 40, no. 2 (1960).
notes include a record of Pruyser’s seminal idea, as explored at length in chapter two of this thesis, that

the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation. His is a unique function: he represents religion in all its aspects on the psychiatric team and to the patients. 641

Nouwen also wrote down Pruyser’s comments on how Boisen changed the way religious data was understood in the clinic as well carefully noting Pruyser’s thoughts on the importance of the case study or method. There is also on file a carefully annotated copy of Pruyser’s 1967 article “Anton Boisen and the Psychology of Religion” in which Nouwen underlines many central ideas by Pruyser including the sentence “Almost all his writings are profoundly autobiographical, and his vocational choice was profoundly personal.” 642 After Nouwen left the Menninger, and while at Notre Dame, Pruyser appears again in the context of Nouwen’s research on Boisen. Nouwen asked Pruyser for his assessment and memory of Boisen for which Pruyser obliged in letter on August 15th, 1967. 643 This letter is cited in Nouwen’s 1968 article on Boisen. 644 Nouwen also returned to the Menninger Clinic to interview Pruyser in 1967, a record of which was written by his research assistant. 645 Nouwen also co-translated for private use into Dutch, along with J. Wissink, an adapted copy of Pruyser’s *A Dynamic Psychology of Religion*. 646 Pruyser will also appear, sometimes cited sometimes not, as will be shown below, in some of the manuscript fragments of Nouwen’s second thesis outline. However, my central purpose here is to show how Nouwen’s first doctoral effort on the case method owes much to Pruyser’s thought.

641 Ibid., 121.
644 Nouwen, "Anton T. Boisen and Theology through Living Human Documents," FN#1,50
645 Nouwen and Norwood, "Paul Pruyser Interview."
2. Documentation referring to Doctoral Outline #2

Nouwen’s second thesis proposal title can be accurately dated to Feb 9, 1971 thanks to official university documentation on file in the archives about Nouwen’s proposed doctoral work from The Social Sciences Faculty of the Nijmegen University. The Dutch title of the thesis is “de betekenis van Anton T. Boisen’s acute psychose in verband met zijn vraag naar verhouding tussen geestesziekte en religieuze bekering. [The meaning of Anton T. Boisen’s acute psychosis in connection to his search of the relationship between mental illness and religious conversion.]” Nouwen never actually defended this thesis either, settling once again for a doctorandus degree, and accepting to start teaching at Yale Divinity School in the fall of 1971.

While there are no draft manuscripts in the archives collated with this exact title, there are two incomplete manuscripts and some fragments which are of potential relevance. There are almost one hundred pages of mostly handwritten texts, they appear related to this topic and most importantly can be dated closely to this period on account of their latest reference being from 1970. There is also on file a brief and dated entry of three topic lines titled “Feb 1971 Pruyser Interview.” If the dating of the longer documents is correct they can, along with the more certain date of the Pruyser interview, provide evidence of the kind of work and ideas Nouwen was pursuing at this time about Boisen.

The first of these manuscripts, 41 pages in length, is titled: “A. Boisen on the relationship between religious experience and mental illness.” The second document, almost 60 pages is titled: “Boisen’s: [sic] Theory about the relationship between Religious Exp [sic] and Mental Illness.” Both these manuscripts share a similar shape in terms of their tables of contents,

647 Dr. O. Schroeder, "Letter from Faculty of Social Sciences of Neijmegen University," *The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives* (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1971).

648 Henri J. M. Nouwen, "A. Boisen on the Relationship between Religious Experience and Mental Illness," *The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives* (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, n.d. [c 1970-71]).

though the second one is much more developed. Both argue that Boisen’s central thesis emerges out of the context of Boisen’s personal starting point in illness. This is to say that Boisen’s central idea about the relationship between some forms of mental disorder and religious experience emerges “in the middle of Boisen’s own crisis,” a psychosis Boisen tried to work out. Both documents’ tables of contents begin with this starting point, “The genesis of a hypothesis” and “The genesis of an interest,” respectively. The second table of contents explicitly ends with a plan to evaluate Boisen’s contribution in terms of psychiatry and theology and this second collection includes a 34 page manuscript which attempts to do just this.

Nouwen’s work in these manuscripts readily admits many limitations in Boisen’s theoretical efforts. He writes, “We cannot speak about a real development of theory [with Boisen].” But the overall tone of the manuscripts is apologetic, endeavouring to explore the ecclesiological, psychiatric, and theological significance of the way Boisen arrived at and explored his thesis. I use the term “apologetic” because Nouwen is clearly responding to the 1970s work of Edward Thornton, Professional Education for Ministry. In fact, Thornton’s work provides the contextual starting point and outlines the problem Nouwen seeks to address in his introduction. Nouwen provides a lengthy citation of Thornton, including Thornton’s suggestion that clinical pastoral training was “something he [Boisen] did not intend;” that he was somehow more of a researcher than one interested in clinical pastoral training.

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650 Ibid., 1.
651 Nouwen, "A. Boisen on the Relationship between Religious Experience and Mental Illness," 1,8.
653 Ibid., 1.
Nouwen disagrees calling this an “exaggeration” and argues that Boisen’s pastoral role and clinical role were united such that “research was an essential part of his ministry.”

Nouwen writes:

When Boisen came to the Worcester State Hospital in July 1924, he did not come as a researcher, but as a chaplain, who also felt that research was an essential part of ministry. He writes: “I arrived in Worcester ready to begin my experiment in the religious ministry to the mentally ill.”

Nouwen continues his defence of the joint research/ministry focus by making reference to the significance of Boisen’s initiative to provide a hymnal, an idea which echoes but does not cite an important contribution by Pruyser. The following references, presented here with the deletions Nouwen made in the text, provide evidence of Nouwen’s effort to clearly identify that Boisen’s research efforts were really clinically focused pastoral efforts.

How much of a minister Boisen was also becomes clear when he says: “One of the first problems with which I was faced at Worcester was that of finding a hymnal and service book suitable for our patients.” (O.D. p. 155) and as a result of this concerned he compiled a hymnbook himself: “Hymns of Hope and Courage” in which he tried to offer his patients with songs which with texts which would not evoke hallucinations or strengthen their paranoid tendencies, but which be more in line with their mental sta curative in their particular situation.

What Nouwen is building up to, in this manuscript, is the idea that “there always was for Boisen a very intimate relationship between ministry and scientific inquiry.” Referencing a few of Boisen’s own ideas about the “distinctive task of the minister” and how these should not be relegated to other disciplines, Nouwen concludes

These words make it clear that for Boisen there are “specialists in religion” who are indispensible in the treatment of certain types of mental illness. From this

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656 Nouwen, "A. Boisen on the Relationship between Religious Experience and Mental Illness," 2.
657 Ibid., 4.
659 Nouwen, "A. Boisen on the Relationship between Religious Experience and Mental Illness," 5.
660 Ibid., 6.
point of view it becomes obvious that research is not only important for overall ministerial work, but even more to identify those cases in which religion is a central part of the problem and which call for a “religious specialist.” On [sic] different places Boisen indeed calls himself such a “specialist in religion.” 661

In the second manuscript’s table of contents this link between ministry and research is made more particular by associating a role for the Church in mental health. Nouwen employs the title “Boisen’s new vocation” 662 immediately after his proposed section on “the genesis of an interest.” He writes that he plans to “describe how Boisen put emphasis on research, but not exclusively so. From the beginning he had an interest in the responsibility of the Church for the mentally ill.” 663 The archival material points to an underlying problematic in the way Nouwen uses Thornton: that Boisen and his effort to understand his own case was a form of ministry and this aspect should not be undervalued in its contribution to the development of clinical pastoral education.

Nouwen’s apologetic efforts concerning Boisen also involve a second focus. This one contests another idea by Thornton, namely the importance of asking whether Boisen’s work should be assessed as the work of a sick man. 664

Nouwen responds, his editing once again revelatory of his purpose to push beyond Thornton.

If this would be the final explanation of Boisen’s theory about the relationship between religious experience and mental illness, the following analysis would

661 Ibid., 7.
663 Ibid., 1.
have not tell us anything else than that Boisen was a sick man. But hopefully our
description will tell us a lot more. Although we believe that Boisen’s illness
explains some of the weaknesses of his thinking, we continue this study on the
with the conviction that Boisen went far beyond the level of self-preoccupation,
but had a substantial contribution to give to the understanding of religious
behaviour. 665

In order to argue for more than a pathological interpretation of Boisen, Nouwen stresses and
attempts to justify Boisen’s scientific attitude. Nouwen carefully and with great detail insists on
Boisen’s statistical analysis, in addition to his more generally known interest in case studies.
Nouwen reminds the reader that it must not be forgotten that Boisen engaged in major statistical
research projects, alone and with others, often using historical hospital records, to “test the
hypothesis born in his own … illness in a scientific way.”666

At the same time, Nouwen admits limitations. “His data are often quite ambiguous, that
the reports he uses are often not consistent in their classifications and the numbers of usable
cases often too limited to make easy generalisations.”667 Limitations notwithstanding, Nouwen
wants to recover the essentially scientific approach in Boisen.

If we want a core term which reveals Boisen’s scientific approach it is the term:
“living human documents.” What ... Boisen wanted was to study the major ...
ideas with which religion has been concerned over the centuries in a new way. ... 
Ideas of a lost paradise, of man looking for salvation, ideas of a redeemer and
certain forms of sacrifice and ideas of a coming state of happiness can be found in
thousands of traditions, books and written documents. But Boisen’s own
experience leads him to the conviction that these ideas are so directly a part of
everyman’s ultimate concerns that we can study them, not only ... through a
critical analysis of historical religions but also, and even better, in “living human
documents.” Boisen found that “in the searching experience of human life there is
a tendency to disregard the ideas and culture pattern of the particular age and race 
and to produce spontaneously just such formulation as we see in Jesus and in
Paul” (E.I.W. p 186) Nowhere better than in human nature under stress, Boisen
says, can we study religion.668

665 Ibid., 29.
666 Ibid., 32.
667 Ibid., 37.
668 Ibid., 30,31.
Nouwen argues that Boisen’s method and life are *unitive* of psychiatry and theology, that they represent a kind of constructive breakthrough in terms of how one discipline can contribute to the inquiry of another discipline. Boisen’s equating of some religious experience with mental illness has resulted in two things: psychiatry being able to consider new data pertaining to the religious and theology to enter into the world of mental illness. Nouwen writes:

Boisen’s emphasis on the purposive and constructive features of mental illness is what makes his contribution to psychiatry important. And it is particularly interesting that it was exactly Boisen’s religious and theological background which gave him the perspective which out of which his optimism could develop. This also includes the opening up of new horizons where psychiatry and theology can meet. The fact that Boisen became the father of the clinical training movement was not only due to his idea that theology students could learn something important in a mental hospital but even more to his conviction that psychiatry had neglected to look at the religious implications of the experiences of the patients. Boisen felt strongly that theology has something very important to say about the mental health of man and that the religious aspects of mental illness could not be denied without losing the deepest levels of the human condition out of sight.  

Nouwen’s writing in these manuscripts develops this unity in great detail and depth, sourcing Boisen’s importance in the work of Pruyser. He starts by reaffirming the essential link with Boisen’s approach to case study including the use of his autobiography:

It must be said that Boisen’s use of the case-study is one his most impressive contributions to the psychology of religion. His cases are indeed “living Human Documents” and in Boisen’s hands they become full of rich sources for understanding “man’s grappling with the ultimate realities of life.” William James had used many short descriptions of pathological behaviour in his “Varieties of Religious Experience.” But as Paul Pruyser says: “Boisen turned James’ brilliant vignettes into full-fledged case studies, with a longitudinal perspective.”

At the end of his life Boisen wrote his own autobiography, his own case study, which probably will be his most important one. It is the story a man who discovered in his own life that much can be gained from an accurate study of the crisis experience of one individual.  

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This case-study explains why all of Boisen’s writing have an autobiographical flavour, but it shows that Boisen was able to take distance and use his own case as well as the case of others as the most important approach to the eternal questions of sin and salvation. And therefore Pruyser is right when he writes: “Of all the case studies he assembled, this the richest and most purposive: to show the dynamics of faith at work in the nooks and crannies of one lonely man’s productive existence.”

Nouwen’s explicit and frequent citation of Pruyser is especially evident in the way Nouwen describes the basic social framework of Boisen’s writings.

We can therefore see a certain development in Boisen’s research from the individual to psychological to the sociological aspects of religious behaviour. But this should not be exaggerated. The first publications of Boisen before 1920 show that his original intent was sociological in nature. Moreover we find in the core of Boisen’s “exploration of the inner world” the idea that the primary evil of man is his sense of isolation and the way to salvation is the establishment of the fellowship of the best.

Nouwen then interrupts his own notes to insert the following quotation from Pruyser who refers to Boisen’s experience in forestry:

Boisen had a penchant for a simultaneous vision of the trees as the forest. As a clinical worker while focusing on the individual, he places a great emphasis on social roles and social learning, in which he felt buttressed by the works of George F. Mead and Sullivan. His aim for the “better life” of the individual always means a socially more responsible like and ethics for him a corporate phenomenon. What attracted him to the study of George Fox was precisely the double vision of the lonely …. It is not difficult to find passages in Boisen’s work in which he appears to champion the individual, whose heroic attempts at problem solving he portrays in intimate detail. But he also regarded these personal problems as social in origin and consequences, as he demonstrated so keenly in his analysis of Jesus, Paul and other leaders. All things that really matter in life, things which produce the tragic crises of existence, are in the last analysis the problems of relation between the individual and his groups.


Nouwen had already written about aspects of these seminal social relationship ideas in his published article from 1968, underscoring the important role the divided loyalties and friendship of the best (God) plays, but in that 1968 text Nouwen only cites Pruyser in regards to his personal correspondence regarding his impressions on meeting Boisen. In these texts, Nouwen cites Pruyser more readily, especially to support his social framework analysis, and his basic idea that the basic evil in mental illness is social isolation, including being cut off from God.

My point in emphasizing Nouwen’s frequent use of Pruyser in these writings about Boisen is further supported by this brief note titled “February 1971. Pruyser interview.” Brief, it reads:

1. Do not stress too much the different influences of the great writers.
2. Realise the general milieu with its emphasis on the social gospel
3. Boisen still victim of old psychiatric categories. But the emphasis positive emphasis on Mental illness is very important.

These three ideas form the foundation of Nouwen’s own approach. Nouwen consistently chooses Boisen’s own narrative as central to Boisen’s purpose over and above Boisen’s understanding of the great writers. Nouwen stresses the social dynamic of Boisen, pointing to the liberal context of social theory and social gospel. Nouwen also reaffirms Boisen’s limitations in terms his inability to move beyond certain psychiatric categories.

In terms of Boisen’s positive emphasis on mental illness, this final focus is also found in these manuscript fragments on Boisen. Nouwen chose to consider Boisen in a way which creatively reverses Thornton’s suggestion about Boisen as a “sick man.” In his section addressing Boisen’s contribution from the perspective of psychiatry, Nouwen presents Boisen as

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674 Henri J. M. Nouwen, "Feb 1971 Pruyser Interview," The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1971).
an engaged researcher who practised a kind of “participatory observation” through his own illness. Nouwen writes that “one of the reasons that Boisen felt he could work so well with schizophrenic patients was that he himself had gone through exactly the same ‘wilderness of the lost.’” He also suggests that Boisen “knew this but in the ‘scientific climate’ of his time his own scrupulosity did not allow him to trust his intuitions.” Citing Pruyser once again, Nouwen’s point here is that Boisen was trapped by the psychiatric concepts of the time. For this reason, Boisen did not directly mine this approach in his statistical writings, for fear he would not be taken seriously; but his underlying personal involvement is indisputable, even if it sometimes was not explicitly exploited.

Nevertheless, Nouwen thinks that Boisen’s insight is important. Nouwen introduces here the psycho-historical work of Robert Jay Lifton who specialised in studies about Hiroshima’s survivors. Nouwen highlights Lifton’s insistence on the ethical importance of engaged rather than detached researchers. Nouwen writes that “some levels of human experience can only be touched by someone who cares and [is] willing to offer his own views, ideas and emotions when asked for.” Interestingly, while Nouwen’s own preference for doing this would surface in most of his later writings, in this manuscript Nouwen does not develop this idea any further. However, its presence nonetheless provides a window on Nouwen’s interest and approach to Boisen.

676 Ibid., 6.
677 Ibid., 7.
Even more than in the first doctoral outline and its related unpublished papers, any analysis of the 1971 thesis material must accept that we are dealing with incomplete ideas. In summary, Nouwen consistently frames the innovative genius of Boisen in terms of his life’s case study and work, and this approach is very influenced by Pruyser. For Nouwen, Boisen is best considered as a pastor and a researcher. Most importantly, Nouwen’s Boisen is a person whose illness was not entirely pathological in its effects; that is, that Boisen’s effort to understand his own mentally ill and lonely life resulted in a call for a unitive approach in the psychiatric clinic. Furthermore, Nouwen’s Boisen offers an essentially insider view or that of a reliable participant observer to suffering related to social and theological isolation.

In a sense, the manuscripts related to his second doctoral attempt most clearly reveal that Nouwen’s Boisen is about holding together divergent emerging trends: the importance of ministry and its link to a research based clinical practice, the value of the individual human experience as relational, and the value of illness as a way to health. Indeed Nouwen’s Boisen, in this period, functions as legitimate pastoral and research witness; he is also an insider, both mental health patient and minister, who reveals the beginnings of a vision for an integrated pastoral ministry in mental health care.

*The Boisen Interview: A “Basic Suffering”*

There is one final document to present from the archives. The date, given by Nouwen himself as August, 1964, returns this study back to Nouwen’s summer in the United States, during the time Nouwen was starting his training at the Menninger Clinic. Nouwen’s three pages of notes describing his encounter in Boisen’s room at Elgin State [Mental] Hospital have already been referred to by Ford. I agree with Ford when he writes that this is “one of [Nouwen’s] most enterprising studies.” Nouwen himself called this meeting “very intense.”

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682 The archives have two certificates related to this period. The first, from the Topeka State Hospital, awards Nouwen credit for the “successful completion of two quarters of clinical pastoral training from September 1964 to March 1965.” The second, from the Menninger Clinic, indicates that he “successfully fulfilled the Graduate Training program in Theology and Psychiatric Theory” on the 19th of June, 1965.

683 Ford, 91.

684 Nouwen, "Boisen,” 1. A photocopy of this record is reproduced in the Appendix.
This document is important for two interconnected reasons. First, it offers a paradoxically isolated but historically dynamic portrait of Boisen at 88 years old, clearly living with evidence of mental instability, just over one year before he died. Second, while more than half of the notes are descriptive revealing Nouwen’s capacity for close clinical observation, the text is also clearly interpretive. Nouwen gives his own impression in a most intimate way, namely that his encounter with Boisen pointed to a longstanding “basic suffering” which disclosed more than injury and illness alone. This aspect is revealed in the concluding paragraph that Nouwen wrote of his encounter with Boisen:

When I left I was very thankful that I had the opportunity to meet this man whose suffering had become a source of creativity. The condition in which I found him clearly showed that his basic suffering had never completely left him [emphasis added]. Two years ago he had a new psychosis and he had lived since then on the borderline of reality. Especially when he became tired, the psychotic contents came more to the surface: his fear of a nuclear war, his many death thoughts and his never completely solved love affair with Alice. He still idealized her who only wanted to be left alone and he still suffers from his puritanical fears. But seeing a man so closely and being able to experience how a deep wound can become a source of beauty in which even the weaknesses seem to give light is a reason for thankfulness.685

From a purely literary perspective, Nouwen’s writing here is excellent, some of the best I would suggest among all the archived files having to do with Boisen. It is remarkable that Nouwen never published this record; although he did make use of it as will be shown below. What is unique about this text, however, is how he weaves together clinical observations and personal impressions about a “basic suffering” and summarises the entire visit with the idea of “thankfulness.”

How does Nouwen achieve this synthesis? In the first two pages Nouwen starts with a detailed description of a disturbingly drab and noisy physical environment. Boisen is in a “poor, not very clean little room” characterised by a “total lack of privacy” and “no door” such that the noise from the next door kitchen and dining room, along with modern music, “intrudes in every

685 Ibid., 3.
But Boisen “was different. He was very friendly and he kept expressing his thankfulness to the hospital, where he could stay after he stopped his work as a chaplain.” At the same time, he presents paradoxically. With slow and often “difficult to understand language,” he states he is “stupid... I cannot say what I want to say.” But then Nouwen shares the direct questions of Boisen: “What do you [Nouwen] think about the messianic claim of Jesus? Who is God?” Boisen also voices questions and concerns about the effect of “nuclear power” on the idea of God and survival of the world.

Nouwen repeats again, “Boisen challenged me to a straight and open answer,” which unfortunately Nouwen does not give in this record. But Nouwen reports he eventually turned the question back to Boisen who answered “God is the internalisation of the highest values of our social relationship, and Jesus Christ is the man in which the apostles found these highest values represented.” Nouwen subsequently reports how Boisen had “an obvious preoccupation with the end of the world and his own personal death.” Nouwen notes, according to the duty chaplain there, Chaplain Sullivan, that suicide was also on his mind as his “highest religious act.” Nouwen then adds, “it seemed that he used his visitors to find an opportunity to test his feelings and ideas and to establish a communication in which he could find some answer.”

Then the conversation changes. Boisen was intrigued by Nouwen’s priesthood, especially its celibacy, about which Nouwen inferred Boisen’s “unresolved sexual problems.” Nouwen writes that this was also evident in Boisen’s description of how his sister had eliminated many of
Boisen’s sections about his sexual issues in the earlier drafts of his recently published autobiography.694

Halfway through his description of the interview, Nouwen finally turns to the questions “I had in mind when I entered Boisen’s room.”695 He adds, “although Boisen himself took the initiative in the discussions, he nevertheless answered many questions.” These questions reveal Nouwen’s own interests in better understanding Boisen. These were about the influence of Dewey, Freud, and Cabot. Dewey, Nouwen reports, influenced Boisen indirectly, through others like Coe, James, and Starbuck. In terms of Freud, Boisen repeated the story in his autobiography (and described in Chapter One of this thesis) about the role Eastman played in getting Freud’s introductory lectures to him right after his psychotic crisis. “Boisen felt himself lucky that he got to know Freud at the right time.”696 In regards to Cabot, it was his book *Differential Diagnosis* that was most influential. The visit ended with Boisen giving him, “with much effort and fumbling,” a signed copy of his book, *Hymns of Hope and Courage*.697

In many ways, the core features of this text have a unity of analysis which is remarkably similar to all of Nouwen’s study and material on Boisen. This is especially evidenced in his published articles. Nouwen actually makes explicit reference to this interview two times in that 1968 article. The first reveals something not included in his notes, namely that Boisen shared in an interview that Raphael Zon influenced his scientific thinking the most.698 Nouwen’s second reference is duplicated in even more detail in the 1977 article.699 It concerns how Boisen named

694 There is a record of correspondence indicating that Nouwen tried to find Boisen’s original manuscript. Correspondence to him from Harper & Row Publishers dated August 2nd, 1967, indicates that they did not have the manuscript, but offered some leads for Nouwen to pursue. Erik A. Langkjaer, "Harper & Row Publishers' Correspondence to Nouwen Re Boisen's Original Manuscript," *The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives* (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1967). There is no evidence in the archives that Nouwen ever found this manuscript or wrote about it, but the 1964 interview certainly reveals why this issue was of interest to him.


696 Ibid., 3.

697 Ibid.


Cabot’s book *Differential Diagnosis* and not his more ethical works as his most influential book.\(^{700}\) This, Nouwen concludes in the article, “gave Boisen the clue for much of his later work: the case-method.”\(^{701}\)

The point is that this encounter gave Nouwen a central and seminal focus. Without providing a citation, he obviously refers to this visit in the general introduction to his unpublished manuscript “Anton T. Boisen and the Study of Theology through 'Living Human Documents.'” Commenting about the Boisen’s funeral, Nouwen writes:

That the sombre atmosphere of the mental hospital in Elgin, Illinois, and the few people who attended the simple service, made one think more of a forgotten patient than an honoured leader.

The small room where he had spent his last years even strengthened this impression, a poor, not very clean roomette. A bed, a table, two bookcases with books and old looking papers and a wheelchair. Total lack of privacy. Only a screen door through which the noise of dishwashing in the kitchen and cleaning in the dining room mixes with the sounds of modern music, intruded on every conversation.

But the man who lived there so long was more than a patient of a mental hospital. His legacy makes this clear.\(^{702}\)

This 1964 interview already reveals Nouwen’s interest in the legacy of Boisen who was for him a person whose case study presentation was operative to the end, where the final days of Boisen’s life maintained continuity with the rest of his life.

Indeed, what is unique in this record of an encounter is Nouwen’s attention to this basic suffering. He writes that there is in Boisen a “basic suffering [which] never completely left him.” Nouwen even documents his response, his personal reaction, of personal gratitude for meeting a man who turns “suffering into a source of creativity,” whose “weaknesses seem to give light.” But it remains to be asked, what is this basic suffering? What is Nouwen’s sense of it?

Reading such an emotionally laden conclusion, it is perhaps easy to understand why biographer O’Laughlin made the interpretive move to frame Boisen in Nouwen’s famous term,

\(^{700}\) Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 58.

\(^{701}\) Ibid., 58.

\(^{702}\) Nouwen, "Anton T. Boisen and the Study of Theology through 'Living Human Documents' (Draft #3)," 6.
as “a wounded healer whose mine of insights was his own suffering... much like Henri Nouwen himself would become later in life.” 703 But such an analysis trends towards a certain kind of eisogesis, in that it reads into an earlier text the meaning of a later term. In this case, it sees in the Boisen experience Nouwen’s very popular 1972 text, The Wounded Healer. 704 It is important to remember that Ford’s application of the term “wounded healer” follows Nouwen’s explicit linking of it to Van Gogh in his introduction to a text from 1989. 705 The point being that it is important to respect appropriate academic limits when speculating about what was in the mind of Nouwen about the value and use of Boisen’s basic suffering. There is simply no published or unpublished reference which I have been able to locate where Nouwen calls Boisen a ‘wounded healer.’ Significantly Boisen is not referenced by Nouwen in this 1972 work The Wounded Healer, which addressed ministry in a contemporary setting.

The evidence therefore warns against a too easy or directly linear connection. More broadly, even Nouwen himself would later caution his readers from treating his “wounded healer” image as a “complete model,” suggesting that it is at most his “attempt to say something – not everything – about ministry.” 706 Interestingly, Nouwen even puts this image in the context of the influence of his earlier training, suggesting it was a kind of corrective to the effects of his own training.

When I wrote about the minister as wounded healer I had recently acquired academic degrees in both psychology and theology. After so much professional training I needed to remind myself that beyond all professionalism, ministry calls me to lay down my life for my friends and to make my own most personal experience with God available to others as a source of healing. 707

703 O’Laughlin, 47.
704 Nouwen, The Wounded Healer.
705 Edwards, x. Cited by Ford, xi.
706 This citation is from Nouwen’s “A response from Henri J. M. Nouwen,” which is inserted in the following article: John McFarland, "The Minister as Narrator," The Christian Ministry 18, no. 1 (1987): 20.
707 Ibid.
The point being that making Boisen into some kind of one-to-one and complete correspondence with the wounded healer, or Nouwen for that matter is not justifiable. Certainly, both persons are more complex than such a model or comparison could contain.

Avoiding a strict “wounded healer” connection, what therefore is the “basic suffering” Nouwen means to describe that Boisen lived with his whole life? It is possible given the text’s emphasis on the evidence of Boisen’s mental instability, to see this basic suffering as his mental illness itself. Nouwen’s careful clinical observations identify how mentally ill Boisen was at the time of this visit. He was living on the “borderline of reality,” and “especially when he got tired, the psychotic contents came more to the surface.”\textsuperscript{708} He had ideas of suicide and unresolved sexual problems.

Seeing Boisen’s basic suffering as his experience of mental illness is consistent with Nouwen’s unpublished and published materials. His critique of Thornton’s question whether Boisen’s whole project was not “a grand rationalization of a psychotic way of coping with life”,\textsuperscript{709} was rooted in Nouwen’s re-framing: Boisen’s genius was his “participatory observation,”\textsuperscript{710} an idea supported by Lifton’s understanding that there is value being an ‘engaged’ researcher. Nouwen argued, following Pruyser, that key to Boisen’s breakthrough was his effort to turn around his isolating experience of mental illness. Four years after this 1964 encounter, when Nouwen published his seminal article on Boisen’s case method, he placed great emphasis on Boisen’s suffering being relational. Boisen’s losses, the death of his father, the failure of his vocational choices, his admittedly distant and unrequited love with Alice, all reflect for Nouwen the fundamental meaning of Boisen’s “life work: discovering ways in which man can overcome the sense of alienation.”\textsuperscript{711}

In Nouwen’s description of Boisen’s final human alienation, with Alice, he raises the ultimate relational factor: God. Nouwen cites Boisen on how “love between man and woman can

\textsuperscript{708} Nouwen, “Boisen,” 3.
\textsuperscript{709} Thornton, 55.
\textsuperscript{710} Nouwen, ”Boisen's: [Sic] Theory About the Relationship between Religious Exp [Sic] and Mental Illness," 5.
\textsuperscript{711} Nouwen, ”Anton T. Boisen and Theology through Living Human Documents," 58.
be truly happy when each is a free and autonomous being, dependent not upon the other, but upon God.” Nouwen is indeed fascinated with the role of Alice in Boisen’s life, stating for her part that “it seems as if she sensed that Boisen needed her, if not as a wife, then certainly as a point around which to center his life.” Specifically concerning the role of Alice for Boisen, Nouwen suggests that “Boisen is saying that he used Alice for his savior, but that his real salvation only came about by the internalization of the values which were deeply hidden in this relationship and which had to be distilled and purified by a long and painful process.” The end goal here is to make room for the one relationship which is “best,” the relationship with God.

In other words, Alice played a role in what Boisen himself called “the guiding hand” and Nouwen clarifies as “a guiding hand to God.” Nouwen notes, “Boisen himself is aware of the fact that the unreachable love was not only the main cause of his suffering but also the main motive for his creative work.” That is why Nouwen seizes on Alice as a kind of Beatrice, a link that Boisen makes himself about her and her role. Boisen writes, “I am thinking of the old Dante-Beatrice story.” I am suggesting that according to Nouwen, Boisen’s basic suffering is the search for God which becomes evident in the lives of some people, like Boisen himself, who find themselves alienated but who still search for some kind of better union. This is the move from finite to infinite relationships. “Alice's role in Boisen's life was exactly to remove this sense of alienation and to bring about the internalization of the

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713 Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 56.

714 Ibid., 57.

715 Boisen, Out of the Depths, 209.


717 Ibid., 56.

718 Boisen, Out of the Depths, 207. This link with Dante is evidenced earlier in his autobiography, Boisen writes, “ever since my decision not to give up hope in love for Alice, Dante had been for me a sort of patron saint, and I had kept his picture hanging in my room.” Ibid., 154.
highest values of his social relationship.” 719 What is remarkable about Nouwen’s verbatim recording from 1964 of Boisen’s actual words that day is its consistency. Boisen’s answer, at 88, to the question who is God was “God is the internalisation of the highest values of our social relationship.” 720 Boisen remained committed, almost verbatim, to the way he first coined this concept almost 30 years earlier in his seminal text, The Exploration of the Inner World. God is “that in the individual’s social experience which he counts of highest value and with which he would be identified.” 721

This development of Nouwen’s idea that Boisen’s “basic suffering” functions like a window on the infinite relationship of fellowship with the best is my effort to make sense of Nouwen’s reaction of gratitude. It betrays, I suggest, that Nouwen’s personal encounter with Boisen captured something essential of Nouwen’s understanding of Boisen’s personal and research life about the experience of mental illness. That is to say that this encounter with Boisen reveals to Nouwen Boisen’s central preoccupation: Boisen never forgot the important place occupied by fellowship of the best, what is in its ultimate form, the human/divine relationship. So while it is true that Nouwen’s writings about Boisen describe very well a basically scientific, pastoral, statistical, and case approach to clinical ministry’s origins, it is his impression of the basic suffering that is of interest here. Nouwen’s gratitude reveals Boisen’s fundamental commitment to the human/divine relationship, as evidenced in the living human documents that Boisen discovered starting with himself.

This chapter has identified how that interpretation is evident in Nouwen’s unpublished works, and in his published uses of Boisen. This also included the manner in which Boisen is featured in Nouwen’s critical focus on the history of clinical training’s emphasis being mainly on the concrete human level, about narrowly considering the human person’s sociality immanently. His concern is the abandonment of the transcendent dimension and its relevance in human affairs. This is perhaps most clearly explained in how the “living human document,” Nouwen

wrote, must give way or engage “the living human God.” This is why I am suggesting that Nouwen’s gratitude provides a revealing window on Boisen’s basic suffering as something which “never completely left him” but which “gives light.”

**Conclusion: Nouwen’s Essential Portrait of Boisen**

As this research demonstrates, with respect to Nouwen’s incredible literary output, he published relatively little about his Boisen connection. His talks and presentations also reveal a similar restraint. Given this silence, it is not entirely surprising that very little attention was given to the Nouwen-Boisen connection by his biographers who mostly followed his literary output. A careful reading of Nouwen’s published material indicates that on four occasions he did cite strategically Boisen in three books, and wrote two articles on Boisen, all between 1968 and 1977. But for all intents and purposes, after that, published references to Boisen disappear. The fact is that Nouwen spent many years becoming an expert in Boisen, tried to complete two doctorates on him, but never did. Neither did he specialise professionally over the long term in Boisen. After 1977 Nouwen effectively moves on to other topics of interest in his public writing. This is why the core of this chapter was dedicated to critically review his unpublished writings on Boisen.

What is true in his published materials and his biographies is also true in the way Nouwen appears to have shared about his Boisen connection in his professional and personal relationships. Dwight Norwood, his student assistant at Notre Dame who was very involved in the research of Nouwen’s 1968 article, does not remember Nouwen ever mentioning that he had already abandoned his first effort to write a doctoral thesis on Boisen; and they spent an entire summer working on this manuscript on Boisen. With John Mogabgab, his assistant at Yale from 1975-1980, there was some limited discussion about what would have been by then two incomplete doctoral efforts. Mogabgab remembers Nouwen clarifying that his university supervisors wanted something more academic in nature, and that Nouwen was not willing to do that.722

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This interesting silence is also evident with Jean Vanier. In 1985-86 Nouwen spent nine months at L’Arche in Trosly-Breuil, France. During that time, Vanier met with Nouwen regularly, encounters which were seminally important to Nouwen’s eventual incorporation into l’Arche. During all the time Nouwen was at l’Arche in France and in Canada, Vanier says he never heard Nouwen speak about his doctoral efforts nor of Nouwen’s early interest in Boisen. In fact, Vanier had never heard of Anton T. Boisen until I introduced this connection to him on March 5th, 2010. 723 That Nouwen would never mention his early academic interest or discuss the person of Boisen at some point in his time with a community committed to living with people with serious cognitive and developmental illnesses seems perplexing. Although it is true that in a way the context was very different – not an asylum, not patients suffering from psychoses, and not patients living with severe and persistent mental illness.

Nouwen’s silence about Boisen during his L’Arche years is not to say that Vanier was unable to offer an observation about the meaning of the Boisen-Nouwen connection, once disclosed. When I read Vanier the summarising quote from Nouwen’s 1964 encounter with Boisen, Vanier immediately suggested that there is indeed a link between Nouwen’s personal study and L’Arche’s collective experience:

I would say that we are touching, particularly with that text of the inner wound, presence, communion, and then celebration, four words. And I think he discovered something in L’Arche which corresponded to what he had heard there… [At L’Arche] we are living with very wounded people who have lived lots of rejection and therefore caught up in loneliness. 724 [emphasis added]

Vanier then deepened his analysis suggesting that this reality of wounded people is also Nouwen’s story. He noted Nouwen’s “own anguish, his own loneliness, his craving for a true relationship, and I think craving to discover where Jesus was in that relationship.” 725 According to Vanier, this is not just Nouwen’s story either:

This is Henri’s search, but what I think is Henri is he is saying this is the search of us all. I think that is why people catch on. It is not just Henri. I think Henri is

724 Ibid.
725 Ibid.
someone sent by God to reveal this cry for relationship. So I think it is not just Henri.\textsuperscript{726}

Just as with my concerns about reading O’Laughlin’s interpretation of the “the wounded healer” too easily into Boisen, I think that as a researcher, one needs to be careful about reading L’Arche and its experience too easily into Nouwen’s early study of Boisen.

However, I do think that Vanier has identified an essential theme operative in the Nouwen he came to know: that Nouwen’s biography is a search for relationship; and that it is ultimately a search for God experienced in the midst of the experience of his sense of a terrible isolation. This too, my research reveals is Nouwen’s essential portrait of Boisen. It is what Nouwen understood Boisen to be and it is what he understood Boisen did with his basic suffering, pastorally and in research on behalf of those struggling with the same isolation. Nouwen’s essential portrait of Boisen, and his critique of early clinical pastoral care education, endeavoured to determine how the human/divine relationship could be visible and possible in pastoral ministry in clinical care.

So what then does Nouwen’s essential portrait of Boisen offer in terms of moving forward this thesis’ specific goal, the rendering of a contemporary and theologically relevant clinical model for psychiatric chaplaincy in response to current issues in contemporary chaplaincy? Of course, in his North American career, Nouwen actually spent very little time in psychiatric or otherwise clinical settings, with most of his professional life in academic environments or intentional communities. In point of fact, his two years at the psychiatric Menninger Clinic are his only years in North American clinical chaplaincy, and those years were both primarily about enhancing his own practical and educational goals. After this intense training, Nouwen himself never pursued active and full time work as a clinical chaplain or psychologist in institutional mental health care settings. Immediately after the Menninger period, he began teaching, in a pioneering way for a Catholic university, at Notre Dame about the unitive interface of psychology and theology.

\textsuperscript{726} Ibid.
Nevertheless, this chapter has achieved some critical conclusions about the Nouwen-Boisen connection. Part two of this chapter has revealed that, in addition to his two published articles on Boisen, there are otherwise strategic references to Boisen up to 1977. Through these uses, Nouwen addressed foundational or seminal concepts in ministry, including this core concept of the place of and search for God in the practice of ministry. Nouwen’s first published book *Intimacy* set the stage for this concern in 1969. There he used psychological terms but this was meant to reflect “the concern of a priest who wonders how to understand what he sees in light of God’s work with man.” Nouwen explored here how one might discover and cultivate a relationship with God and one another on the university campus, starting with Boisen’s idea, that empirical theology can emerge from working with people as “one of the main sources for their theological understanding.” Two years later, in *Creative Ministry*, Boisen surfaced again. There Nouwen suggested that the basic Boisen question “what can I learn from person I meet as a pastor?” is more important, prior, and only to be served by technical and professional skill building, not replaced by it. Six years later, in *The Living Reminder* Nouwen explicitly looked at ministry as “remembrance” where the minister serves an anamnetic purpose helping “the faithful remember what they have received or already know –or should know.” The core message being the link between ministry and spirituality, prayer and service. In this conceptualisation, the minister is central to the process of helping people remember, to see and to experience a living God in the midst of their human experience, because that is his or her vocation.

Although there was no mention of Boisen in Nouwen’s 1975 publication *Reaching Out*, it is possible to link these ideas about a relational focus on spirituality with Nouwen’s

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727 Nouwen, *Intimacy*.
728 Ibid., 1.
729 Ibid., 137.
emphasis on ministry as a kind of hospitality that creates “free and friendly space”\textsuperscript{733} where spiritual change in one’s relationship with self, others, and God can take place. In fact, this approach to Church ministry, particularly in terms of its implications for mental health ministry, will be developed in Chapter Three.

Before moving forward to that chapter, by way of summary, part three of this chapter underscored how core aspects of Nouwen’s published concerns about developments in pastoral ministry developed in Nouwen’s unpublished and archived work on Boisen. This tension was most explicitly framed in Nouwen’s 1965 unpublished document \textit{Pastoral Supervision in Historical Perspective}. In that critique of pastoral care’s almost exclusively immanent and concrete approach to Boisen’s “living human document,” Nouwen asked: “Is there something like the experience of the living God, or better of the \textit{living human God}?\textsuperscript{734}” Nouwen’s critique here charged that in clinical pastoral circles, discourse about God had “become vague, undefined, distant ... whereas man was concrete, defined and close.”\textsuperscript{735} Knowledgeable guides for the experiences of conversion, Nouwen found, were absent.

Nouwen’s two doctoral outlines revealed Pruyser’s influence, especially as it related to Nouwen’s interest in Boisen’s biography and Nouwen’s effort to be theologically corrective. The first effort, focused on the history, use, and value of the case method in American pastoral education, centred on how “the personal experience of Boisen started a movement.”\textsuperscript{736} The second effort, which focused on the meaning of Boisen’s acute psychosis in connection to this search of the relationship between mental illness and religious conversion, explicitly returned to Boisen’s experience of illness as the genesis of his hypothesis.\textsuperscript{737} Most explicitly in the second doctoral effort, Nouwen reclaims Boisen in what is essentially an apologetic manuscript.

\begin{itemize}
\item \textsuperscript{733} Ibid., 50.
\item \textsuperscript{734} Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," 68.
\item \textsuperscript{735} Ibid., 68.
\item \textsuperscript{736} Nouwen, "Dissertation. Subject: The History Use and Value of the Casemethod [sic] in American Pastoral Education.," 1.
\item \textsuperscript{737} Nouwen, "A. Boisen on the Relationship between Religious Experience and Mental Illness," 1,8. See also Nouwen, "Boisen's: [Sic] Theory About the Relationship between Religious Exp [Sic] and Mental Illness," 1.
\end{itemize}
contradistinction to the contemporary work by Thornton, Nouwen argues that for Boisen, ministry and research were central to his project. This is evidenced in his call for distinctive ministers who were specialists in religion. For Nouwen, Boisen’s “sick man” status was more than pathological. Nouwen’s Boisen is committed to the scientific method, even if his work is hampered by his being, in Pruyser’s phrase from one of his several interviews with Nouwen, a “victim of old psychiatric categories.” Indeed, in this work, one glimpses Nouwen’s effort to frame Boisen as an engaged researcher, a participant observer of his own struggles such that he is able to develop a positive emphasis on his mental health experience and regarding the role of the Church in mental health care.

Certainly, part three of this chapter would have been incomplete without some analysis of Nouwen’s personal encounter with Boisen, from August of 1964. This text offered what I believe to be Nouwen’s most seminal portrait of Boisen and certainly reflected some excellent writing. It is my conclusion that this text revealed some of Nouwen’s own questions about the ultimate meaning of Boisen; but it also essentially personalised Nouwen’s Boisen in that it concluded with Nouwen’s gratitude for having been a witness to the transformation of Boisen’s basic suffering. Indeed, Nouwen’s Boisen witnesses that Boisen’s own case study revealed two important things: an isolating experience of mental illness, and the search for God within that experience, what Boisen discovered to be the fellowship of the best.

With this chapter’s conclusion, it is important to look forward, and map out what I propose to be the first of two credible options for furthering Nouwen’s portrait of Boisen, in the service of developing a contemporarily relevant model for clinical psychiatric chaplaincy. This next stage of my research, Chapter Three, is inspired by Nouwen’s assessment of the biographical and pastoral purpose of Boisen’s “life work: discovering ways in which man can overcome the sense of alienation.” The first option I will pursue critically engages a contemporary model of psychiatric chaplaincy, one that considers the role of the Church as

738 Nouwen, "Feb 1971 Pruyser Interview."


740 Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 58.
essential to responding to the social isolation occasioned by the experience of mental illness. This option, interestingly, calls for ‘friendship’ from the Church and the psychiatric chaplain.
CHAPTER THREE:

CHAPLAIN AS FRIEND:
IMPORTANCE, VULNERABILITY, AND RELEVANCE

The primary goal in this chapter is to develop the implications of Nouwen’s portrait of Boisen, specifically his witness that Boisen’s own case study revealed two important things: an isolating experience of mental illness, and the search for God. As reviewed in Chapter Two, Nouwen, understood that Boisen’s was a fundamentally theological search to “overcome the sense of alienation”741 which characterized his basic suffering. Nouwen showed that Boisen emerged from “out of the depths” of his own mental illness with a call for a theologically integrated clinical pastoral ministry in mental health care characterised by three things: that the individual human experience of mental illness must be considered relationally, that mental illness can be the occasion for health and indeed salvation, and that clinical pastoral mental health ministry begins with a view as to how the “living human document” is open to the “living human God.”742

In a practical way, this chapter asks what it would look like to operationalize these contributions gleaned from Nouwen’s portrait of Boisen. Chapter Three begins with the early but still contemporary work of practical theologian John Swinton, a member of clergy of the Church of Scotland. He is currently Chair in Divinity and Religious Studies and Professor in Practical Theology and Pastoral Care at the School of Divinity, History and Philosophy, King's College, University of Aberdeen.

Swinton’s principal concern in these early writings is for the practical theological significance of isolation in the contemporary mental health context. For this, he proposes an


742 Henri J. M. Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)." The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1965), 68.
ecclesial response of “friendship” to the mentally ill. Although Swinton’s work bears few explicit references to Boisen, Swinton’s work is in fact a contemporary and creative implicit echo of Boisen’s call to the Church to attend to the mentally ill. Swinton explicitly uses Nouwen’s concept of ministry as “friendly space” to suggest the Church critically be that kind of space

where people of all kinds and with all types of difficulties and none, can openly discuss mental health issues and develop the type of empathy and understanding which is necessary for healthy human living and a truly healing community.  

Structured in three parts, part one of this chapter critically reviews the sources and inspirations for Swinton’s pioneering ideas about ecclesial friendship in the quest for mental health. This expository work argues that the model is consistent with aspects of Boisen, in that it challenges the Church’s ministry to abandon neither the mentally ill in their isolation nor the clinical theological problems/opportunities that mental illness presents. Part two of this chapter considers what appear to be serious vulnerabilities or pitfalls with Swinton’s proposal, primarily in terms of its applicability in clinical inpatient settings. The pitfalls are the challenges of settings, in two key areas: firstly, the challenge of clinical befriending and, secondly, the dominance of “generic” spirituality in society and the clinic. Interestingly these shortcomings are conceptually very helpful to the contemporary context at the heart of this dissertation, especially when considered in light of recent scholarship by Charles Taylor. Part three of this chapter engages these concerns in light of Taylor’s arguments: about the credibility of religious spirituality in the first place; the important role that generating a moving insight into higher reality plays in contemporary spirituality; and just how important “new and unprecedented itineraries” to God can be in the support of human flourishing when considered theologically. Furthermore, the life and work of Boisen emerge in this chapter as just such a “new and


unprecedented” intinerary to God worthy of critical attention by the Church and the chaplain, especially in the context of faith sponsored mental health care.

**John Swinton’s Pioneering Work on the Friendship Model**

Swinton’s seminal work on theological friendship appears primarily in two books published in the same year, 2000, *From Bedlam to Shalom: Towards a Practical Theology of Human Nature, Interpersonal Relationships, and Mental Health Care* and *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. Both books are essentially complementary works of practical theology though the scope and approach of each is different. *From Bedlam to Shalom* is the broader theoretical book, and *Resurrecting the Person*, the more practical one. The first book sets out to develop an “understanding of human nature and a model of mental health care for the Church.” The practical details of that model follow in the second book so as to “enable local congregations to develop a ministry of friendship to people with severe, long-term mental health problems.” Swinton’s work has two central ideas mediated by a theologically conceived and ecclesiologically practiced concept of friendship. The first has to do with what it means to be human, the second with what mental health and illness actually mean.

*On Being Human: Made in the Image of God*

Swinton’s understanding of being human is rooted in the Biblical idea that humans are made in the *Imago Dei*. Consistent with the Christian tradition’s basic Trinitarian approach to

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746 Swinton, *From Bedlam to Shalom*, 1.

747 Ibid., 147.
God, Swinton understands the mystery of God to be one of persons in relation. Thus for him, the definitional human/divine construct of *Imago Dei* has two main consequences: the first is that “human beings are fundamentally relational creatures”\(^{748}\) who relate to God, one another and the self; and the second, is that

a person’s basic humanity is not defined by their temporal relationships or their ability to respond to God or others. God’s relational movement towards humanity precedes any potential response. A person’s humanity is defined and maintained by God’s gracious movement towards them in love.\(^{749}\)

Swinton’s consistent theme is humanity as both dependent on and initiated by God. In 1993, Swinton wrote a short dissertation\(^{750}\) on “the oft fraught relationship between people with profound learning difficulties and the Church.”\(^{751}\) The work reflects the early beginnings of what has become Swinton’s interest in the theology of disability.\(^{752}\) Swinton’s current approach to mental health is certainly influenced by these ideas, specifically on how a dominantly cognitive approach to faith may be inaccessible to those who have cognitive deficits. Swinton’s sourcing of all humanity in the initiative of God provides “a promise and an assurance that one’s humanity is held and sustained by the very hand of God as he reaches out to affirm the humanness of each person irrespective of their circumstances.”\(^{753}\)

Swinton also argues that the actualization of the *Imago Dei* finds its zenith in the Jewish Biblical concept of Shalom which “may be viewed as the integral experience of a person who is functioning as God intended, in consonant relationship with Him, with others, and with one’s

\(^{748}\) Ibid., 31.

\(^{749}\) Ibid.


\(^{751}\) Swinton, *From Bedlam to Shalom*, 1.


\(^{753}\) Swinton, *From Bedlam to Shalom*, 32.
For the Jewish, as well as the Christian tradition, this harmony of relationship is not yet entirely realized. Swinton categorises this state of fallenness as a type of sin that can be understood as a “relational disconnection,” a failure of sorts for all humanity to live out the _Imago Dei_ that is actualised in Shalom. Swinton does not attribute this failure to individual sinful acts per se, but to “a position, an attitude which humanity adopts towards God and consequently towards other beings (Sin).” That attitude is the “turning away of the whole person from their true nature” and it constitutes what Swinton calls the “fundamental alienation between God and Humanity.” This is an important idea for Swinton. Swinton integrates some of the language of David Noel Freedman when he describes humanity in its fallen state as “fragmented, scattered, disunited, and without peace.” Swinton also suggests that Shalom offers the promise of reconciliation. “Shalom is a personal gift from a relational God to His fallen creation.”

As a Christian theologian who was previously a psychiatric nurse and a onetime community mental health chaplain, Swinton interprets this relational disconnection as a kind of relational chaos, and borrows the historical term “bedlam” to make a metaphorical point, as evidenced with his title, _From Bedlam to Shalom_. Although placed as a supporting idea in Swinton’s footnotes, it is central to his understanding of mental illness.

The term Bedlam originates from the thirteenth century mental hospital, “The Hospital of St. Mary of Bethlehem,” in London, which was notorious for its cruel and inhumane treatment of its inmates. At this point the use of the word ‘Bedlam’ is metaphorical, designed to indicate the disorder, chaos and confusion which typifies personal and corporate humanity in its fallen state. _This disorder, may be considerably more focused and condensed in a mentally disordered person, but in essence it is a universal aspect of the human condition._ This being so, the metaphorical phrase ‘from Bedlam to Shalom,’ is intended symbolically to

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754 Ibid., 60.
755 Ibid., 54.
756 Ibid.
758 Swinton, _From Bedlam to Shalom_, 58.
759 Ibid., 59.
represent humanity’s journey out of this primordial chaos and towards mental health.\textsuperscript{760} [emphasis added]

There is a core idea here that people living with serious mental health problems share the same universal disconnection with all of humanity, only in a “more focused and condensed way” and that “mental health has fundamentally to do with interpersonal relationships,”\textsuperscript{761} including relationships with God.

For Swinton, the journey to mental health “is a corporate developmental, process, the epicentre of which is to be found in the mutually constructive and supportive matrix of relationships that constitute human beings, human societies, and human communities.”\textsuperscript{762} The social matrix of Swinton’s approach to mental health is both horizontal and vertical, as Swinton is fundamentally relational and theocentric. In this, Swinton is consistent with his starting point concerning the human being’s foundational relationship with God, and how Shalom actualises this \textit{Imago Dei}. In fact, Swinton’s social matrix would be illogical without God. This is because Swinton suggests “one might understand the human quest for mental health as an ongoing communal-historical journey towards shalom and the restoration of God’s image in humanity.”\textsuperscript{763}

\textit{On Defining Mental Health}

Swinton’s operational definition of mental health is “the strength to be human and to remain human despite one’s circumstances.”\textsuperscript{764} Swinton’s definition reflects his use of other theologians’ considerations about living humanly with illness. He cites Karl Barth’s “the strength

\textsuperscript{760} Ibid., 62-63, FN #31.
\textsuperscript{761} Ibid., 74.
\textsuperscript{762} Ibid.
\textsuperscript{763} Ibid., 71. For parallel considerations on this point, see for example Philosopher and Theologian Donald Evans who affirms that the role God or Transcendence has to play in human transformation cannot be taken for granted. In \textit{Spirituality and Human Nature}, Evans claims that “human beings have a spiritual dimension that links us with trees and animals, with each other, with spiritual energies, with disincarnate spirits and angels, and with God.” Donald D. Evans, \textit{Spirituality and Human Nature}, Suny Series in Religious Studies (Albany: State University of New York Press, 1993), 267.
\textsuperscript{764} Swinton, \textit{From Bedlam to Shalom}, 74.
to be as man,”765 Jürgen Moltmann’s “the strength to be human,”766 and John De Gruchy’s “the terminally ill may nevertheless be more healthy,”767 to illustrate that each embraces the idea that health, broadly defined, is not antithetical to illness, but has to do with the way one lives the tension in between. Swinton applies these ideas to mental health: “These writers open up the prospect that it may be possible to continue to grow into mental health even in the midst of interminable illness and severe psychological distress.”768 Swinton’s definition also anticipates recent trends in mental health, namely recovery theory,769 especially the idea that mental health is both the product of and a producer of a life lived in community with others. Swinton specifically places a theocentric emphasis on the definition of community: it includes God.

Swinton does consider and reject other ways to define mental health.770 In this context it must also be remembered that, as pointed out by Hans Fortmann, the Dutch psychologist of culture and religion, mental health’s cultural relativity makes it “not easily definable on a

765 Karl Barth, Church Dogmatics III/4 (T & T Clark, 1961), 363-373. Cited by Swinton, From Bedlam to Shalom, 72.
768 Swinton, From Bedlam to Shalom, 72.
769 The Kirby report advocates this approach and defines it this way. “Very broadly, recovery suggests that the goal of mental health policy should be to enable people to live the most satisfying, hopeful, and productive life consistent with the limitations caused by their illness.” The Honourable Michael J. L. Kirby, Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, Final Report of the Standing Senate Committee on Social Affairs, Science and Technology, 2006, 44, Sec 3.2.1.
770 Swinton identifies at least three other ways to approach mental illness that he believes need to be rejected. The first is defining mental health in opposition to mental illness, such that for example, a mentally well person would have an absence of psychopathology. Since some people’s psychopathology can be so chronic and interminable, it would be possible then to suggest that since some people are not cured of their illness, they have no hope of being mentally healthy. The second is thinking statistically about what normal is, and then defining the mentally ill among the statistically abnormal. The problem here is that statistics about what is normal are not really value neutral. Statistical numbers require interpretation, and interpretation requires an understanding of the context out of which these numbers emerged. This also makes them open to manipulation. People may choose to count certain numbers of people (i.e. the mentally ill) as abnormal. Hence the statistical process becomes somewhat tautological. The third trend is to consider mental health as a social ideal. Again, the problem of context and social expectations and manipulations are plentiful, as evidence by the Nazi experience.
scientific level.” Swinton’s essential point in retaining the possibility of mental health coexisting with chronic mental illness is meant to show that all people, including those who are severely mentally ill, are able to participate in some way in mental health. Essential to this participation is Swinton’s emphasis on the theocentric. Just as his definition of being human is foundationally related to God, so the human capacity for mental health includes a theological dimension. The strength to remain human despite one’s circumstances speaks to how meaning is inextricably “wrought out in the midst of ... [a person’s]... relationships with God and with one another, a meaning that is severely tested by physical and psychological trauma.” Swinton’s ultimate goal is to ensure that persons living with mental health problems are “enabled to develop the ability (and given the opportunity) to make and sustain positive relationships with God, self, and others, and to grow and be sustained by means of them irrespective of their circumstances.”

**A Role for the Church in Mental Health Care**

For Swinton, an important question for the practical theologian is: what is the place of the Church in mental health care? First of all, given Swinton’s conclusion that mental health is a relational concept integrally connected to God’s shalom, Swinton places mental health care as belonging to (a) “the ministry of the whole people of God” and (b) that the Church’s care will

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772 Swinton’s broad approach means to understand mental health as more than the absence of mental disorder or disability. This is consistent with the way the World Health Organization (WHO) defines mental health: “Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO’s definition of health: ‘A state of complete physical, mental and social well-being, and not merely the absence of disease’. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.” WHO, “Mental Health,” http://www.who.int/topics/mental_health/en/ [accessed January 5, 2012].

773 Swinton, *From Bedlam to Shalom*, 73.

774 Ibid., 73.

775 Ibid., 4.
have something to do with becoming a supportive “community of friends.” However two obstacles stand in the way.

Swinton charges that contemporary mental health care has become so professionalized, specialized and narrowly medically interpreted that it is challenging to conceptualise it in any other way. The consequence is a strictly medical model where the specialized medical practitioner builds a kind of hierarchy in the helping relationship, one that excludes the wider Church membership. The medical model is singled out by Swinton in Resurrecting the Person. Using the example of someone living with schizophrenia, he writes:

if it [schizophrenia] is seen to be a purely medical condition, then obviously the care of people diagnosed with it will be assumed to lie primarily with mental health care professionals. The danger is that even if the individual is sent back to the community, the perception remains that she is the responsibility of the specialist. Such a way of framing schizophrenia often means that the primary form of relationship that is open to a person diagnosed with this form of mental health problem is with the “specialist”, the professional who is paid to relate to them.

One troubling consequence of this socially framed construct is that people living with mental illness end up being defined by their illness. Swinton is well supported in his identification of depersonalisation, a process which he describes as “fundamentally degrading, exclusionary, and frequently dehumanizing.” Developing this from a modified liberation theology

776 Ibid., 105.
777 Ibid., 104.
778 Swinton, Resurrecting the Person, 83.
780 Swinton, Resurrecting the Person, 10.
perspective, Swinton suggests the mentally ill can rightly be considered a people for whom profound social and structural change might be “a force for rehumanisation” 781 where the “new person [might] arise from the ashes of the old.” 782

Swinton therefore calls for the Church “to liberate itself from its overconcentration on specifically therapeutic relationships such as counselling and psychotherapy, and regain a vision for those who require different forms of pastoral relationship.” 783 He suggests it must move to the conception that mental health is a communal process and not a “personal possession which can only be gained with specialist help.” 784 Although to present Swinton as anti-therapeutic is unfair, he clearly wants to move the discourse “beyond the therapeutic paradigm” 785 which he considers too strictly individualistic and too stifling of the broader communal mental health process for which he argues. At the same time, the neuropsychological foundations of the psychoses are well documented.

Frank Füredi provides some context to Swinton in Therapy Culture: Cultivating Vulnerability in an Uncertain Age in which he suggests not only that this new turn makes therapists into “relationship experts” 786 but that therapeutics has quickly become a system of meaning for our time. 787 Füredi’s point is that a therapeutic culture includes more than what

781 Ibid., 17.
782 On this point, Swinton references how Gustavo Gutiérrez’s liberationist perspective challenges traditional ways of relating. “We have to break with our mental categories, with the way we relate to others, with our way of identifying with the Lord, with our cultural milieu, with our social class, in other words, with all that can stand in the way of a real profound solidarity with those who suffer, in the first place from misery and injustice. Only thus and not through purely spiritual attitudes, will the ‘new person’ arise from the ashes of the old.” Gustavo Gutiérrez, A Theology of Liberation: History, Politics, and Salvation, Rev. ed. (London: SCM Press Ltd, 1988), 118. Cited by Swinton, From Bedlam to Shalom, 84.
783 Swinton, Resurrecting the Person, 19.
784 Swinton, From Bedlam to Shalom, 155.
785 Ibid., 157.
happens between a therapist and a client because it shapes “public perceptions about a variety of issues.” One of those issues is the privatisation of the individual. In fact, Füredi argues that “therapeutics is oriented to the experience of atomised individuals and tries to give meaning to the experience of isolated alienation.” This isolated meaning-making process is at odds with Swinton’s ideas about the emergence of meaning in a relational matrix which includes God, self and others. Füredi’s observations about how western religion “has been forced to internalise important elements of therapeutic culture” support Swinton’s criticism of pastoral care. In particular, Füredi documents trends in pastoral organisations such as the American Association of Pastoral Counsellors which intentionally promotes itself “as a mental health service.” Füredi writes that “organisations that have sought to harness therapeutic expertise for the work of the Church inevitably assume a secular orientation.” In this way, Füredi’s general conclusion on Churches taking a therapeutic turn is not dissimilar to Swinton’s, nor to the contextual issues explored in chapters one and two of this dissertation.

**Friendship: A Model for Mental Health Care by the Church**

Swinton pursues a relational model, one that involves the entire people of God, not just the specialists. Swinton proposes therefore a model of health care built on friendship rooted in a critical reading of the social sciences, philosophy and theology. This model is meant to be corrective of the Church’s current practice. A summary follows.

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788 Füredi, 22.
789 Ibid., 89.
790 Ibid., 91.
791 Ibid., 91. In Ontario, development work for new provincial legislation to regulate the practice of psychotherapists and mental health professionals is currently underway and clinical spiritual care is currently meant to fall under these professional guidelines. See The Transitional Council of the College of Registered Psychotherapists and Mental Health Therapists of Ontario (CPRMHTO), "The Transitional Council: What Do We Do" http://www.cprmhto.on.ca/pages/Home/About_Us [accessed April 9, 2012].
792 Füredi, 17.
1. Towards a Definition of Friendship

Referencing contemporary social sciences, Swinton underscores that friendship is normally conceived of in three ways: firstly as voluntary; secondly as mutual and reciprocal; and thirdly, as non-exclusive in nature. The voluntary quality of friendship separates it from kinship relationships. “Friends choose to be with one another,” 793 writes Swinton, introducing a fundamental freedom related to Swinton’s understanding of God’s option or choice to befriend humanity. The second principle, mutuality and reciprocity, underscores how friendship is not essentially instrumental, that is, not so much a means to an end but a context within which care and concern for the other exists. Swinton explores friendship in the context of mental health to move the discourse away from cures (which may not be possible) to relationships that are caring and full of concern. Thirdly, as pertains to the matter of exclusivity, friendship offers a much broader form of interpersonal relationships than, for example, more intimately binding institutions like marriage. By way of summary, Swinton understands the social sciences’ “ideal of friendship ... to be an evolving, living and dynamic relationship, the product of commitment, care, and a mutual willingness to be with and for the other in solidarity and sacrifice.”794

Philosophically, Swinton introduces the foundational work of Aristotle who wrote extensively about friendship in book eight of the *Nicomachean Ethics*. Swinton reinforces Aristotle’s appreciation of the depth of possible intimacy, of interconnectivity and mutual obligation that friendship can bring. Swinton references how Aristotle “describes it as like ‘a single soul dwelling in two bodies’.”795 Swinton also connects this intimate view of friendship with his ideas of shalom and God’s *Imago Dei*. He develops these ideas through Aquinas’s use of Aristotle, especially his idea that God offers an “agape love” to all human beings.

In the ‘*Summa Theologica,*’ Aquinas concludes that friendship is an appropriate term to describe humanity’s relationship with God. ‘Now there is a sharing of

793 Swinton, *From Bedlam to Shalom*, 79.
794 Ibid.
man with God by his sharing his happiness with us, and it is on this that friendship is based."\textsuperscript{796}

Locating friendship as central to the human/divine relationship forms the foundation of Swinton’s conceptual approach.

However, Aristotle’s understanding of friendship as essentially between equals who are seeking the virtue of goodness presents a problem. Swinton’s major concern here is not particularly with the end sought, the virtue, but with the relationship of equals, that is, the “principle of likeness.” From a social perspective, the principle of likeness and its derivatives are not uncommon. People are often attracted to those like them and they tend to reject those unlike them. In the experiences of people living with mental health problems, however, the principle of likeness is problematic because they often experience a principle of difference. As The Standing Senate Committee on Social Affairs, Science and Technology Report \textit{Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada} highlights, people shun the mentally ill, there is stigma, and social integration is often rendered difficult.\textsuperscript{797}

In Swinton’s own work, in addition to these stigmatising effects, professionalized care by specialists also reinforces this difference.

Swinton redefines the terms of difference in friendship in an attempt to resolve the problems of likeness. His foundational theory, the shalomic model, is essentially a relationship of unequals: God and humanity. As a Christian theologian, Swinton writes, “in the incarnation, one finds God willingly entering into friendship with his creatures who could never be his equal.”\textsuperscript{798}

Swinton develops this further. In John’s gospel in particular, the New Testament explicitly circumscribes friendship as “intricately bound up with the nature of discipleship and the


\textsuperscript{797} The Kirby Report stresses that “peer support” by people living with mental health problems for people living with mental health problems was identified for the Committee as one of “a number of services they believed necessary for them to cope with and recover from their disorders.” Kirby. Sec 6.1.3.1.

\textsuperscript{798} Swinton, \textit{From Bedlam to Shalom}, 84.
character of authentic human relationships with God and between human beings.”799 Jesus calls his disciples “friends” in John 15:15. Furthermore, Swinton writes,

For Moltmann, friendship is the primary mode of relating within the ongoing historical, eschatological movement of God in history. Friendship at least in its ideal form, is a foretaste of the way relationships will be when God finally brings in his kingdom in all its fullness.800

In other words, Moltmann considers that “through Jesus, friendship has become an open term of proffer. It is forthcoming solidarity.”801

Swinton’s social theological analysis is used to justify his point that Jesus extended his circle of friendship beyond the principle of likeness. In fact, he argues that Jesus “chose to become friends with a particular class and type of person who were considered unworthy of friendship by the civil and religious authorities of the day.”802 The point was not lost by Jesus’ detractors who used Jesus’ affiliation with tax collectors, and sinners (cf. Matthew11:19) to denigrate him. Ironically, from Jesus’ perspective the opposite was intended:

In the friendship of Jesus, people are no longer identified by their professions, their pasts, their race, religion, their handicaps, or any other human characteristic. All are called to become friends of Jesus and all find value by reason of their shared and restored humanity.803

This radical inclusionary approach, offered by Jesus’ shalomic friendship, is for Swinton directly linked to how the Church understands itself and its pastoral activities. He challenges the Church to consider what to do with this “powerful relationship” called friendship in its pastoral ministry.804 This means that for Swinton, one of the critical questions is how to resituate the Church’s pastoral practice in light of those living with mental health problems.

799 Ibid., 80.
800 Ibid., 81.
802 Swinton, From Bedlam to Shalom, 82.
803 Ibid., 83.
804 Ibid., 2.
2. The Church as Friend at the Congregational Level

When Swinton calls the Church to his friendship model, he is not specifically addressing mental health care inside the clinic, but how “the Church might actually carry out its ministry of mental health care at a congregational level.” He writes:

the model of mental health care proposed here has to do with the whole people of God acting out the gospel, and in acting it out revealing a new way of being human. It concerns the development of healing, sustaining, guiding, and reconciling forms of friendship that will enable the formation of the type of community that reveals a new way of living in the world and for the world.

In Swinton’s broader focus, healing is considered communally, within the context of a theologically defined congregation, that is Church. Here Swinton cites and builds on the work of British physician and pastoral theologian Bob Lambourne, highlighting how Lambourne’s work “argues against a model of care that is professional, problem solving or problem preventing, standardized and defined.” Instead, Swinton calls for the Church to adopt a model of care which “is lay, corporate, adventurous, variegated and diffuse.” For Swinton, individual healing only makes sense when it is included in the process of “mutual growth.”

One of the benefits that Swinton identifies in this model is that it permits the possibility that both groups (the inpatient clinical and the outpatient/community people) can work together. Much of the practical focus of Resurrecting the Person addresses this concern. In Swinton’s model of a “Community Mental Health Chaplain,” the chaplain has three actions which

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805 Ibid., 77.
806 Swinton’s use of these categories, while unreferenced, is a clear allusion to Seward Hiltner’s seminal reflections on the chaplain as “shepherd.” Seward Hiltner, Preface to Pastoral Theology, The Ayer Lectures (New York: Abingdon Press, 1954). These categories, though reworked are also developed by Clebsch, William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective: An Essay with Exhibits (Englewood Cliffs, N.J.: Prentice-Hall, 1964). As discussed in Chapters One and Two, Seward Hiltner was one of Boisen’s first students, and a strong advocate for Boisen’s and CPE’s need to be theological in practice. He was also influential in the life of Nouwen.
807 Swinton, From Bedlam to Shalom, 104.
808 Ibid., 103. For more on Lambourne, see Chapter One of this dissertation.
809 Ibid.
effectively bridge the two groups, clinical and congregational: first, to help people discharged from mental hospitals or already living in the community with mental health problems to find “an accepted and personally acceptable place within the life of a local Church community;” second, to “facilitate the development of forms of education for local Churches” so that this might be possible; and third, to build up “relationships with other [mental health] agencies working in the community.”

3. The Chaplain as Friendship Facilitator

The core work of the Community Mental Health Chaplain is to be a “friendship facilitator” between a person with mental health problems and the community. To explain the functional aspect of the chaplain as friend, Swinton borrows an analogy from John Bowlby’s Attachment Theory, the concept of “secure base.” Swinton’s concern, given the isolation characteristic for many living with mental illness, is that when a person is invited into friendship in a new community, the process can be a daunting one. Swinton uses Bowlby to describe how the task of navigating loss or change positively requires a certain degree of personal and interpersonal safety or security. Such a person needs a secure base to “explore his new environment and discover the possibility of developing positive interpersonal relationships, and a subsequent new and more affirming self-identity.” More than just a functional base, however, for Swinton the “chaplain’s relational bond of friendship very clearly imaged God’s relationship with the person, and in so doing, helped to resurrect and sustain the humanity of the sufferers in the eyes of themselves and others.”

Swinton extends friendship beyond the chaplain to the whole Church which is meant to become a community of friends with the mentally ill. In fact, the Church “must take the gift of

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810 Swinton, *Resurrecting the Person*, 149.
811 Ibid., 151.
814 Ibid., 154.
friendship seriously if it is to be effective in its task of offering humanizing care.”

Citing Paul Wadell, Swinton believes that friendship is a “moral enterprise,” 

“a way of living that ensures that human beings can be enabled to live their lives humanly.”

This approach, Swinton argues, brings hope to mental health care. “Where there are friends, there is hope. Where there is hope there are possibilities.”

To support this idea that friendships occasion hope and possibilities, Swinton cites Jewish psychologist Schlomo Breznitz whose research on stress has brought him to consider hope as a “‘protected area,’ a small area of experience that still maintains its positive features when everything around it is threatening, ‘a small island of peace surrounded by storms and disasters.’”

Understood this way, Swinton sees in friendship the basic building block of any healing community because it brings people back into relation after being isolated.

Swinton also argues that friendship “can be a primary focal point for the negotiation of meanings.” Swinton references this idea in narrative theory, citing clinical pastoral theologian and educator Charles Gerkin who suggested that “to tell a story is to have a self and to lose the sense of one’s life is to lose the sense of being a self.”

This central idea characterises most narrative approaches to care, in which it is suggested that a defragmentation of meaning can be mediated by the restructuring of the person’s identity through storytelling and the thickening or strengthening of relationships. Swinton’s goal here is to make room for more than

815 Swinton, From Bedlam to Shalom, 157.


817 Swinton, Resurrecting the Person, 49.

818 Ibid., 163.


820 Swinton, From Bedlam to Shalom, 117.


professionals in this story telling and relationship thickening practice. Narrative is more than a therapeutic method, he argues, and “is fundamental to the way in which we function as healthy human beings. As such it is one of the building blocks of the type of shalomic community which this book [From Bedlam to Shalom] has sketched out.”

4. Friendship’s Relationship to Nouwen’s Idea of a “Friendly Space”

Swinton’s use of Nouwen, referenced in the introduction to this chapter, also illustrates that Swinton conceives of this friendship practice as the creation of a kind of “space” through the Church. Nouwen’s insight to use “hospitality” as another word for “friendly space” is not unimportant here. In works such as Reaching Out and The Wounded Healer, Nouwen defines this idea as the “creation of a free and friendly space where we reach out to strangers and invite them to become our friends.” Nouwen uses this concept in his broader considerations on the spiritual life as including a movement from hostility to hospitality. For Nouwen, this “friendly empty space” is structured to make room for personal conversion, which is “an inner event that cannot be manipulated but must grow from within.”

Swinton’s identification of the mentally ill with Nouwen’s strangers, along with Swinton’s development of friendship as a kind of space for Shalom, represents a reasonable and creative use of Nouwen. It recognizes that that the experience of mental illness can be alienating, fearful, and chaotic. Thus, a shift toward a hospitality model creates new possibilities for the person with mental health problems. Swinton uses the concept of “friendly space” in order to facilitate in the Church the “type of empathy and understanding which is necessary for healthy human living and a truly healing community.” This friendship does not come with

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823 Swinton, From Bedlam to Shalom, 118.
825 As John Mogabgab has pointed out, space is a central and structural concept for Nouwen who, for example, used it strategically in his classroom methodology as well. John S. Mogabgab, “The Spiritual Pedagogy of Henri Nouwen,” Reflection 78, no. 2 (1981): 4-6.
827 Swinton, From Bedlam to Shalom, 158.
prescriptions about God even though it is inspired by the Church’s experience of God. Rather the practice of friendship as hospitality, to be true to Nouwen’s ideas, is “the opening of an opportunity to others to find their God and their way.” Friendly space, in other words, creates space for the careful discerning discovery of possible theological/religious dimension of experience, even in the midst of mental illness.

Thus the Church, for Swinton, as a “community-of-friends” is “a framework and theological rationale” for a mental health strategy, as well as a practical reflection of its own identity. Swinton clearly suggests that the identity of the Church and the chaplain must be visible in its pastoral action, revelatory of its sources. Grounded in the social sciences as well his theocentric anthropology, Swinton argues that in “the relationship of friendship” the Church finds “one important conduit through which this loving care can be expressed in tangible ways that reveal something of the God who inspires it.”

So, using friendship facilitation by the chaplain, Swinton proposes a way the Church can create friendly space which “can image God in its care for the mental health needs of its community and beyond.” Through numerous case studies in both books, Swinton shows that the Church’s solidarity in friendship, facilitated through the chaplain, does at least three things: it 1) affirms and resurrects the person which/whom the illness obfuscated or even obliterated; 2) images and reveals the friendship of God in the midst of mental illness; and 3) reframes friendship from relationships of “likeness” to relationships of “care” where the kind of difference often experienced in mental illness is no longer necessarily alienating.

5. “Friendly Space” and its Relationship to Boisen

Swinton’s use of Nouwen’s “friendly space” echoes important aspects of Boisen’s own original ideas. Like Boisen, Swinton identifies the issue of isolation and alienation at the heart of mental illness. Like Boisen, Swinton challenges the Church in its relationship with people living

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829 Swinton, *From Bedlam to Shalom*, 158.
830 Ibid., 157.
831 Ibid., 159.
with mental illness. Like Boisen, Swinton’s friendship does not separate the possibility of meaningful religious and theological experience from happening in the midst of mental illness. Like Boisen, Swinton argues for a social and relational framework, one grounded in an anthropology which includes human and religiously transcendent relationships, in the quest for mental health. Finally, like Boisen, Swinton provides a concrete model, something for the Church to do, as a corporate practice which involves the whole church, a kind of activity which could easily be understood in Roman Catholic thought as a corporal work of mercy.

There is however an important difference: Boisen’s model is primarily inpatient and clinical while Swinton’s focus is outpatient or community based, a difference with implications for the Church. This distinction is particularly important, given the limited scope of this dissertation concerning the role of the psychiatric chaplain inside mental health facilities characterised by faith based sponsorship. As evidenced in the particular geographic context of this dissertation, a major part of Church sponsorship in Ontario’s mental health care involves large inpatient centres which offer significant acute and chronic mental health care. While these inpatient programs are designed to interface with outpatient care, and other community programs which assist people in their homes and communities, there is nevertheless a larger and more intensive array of clinical resources available for the inpatients on account of their acuity.

Boisen envisaged the Church and the chaplain as a central part of institutional mental health care, as developed in Chapter One’s presentation of Pruyser’s exploration and adaptation of Boisen. Pruyser—and Nouwen after him—understood Boisen’s genius in the way he

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832 Chapter One developed this “corporate” idea in particular detail. Boisen never saw clinical pastoral care as only involving private one to one encounters but as a corporate responsibility that involved community activities, including worship. See for example, Paul W. Pruyser, *The Minister as Diagnostician: Personal Problems in Pastoral Perspective* (Philadelphia: Westminster Press, 1976), 38.


combined clinical and pastoral approaches, with a focus on theological diagnosis and religious corporate care inside the clinic. And while Boisen could not have envisaged Church sponsored care as it exists today in Ontario, his own case study approach paved the way for the religious/theological worldview to be a perspective at the heart of the inpatient clinic, inside the mental hospital. That is why Pruyser wrote that “the mental hospital chaplain with special clinical training as part of the psychiatric team is chiefly Boisen’s creation.”

It is true that Swinton’s model interfaces somewhat with inpatient clinical programs, but his published material exists primarily as a congregational referral model. In this context, the question arises whether Swinton’s friendship model is applicable in the context of clinical inpatient psychiatric chaplaincy? Interestingly, the answer to this question not only identifies two contemporary pitfalls with the friendship model, but in so doing significantly advances the conversation.

**Vulnerable but Revelatory: The Friendship Model**

*Problems with Clinical Befriending*

In correspondence I initiated with Swinton to pursue this problem, I specifically asked him about the role or job description of the inpatient hospital chaplain: “Did someone assess and otherwise befriend the patient upon admission?” Swinton’s reply initially mapped out an institutional structure of two chaplains. The first, the hospital chaplain, had overall responsibility for the spiritual care. The second, Swinton’s role as the Community Mental Health Chaplain, worked under this chaplain with the task of developing community spiritual care in the way this chapter [and his book *Resurrecting the Person*] laid out.

So in terms of job descriptions, his was the general and mine was the particular if you see what I mean? I think the answer to your question is that there was *no formal befriending within the hospital* although, in a real sense, my job was to provide precisely that for the groups that I worked with.  

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I also asked how his friendship model negotiates or otherwise can engage the trend sometimes captured in the statement, “I am spiritual but not religious.” My intention here was to use this phrase to point to the trend towards an effective separation of spirituality from religion, identified in the introduction of this dissertation. Swinton responded:

   Good question! The model of spiritual care that chaplains work on is based precisely on the generic model of spirituality you highlight. The problem there though is that a) no one is really that sure what the term spirituality means b) with the push towards professionalization within chaplaincy the term 'friendship' does not sit easily with the professional identity of chaplains as spiritual carers. By that I mean that the term friendship tends to challenge professional boundaries. Spiritual care is subject to risk management ideology and is therefore not comfortable with terms like friendship. So the changes within the institution in response to the changing understanding of spirituality lead to difficulties with friendship as a model of professional practice. So I guess the question is what role can friendship play in a healthcare context where spirituality (and by definition the basis of the model I develop) is shifting and changing in quite profound ways.  

Swinton’s responses confirm how problematic his friendship model can be, especially in an actual inpatient setting. His first response distinguishes the different roles and goals of spiritual and pastoral care inside the hospital from the work of the community. He states that there was no befriending in the hospital. This insight is reminiscent of Swinton’s published work, analysed in part one of this chapter, where he states that the current reality of mental health care is characterised by different and often disconnected spheres of care. His job, outside of the hospital, was to practice befriending, as a way of bringing both real connections to the care continuum as well as treating patients as relational persons.

Swinton’s second answer, however, is more interpretative. He offers two explanations for this: risk issues related to professional boundaries, and the context of fluidity about spirituality. The first reason is relatively straightforward.  

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837 Ibid.

838 When I suggest “relatively” straightforward, I mean in terms of accepted clinical practice. This apparent consensus should not ignore, however, that boundaries are always more subtle than hard and fast ethical rules. For a consideration on how the way clinicians navigate boundaries may reveal something about the relations clinicians
where it is suggested that clinical work should rightfully foster people’s capacities for friendship, clinicians actually befriending clients is not a methodology proposed for mainstream clinical practice. This is because friendship is understood to introduce a dual relationship which in turn limits therapeutic effectiveness. This example, drawn from social work theory, makes this point explicitly:

However, we caution the helping specialist to avoid confusing the professional boundaries of social support with friendship. Social workers realize that as helping professionals, it is not constructive to our clients to try to be their friends if we intend to maintain a supportive therapeutic partnership. Rather, we help to integrate skills of friendship through problem solving about how and where to find friendships, through role-play about how clients may engage potential friends or establish more meaningful relationships with friends, and through teaching the skills that improve patterns of communicating.  

In this example, it is important not to forget the basic advocacy, shared across the social sciences, for enhancing friendships. The recognition that friendship can operate as a determinant of health and that it is specifically helpful in the quest for mental health is consistent with Swinton. The disagreement, in the clinical milieu, is simply that the clinician ought not be considered a friend; exactly the opposite of what Swinton proposed for the Community Mental Health Care Chaplain and why, in his response to me, he wrote, “the term friendship tends to challenge professional boundaries.”


Friendship and “Generic” Chaplaincy/Spirituality

Swinton’s second insight that the changing face of spirituality towards a “generic” kind characterises contemporary chaplaincy is more complex. He suggests this is at the root of there being two kinds of chaplains: the inpatient “generic” one and his outpatient model. Swinton’s brief analysis suggests a generic practice which avoids theological and religious particularity is the option preferred in inpatient centres. In many ways, it is consistent with the contextual analysis established in the introduction of this dissertation; that is Zock’s summary insight that there are major shifts afoot in clinical chaplaincy causing “split identity” issues for chaplains. It was Zock who first characterised that a consequence of this contemporary clinical practice is that is difficult to separate the particularity of the existential counsellor who is a chaplain from her peers in social work and psychotherapy. It can be argued that Swinton’s observations about generic spirituality point to another way to comment on Zock’s idea. A “generic” inpatient chaplaincy is one that has become a kind of existential counselling that focuses on “the search for meaning and life orientation of the clients/patients/residents, irrespective of their religion or philosophy of life.”

Swinton’s use of the term generic spirituality also betrays a real conceptual problem in contemporary practice. The term can be used, as by Swinton in this case, to suggest that particularity in spirituality is only of the religious kind, and is best avoided in the clinic or in the clinical staff. As developed in Chapters One and Two, this line of thought has a historical precedent in early clinical chaplaincy. Pruyser’s critique of the choices chaplains were making in the clinic was presented in detail to make this point; the consequence being a growing absence and marginalisation of any theological content and expertise on the clinical psychiatric team. Nouwen too was critical of the movement’s shift exclusively to the “living human document.” Both Pruyser and Nouwen used their critique as a basis for reclaiming the pastoral, theological, and research intentions behind Boisen’s foundational intention to place chaplains inside psychiatric hospitals and on clinical psychiatric inpatient teams. Swinton’s contemporary critique  

thus shares an important heritage. What was a major concern to Boisen has once again moved to the periphery of clinical practice, only now spirituality that is “generic” has an integrated place in the clinic.

In a fundamental way, this conceptual conclusion concerning generic spirituality is definitional. That is why this dissertation chose to follow Schneiders’ concept of spirituality as a key term: that it is a universally true human process which is always and necessarily particular in its manifestation. When Schneiders comments that “there is no such thing as ‘generic spirituality’”\textsuperscript{842} her intention is to show that spirituality is always someone’s or some community’s articulated concrete “lived experience” about (a) what it means to be human, and (b) what the ultimate value is. And so, according to Schneiders’ anthropological conceptualisation, it is possible to have secular, scientific, medical and otherwise non-religious spiritualities. Only when the ultimate value is “the Absolute” or God, then Schneiders suggests, “the spirituality would be religious.”\textsuperscript{843}

While it is undeniable that all these particular ways of bring spiritual end up being represented in the general population, and hence in the clinic, the risk lies in the dominance of any one particular approach in the way the diverse spiritualities are clinically accommodated. The point is that even non religious spiritualities are necessarily particular (i.e. non generic), but when understood to be mainstream and solely legitimate, they can render unintelligible the particularity of religious expression to the point of limiting its access in the public space.\textsuperscript{844} Swinton’s use of the word “generic” appears meant to capture how much contemporary study of spirituality is not particularly religious or theological in foundation. His use of the word actually draws attention to how “generic” contemporary trends in spirituality may actually be


\textsuperscript{843} Sandra Marie Schneiders, \textit{Religion and Spirituality: Strangers, Rivals, or Partners?}, Santa Clara Lectures (Santa Clara, CA: Santa Clara University, Dept. of Religious Studies, 2000), 682.

\textsuperscript{844} There is a parallel expression of this in contemporary law in Canada. The debate includes whether “secular” when applied to institutions, for example, should mean “free from religion” and that “religion has no place in the public sphere.” Iain T. Benson, "Living Together with Disagreement: Pluralism, the Secular, and the Fair Treatment of Beliefs in Canada Today," in \textit{The Ronning Centre Forums II} (Camrose, Alberta: The Chester Ronning Centre for the Study of Religion and Public Life 2010), 6.
operationalizing their particularities, that is their own anthropologies and assessments of ultimate value, in an exclusive way.

So, while it needs to be admitted that it is possible to think about anthropology and ultimate value differently, I think Swinton, as expressed in his correspondence with me, is correct: beyond the more obvious and legitimate risk concerns about professional boundaries in clinical relationships, his friendship model’s explicit rootedness in theology does “lead to difficulties” in “the changing understanding of spirituality.”

Re-Imagining the Church and Chaplain: Charles Taylor

This consideration of Swinton’s reflections on clinical befriending and the “generic” but exclusively value laden approaches to spirituality, raise three further issues: (1) Is the dominance of the current “generic” clinical climate unsurmountable? (2) Given Boisen’s and Swinton’s challenge to the Church, what is is the role for the particularity of the Church sponsoring mental health care clinical practice; And (3) is “friendship” the best heuristic afterall for the Church and chaplain for that role? In this dissertation’s context of Catholic sponsored mental health care, these three questions point to an all-embracing issue when Swinton’s contribution is considered in conversation with Boisen: is there still a role for the Church in inpatient mental health care, and if so, what might it look like? Recent philosophical work by Charles Taylor offers four important ways to begin thinking through this problematic.

Making Religious Spirituality Credible

First of all, Taylor’s A Secular Age challenges the “mainstream master narrative of secularization” which suggests that “religious, transcendent views are erroneous, or at least have no plausible grounds.” He argues that this master narrative of secularisation holds that all

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845 John Swinton, e-mail message to author, May 7, 2009.

846 Taylor, 534. For an earlier consideration of some of these ideas, particularly in a Catholic context, see Taylor’s 1996 address to the University of Dayton, at which time he was given the Marionist Award. An insightful compilation of responses to the lecture is included in Charles Taylor and James Heft, A Catholic Modernity? Charles Taylor’s Marionist Award Lecture, with Responses by William M. Shea, Rosemary Luling Haughton, George Marsden, and Jean Bethke Elshtain (New York: Oxford University Press, 1999).

847 Taylor, A Secular Age, 768.
human flourishing can only be achieved immanently, that is, in a way that requires no reference to religiously transcendent beliefs. In fact, Taylor is most valuable for his deconstruction of this very popular but limited understanding of the secular, arguing in fact that there are more dynamic ways to approach secularity.\footnote{Taylor identifies three ways of approaching the secular: the first being the emptying of God or ultimate reality from public places, the second being the decline of practice and belief, and the third being the new conditions for belief in transcendence. His main focus is to examine contemporary society in terms of this third way: “the change I want to define and trace is one which takes us from a society in which it was virtually impossible not to believe in God, to one in which faith, even for the staunchest believer, is one human possibility among others.” Ibid., 3.} He suggests it is intelligible to speak of and to explore “new conditions of belief;”\footnote{Ibid., 20.} and that these new conditions include the possibility of a “more than immanent transformation perspective,”\footnote{Ibid., 530.} one that can include religious transcendence. This perspective, as argued in the introduction of the dissertation, is the “necessary postulate of the religious life”\footnote{John Hick, Dialogues in the Philosophy of Religion (Basingstoke: Palgrave Macmillan, 2010), 17. Hick calls this the “Real.” See especially pages 15-17. For a more detailed note, see this dissertation’s section on “Key Terms” in the introduction.} but is contrary to the dominant “generic” model Swinton critiqued.

Taylor’s work, therefore opens up the possibility that a religious anthropology and worldview, like Swinton’s and the Church’s, be considered at least as credible as a non-religious anthropology and worldview. This is a very important opening. An honest engagement with the Church in any human health service it offers, especially mental health care, must recognise that the Church’s service is motivated by its fundamentally religious identity. As identified in the introduction of this dissertation, Pope John Paul II addressed the American Psychiatric Association and the World Psychiatric Association in Rome in 1993 stating that the Catholic Church is “convinced that no adequate assessment of the nature of the human person or the requirements for human fulfilment and psycho–social well–being can be made without respect for man’s spiritual dimension and capacity for self–transcendence.” The Pope, just like Swinton, affirms that the Church’s anthropology is based on the human person “made in the image of God
and called to a transcendent destiny.”\textsuperscript{852} While an important and legitimate question concerns how Church sponsored health care might engage the people it serves who prefer not to seek religious spirituality, my intent here is to show that religious spirituality is one credible option to achieve human flourishing that is contained in Taylor’s argument.

Furthermore, in contradistinction to the mainstream paradigm, it is possible that a Catholic sponsored health system [or any another faith based hospital for that matter] may well be the only discourse partner in contemporary culture capable of engaging or at least offering such an alternative. This challenge, it can be argued, is fundamental to the mission and ministry of the Church in the world. A few years prior to his address that advocated for a mental health care that includes a self-transcendent dimension that includes religious spirituality, Pope John Paul II wrote: “In the modern world there is a tendency to reduce man to his horizontal dimension alone. But without an openness to the Absolute, what does man become?”\textsuperscript{853}

Highlighting the Church’s responsibility as a discourse partner in health care provision requires that the Church witness to its own experience of religious spirituality; failure to do so would mean it would lack integrity. The introduction to the dissertation argued that chaplains, as a discipline, appear to be adopting a non-religiously spiritual (what Swinton referred to as a “generic”) approach. Just as it has already been shown that Zock indicated that one result of adopting such a strategy is that clinical chaplaincy becomes indistinguishable,\textsuperscript{854} the same


\textsuperscript{854} The analysis of George M. Furniss takes this one step further and “differentiates the minister who is a religious professional doing pastoral care from the minister who poses as a humanistic professional.” George M. Furniss, The Social Context of Pastoral Care: Defining the Life Situation, 1st ed. (Louisville, Ky.: Westminster John Knox Press, 1994), 13.
concern presents itself in the context of facilities under Catholic sponsorship: the temptation to simply adopt a strictly secular, scientific, and medical approach to spirituality. Applying the words of Parker Palmer here, it is indeed possible for Catholic sponsored mental health care to practice a kind of “functional atheism” in the management and structure of its health care practice. In such an approach, no credible role for God or transcendence would ever be considered or attended to clinically. Rather, the ultimate responsibility for transformation remains at the purely immanent level, essentially with the person who is ill, and within the strictly secular, scientific and medical means available to the staff. Palmer warns that functional atheism is “a conviction held even by people who talk a good game about God.”

Such an idea is reminiscent of McCormick’s prophetic question concerning Catholic health care in the 90s under managed care: “Does not the claim of distinctiveness dissolve in the reality of practice?” The core idea here, in applying the Taylor insight, is whether faith based mental health sponsored care in the public domain includes and supports the possibility of a more than immanent approach to human transformation and flourishing. “Functional atheism” means that when one asks Elaine Graham’s question about whether a “practice” discloses or forecloses the possibility of a human/divine encounter in the clinic, the answer is that the clinical practice is actually structured to foreclose on the appearance of religious spirituality.

What’s Important in the Contemporary Spiritual Life

Taylor offers an important set of insights into what this practical approach which discloses an openness to religious/theological transcendence might look like. He critiques certain institutional Church statements about and practical manifestations of the religious worldview.

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856 Ibid., 88.
When applied to Swinton’s (and Boisen’s) call for a role for the Church in mental health care, Taylor’s observations are very important because they warn that certain developments within some religious traditions actually work against the viability of integrating transcendent beliefs into human flourishing and transformation. Taylor argues that “traditionalist” approaches which tend towards “homogenization” obfuscate the spiritual in a person’s life story. Taylor includes expectations of “impeccable intellectual orthodoxy,”\(^{859}\) the rise of “Vatican rule makers,”\(^{860}\) and monolithic codes of conduct.

The important thrust of Taylor’s argument, when applied to clinical practice, is more than a simple critique against the almost unimaginable situation where Church sponsored care would force or impose the “correct” transcendent beliefs on patients or staff. Taylor’s argument is rather based on his more nuanced understanding that in the contemporary spiritual life “getting assent to some external formula is not the main thing, but being able to generate the moving insight into higher reality is what is important.”\(^{861}\) In this, Taylor’s approach to the spiritual life shares an important feature, once again, with this dissertation’s adoption of Schneiders’ approach. It too focuses on the movement towards some higher reality, the ultimate value one preceives.

However, Taylor’s critique has importance when one considers how a clinical process is attentive, supportive or even obfuscates the generative process of moving insight into higher reality. In at least two ways, Taylor’s analysis is remarkably consistent with the core findings of this dissertation about Boisen’s clinical spiritual approach and his call that the Church must have a role to play in mental health care. First, it is essential to remember that Boisen struggled to understand the appearance, meaning, and value of the experience of religious spirituality in the context of personal crisis and mental disturbance. Second, Boisen believed that certain struggles in mental health, when attended to, could potentially generate a moving insight (to use Taylor’s words) to higher reality, what Boisen called the idea of God.

\(^{859}\) Taylor, *A Secular Age*, 488.

\(^{860}\) Ibid., 504.

\(^{861}\) Ibid., 489.
Chapter One captured the innovative reversal Boisen’s approach made to the clinical practice of his day. It developed Pruyser’s focus on Boisen’s interest in the relationship between pathology and the spiritual life. While it is true that Pruyser had concerns about some of the particular conclusions Boisen drew here, Pruyser considered Boisen’s linking of pathology and spirituality to be a major breakthrough in the sense that it opened wide the way clinicians could think about religious spirituality appearing in human life. Pruyser suggested that once Boisen’s approach is admitted, the clinical question is no longer “Which are the significant data of religious experience? The new question is: which data of experience are of religious significance?” 862

Pruyser’s study and adaptative use of Boisen meant not only to show that religious spirituality legitimately shows up in the mental health clinic, but that it does so in such novel ways that careful clinical interpretation is required. Indeed, both would agree with Taylor and his concern that the Church should never homogenise or otherwise impose a spiritual meaning. In his own words, Boisen “sought to begin not with the ready-made formulations contained in books but with the living human documents and with actual social conditions in all their complexity.” 863 Thus, Pruyser’s qualified adaptation of Boisen actually strengthens Boisen’s clarion call: the Church and its ministers must offer and be resources that help patients and clinical teams explore this new data of religious significance occasioned by the health crisis. Boisen believed this co-operative effort between the social sciences and the Church which would organize and test religious experience, would “build a theology on the basis of a careful scrutiny of religious beliefs.” 864

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862 Pruyser, A Dynamic Psychology of Religion, 12.
In a way that anticipates Taylor’s warnings, it is important to underscore that Boisen did not only call the Church to mental health care in some indiscriminate or “formulaic” way, but he called the Church to be intimately involved, pastorally and in terms of research, in the way people work through their mental health crisis and any data having religious significance that might appear in the midst of it. The import here is that a contemporary Church’s role in mental health needs to be a careful, interpretative and discerning discovery of how the living human document encounters religious spirituality as it appears in the clinic. In contemporary terms, Boisen can be interpreted as calling for new and novel way for the Church to sponsor mental health care.

**New and Unprecedented Itineraries to God**

Taylor’s work on the limits and possibilities of contemporary spiritual life in *A Secular Age* suggests there is an essential value for the Church in those lives which evidence new ways of moving towards religious transcendence or God in their particular situation. He writes:

One could say that we look for new and unprecedented itineraries. Understanding our time in Christian terms is partly to discern these new paths, opened by pioneers who have discovered a way through the particular labyrinthine landscape we live in, its thickets and trackless wastes, to God.\(^{865}\)

An important question is whether it is possible to situate Boisen’s personal and clinical breakthrough as a model of just such a new and unprecedented itinerary to God? Taylor’s own analysis celebrates both historic pioneers (such as St. Francis, St. Therese de Lisieux) as well as contemporary ones (John Main, Jean Vanier, and Mother Teresa) in order to make the point that a “rich variety of paths to God”\(^{866}\) is indeed the norm, and that these paths are of special importance to the Church. Pioneers like these open up “previously uncharted terrain,”\(^{867}\) starting with their own life’s witness that religious transcendence fits into—Taylor uses the term

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\(^{865}\) Taylor, *A Secular Age*, 755.

\(^{866}\) Ibid., 765.

\(^{867}\) Ibid., 764.
“incarnates”\textsuperscript{868}—their contemporary reality in new ways. Referencing Rowan Williams, Taylor argues that the Christian task is never to harken to some golden age or rigid paradigm on which to model today’s paths to God.\textsuperscript{869} This is why Taylor stresses the threat of homogenising the spiritual life, an idea with which I have already argued that Boisen would have agreed.

It is my proposal that Boisen’s life and work reflect a kind of new and unprecedented path to God. His unique case models that a relationship with religious transcendence, what he called “fellowship with the best,” is sometimes possible in the midst of the turmoil of mental illness. This metaphor is, of course, Boisen’s fundamental metaphor for the idea of God. It is what everyone seeks, Boisen believed, when he wrote: “I believe that the paramount human need is that for love and that there is a law within which forbids us to be satisfied with any fellowship save that of the best.”\textsuperscript{870} Consistently, it is what Boisen proposed as the goal for clinical pastoral education from a religious standpoint: “to lead the growing individual to transfer his loyalty from the finite to the infinite.”\textsuperscript{871} This core idea shaped his understanding of the distinctive work of the minister in psychiatric care. Boisen never advocated for the minister in traditional terms, as a representative of the supra natural, but as a researcher and pastor who works in the clinic to “help the soul in jeopardy to a solution on the level of the abiding and universal,”\textsuperscript{872} just as Boisen was able to do.

As shown in Chapters One and Two, Boisen spent the second half of his life researching the religious significance of lives lived in mental illness. He believed that the Church and the chaplain should be involved in that search inside the clinic because his inspiration was his own life (his case record) and intention was to be clinically pastoral. Boisen himself made this clear:

\textsuperscript{868} Taylor argues that through the incarnation, “it becomes possible for human suffering, even the most meaningless type, to become associated with Christ’s act, and to become the locus of renewed contact with God, an act which heals the world.” Ibid., 654.

\textsuperscript{869} Williams wrote that “The whole idea that there is a privileged era for being Christian is a strange one.” In Rowan Williams, \textit{Why Study the Past? The Quest for the Historical Church}, Sarum Theological Lectures (Grand Rapids, MI: Eerdmans, 2005), 105. Cited by Taylor, \textit{A Secular Age}, 766.

\textsuperscript{870} Boisen, \textit{Out of the Depths}, 187.

\textsuperscript{871} Boisen, \textit{Out of the Depths}, 197.

\textsuperscript{872} Boisen, \textit{The Exploration of the Inner World}, 281.
“I am profoundly convinced of the purposive nature of the searching experiences through which I have passed. ... [and] For these beliefs my own experience furnishes evidence to me.”

Furthermore, what he found to be his own trouble, “I think it is the trouble with many others also.”

Pruyser was one of the first to recognize that Boisen’s hope was to communicate and capitalise on his understanding of his own “mutation” in life, with the idea that it would be “exemplary and inspiring to others as well.” This is why he set about “aiding and helping them [other patients] come to a good ending,” which involved the “best.” Pruyser argued that Boisen essentially created the clinical psychiatric chaplain for this reason. That is why Pruyser used Boisen’s own path, his own case, as a model to argue for a clinically active theological and religious perspective to the human experience of mental illness.

Perhaps most critical, in this context of new paths, is Nouwen’s idea that the central pioneering importance of Boisen lies in his “life work: discovering ways in which man can overcome the sense of alienation” from God and others, as occasioned in Boisen’s life experience of mental illness. Nouwen’s Boisen is a man of significant losses: the death of his father, the failure of his vocational choices, and his admittedly distant and unrequited love with Alice. Indeed, Nouwen is extremely attentive to Boisen’s isolation and alienation. In a fundamental way, Nouwen recognises that Boisen’s map charts the movement from finite to infinite relationships, through his human relationships. Nouwen focuses on Alice, and repeats Boisen’s own insight that his life shares an echo with Dante. Boisen writes, “I am thinking of the old Dante-Beatrice story” identifying her as a kind of “guiding hand.” Nouwen concludes:

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876 Ibid., 210.

877 Ibid., 214.

878 Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 58.

879 Boisen, Out of the Depths, 207.
“Alice's role in Boisen's life was exactly to remove this sense of alienation and to bring about the internalization of the highest values of his social relationship,”\textsuperscript{881} that is, his encounter with the fellowship of the best, God.

What is remarkable about Nouwen’s portrait of Boisen’s itinerary is how it reveals the consistent social basis for religious transcendence in a whole life characterised by significant mental illness. Boisen, as a case study, reveals longitudinal consistency. Nouwen’s documented verbatim conversation with Boisen in 1964, just a year before he died, is historically important here. The encounter witnesses to a high degree of consistency with Boisen’s original insights in clinical pastoral care and education. At the age of 88, while obviously suffering from additional mental distress, Boisen’s first question to Nouwen was “Who is God?” And his answer, after Nouwen successfully reversed the question to him, was: “God is the internalisation of the highest values of our social relationship.”\textsuperscript{882} When one returns to Boisen’s original seminal text written almost 30 years earlier, \textit{The Exploration of the Inner World}, God is “that in the individual’s social experience which he counts of highest value and with which he would be identified.”\textsuperscript{883} Boisen persisted, to the end, in his socially dynamic approach to religious spirituality. God is to be found in the movement from finite to infinite relationships, where the evil of mental illness that gets expressed as isolation and alienation from others and God is resolved.

Once again, while Nouwen and Pruyser remain careful critics of the limitations of Boisen’s work and life, they nevertheless affirm his fundamental and pioneering witness. This is essential if an adaptation of Boisen’s notion of the clinical psychiatric chaplain is to be of any value today. Even Taylor, in the midst of his argument for the importance of pioneers who can model “whole itineraries towards God,”\textsuperscript{884} reminds the reader that

\begin{itemize}
\item \textsuperscript{880} Ibid., 209.
\item \textsuperscript{881} Nouwen, "Anton T. Boisen and Theology through Living Human Documents," 57.
\item \textsuperscript{882} Henri J. M. Nouwen, "Boisen," \textit{The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives} (Toronto: John M. Kelly Library the University of St. Michael's College, University of Toronto, 1964), 1-2.
\item \textsuperscript{883} Boisen, \textit{The Exploration of the Inner World}, 307.
\item \textsuperscript{884} Taylor, \textit{A Secular Age}, 754.
\end{itemize}
Neither of us grasps the whole picture. None of us could ever grasp alone everything that is involved in our alienation from God and his action to bring us back. But there are a great many of us, scattered through history, who have had some powerful sense of some facet of this drama. Together we can live it more fully than any one of us could alone.885

What Pruyser and Nouwen’s analyses of Boisen especially capture, I suggest, is one contemporary “facet of this drama”: the search for God in the social dynamic of life, especially when that life is experienced in this case with severe mental illness.

One might even say, that Boisen’s pioneering difference is that he wondered, based on his own experience, if the mental state of the patient might in fact open him or her to the religious transcendent, theologically and experientially. This is very much, Boisen’s “distinct question,” 886 to use David Tracy’s term; that is the original question behind the innovation of his life’s work which resulted in the call that the Church be intimately involved in mental health care and which created the clinical psychiatric chaplain. It is also why Nouwen affirms Boisen’s original assessment, that the Church, along with psychiatry had neglected to look at the religious implications of the experiences of the patients. Boisen felt strongly that theology has something very important to say about the mental health of man and that the religious aspects of mental illness could not be denied without losing [sic] the deepest levels of the human condition out of sight.887

This is what actually distinguishes Boisen’s genius: that his path to God led to the possibility that religious spirituality might explicitly be sought and witnessed to in the mental health clinic.

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885 Ibid., 754.
Beyond Friendship: Where Itinerants Meet Along the Way

Taylor’s final contribution to the focus of this work relates to the concern, shared by Boisen, that the Church and the chaplain engage the mental patient in the religious implications of his or her experience of mental illness. Taylor suggests that a Church that tries to manage people’s spiritual lives externally, by forcing or imposing homogenisation, is flawed as such a Church fails to be what it is meant to be. In the final pages of *A Secular Age*, Taylor concludes:

> The Church was rather meant to be the place in which human beings, in all their difference and disparate itineraries, came together, and in this regard, we are obviously falling far short.\(^{888}\)

Since Swinton’s friendship model for the Church is definitely about a kind of “coming together,” it is important to ask if Swinton’s model satisfies Taylor’s criteria. I suggest it is certainly possible to identify important similarities here with Swinton’s original proposal of friendship as a model of the Church in the service of the quest for mental health. Swinton intends the Church to be a peaceful or Shalomic place “that reveals a new way of living in the world and for the world.”\(^{889}\) Swinton’s reasonable and creative use of Nouwen’s concept of friendly space especially captures the value of such an approach when the experience of mental illness can be alienating, fearful, and chaotic. He successfully argues that the Church be a place where there is the “type of empathy and understanding which is necessary for healthy human living and a truly healing community.”\(^{890}\) Furthermore, Swinton’s proposal is theologically grounded, witnessing “something of the God who inspires it,”\(^{891}\) and thus suggesting, following Aquinas, that friendship “is an appropriate term to describe humanity’s relationship with God.”\(^{892}\) Moreover, it has been shown that social studies confirm the importance of friendship for health, in that

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888 Taylor, *A Secular Age*, 772.
889 Swinton, *From Bedlam to Shalom*, 104.
890 Ibid., 158.
891 Ibid., 157.
facilitating friendship is a legitimate better practice in clinical care.\textsuperscript{893} This line of thought points in the direction of considering that “health is membership,”\textsuperscript{894} that health care at some basic level needs to account for humanity’s relational nature, be that horizontally and/or vertically. Considered this way, Swinton’s work operationalises in a very particular way the Church’s call to practice hospitality by creating communities of friends where everyone, including those people living with mental health problems, is welcome.

Therefore, it is not the intention of this dissertation to downplay the role that friendship brings to all people, including the most marginalised, but this research applies Swinton to a clinical context. Swinton’s work faces clinical challenges mostly because of the power imbalances inherent in the medical model of patient and clinician. The strength in Swinton’s model remains its resistance to seeing people living with mental illness as strangers, by both society and clinicians. Swinton’s incredibly strong advocacy for communities of friends inside congregations reminds the reader that clinical concerns should never be isolated from those social contexts and spiritual communities people live in. For this reason alone, Church involvement in discharge planning, friendship facilitation, and hospitality seem to be relatively untapped resources for mental health care.

Nevertheless, Taylor’s careful development of the Church as the place where new and unprecedented itineraries to God ought to be welcome, while conceptually open to the concept of friendship, significantly pushes beyond it. Taylor’s analysis of mainstream secularity convincingly counters how, in societies like our own, “many people have trouble understanding how a sane person could believe in God.”\textsuperscript{895} Applying Taylor’s ideas about new paths to God to

\textsuperscript{893} This chapter has argued in favour of respecting the boundary limitations friendship poses for clinicians, primarily on account of contemporary standards regarding the risks inherent to dual relationships. Nevertheless, there is still need for more work in this area, especially where clinical work interfaces closely with community resources. One promising conceptual approach, found in the work of William K. Rawlins, is the idea that friendship is a “dimension” of existing relationships, and not a replacement of them. Rawlins sources this idea in Aristotle’s differentiation between friendship as a “free standing bond or as a dimension of other relationships like marriage, family, neighbourhood, work, and politics.” See William K. Rawlins, The Compass of Friendship: Narratives, Identities, and Dialogues (Los Angeles, Calif.: Sage Publications, 2009), 8.

\textsuperscript{894} Wendell Berry, Another Turn of the Crank: Essays (Washington, DC: Counterpoint, 1995), 86-109.

\textsuperscript{895} Taylor, A Secular Age, 770.
the work of Boisen, as I have done, intensifies the impact of Boisen’s contribution. Now, after Boisen, there might be even greater trouble understanding how a mentally ill person could, just as Boisen did, believe in God.

Boisen’s challenge remains even if society at large chooses not to admit this possibility for the sane or the insane. As pointed out by Pruyser and Nouwen, Boisen’s critical call is that the Church should explicitly search for and support, through the clinical practices it sponsors, the possibility that God might just appear in these kinds of human experiences of mental illness. Boisen called for a clinical resource in the person of a psychiatric chaplain who is integrated into inpatient care and capable of bringing these theological perspectives to mental health. If this were to happen, the Church would, through its careful attention, presence, and clinical involvement in mental health care, end up offering, as Elaine Graham has noted,

a way of valuing the insights into suffering and salvation elicited by accounts of vulnerability and illness whilst being able to distinguish those forms of mental illness that express themselves in religious delusion and distorted spirituality.896

Conclusion

This chapter began with a consideration of Swinton’s theologically framed friendship model for a role for the Church and the chaplain in mental health delivery. Swinton’s explicit use of Nouwen’s concept of “friendly space” was explored, and links were made to the important but unreferenced similarities his thought shared with aspects of the work of Boisen. In particular, Swinton and Boisen share some common ground concerning the isolating experience of mental illness and its theological importance, along with the basic task of attending to the social networks that can assist those living with mental health problems. A Church that offers friendship to counteract the depersonalising effects of mental illness is, therefore, consistent with some basic elements of the work of Boisen.

However, critical analysis of Swinton’s proposal that the Church and chaplain be a “friend” revealed important challenges, particularly when boundary issues of inpatient clinical

896 Graham, 138.
befriending and the dominance of “generic” trends in clinical spirituality were identified. Nevertheless, when these pitfalls in Swinton’s model were considered in light of recent scholarship by Taylor, new possibilities emerged. Taylor’s contributions made it possible, for example, to argue credibly for religious spirituality, something the trend towards generic or non-particular conceptualisations challenges. Taylor’s work also permitted the development of a more focused understanding of the role of the Church in contemporary spirituality. More than friendship, his work opened a clinical way to consider Boisen’s life and work as a “new and unprecedented path” to God. In this, Boisen evidences what Taylor considers central to the contemporary spirituality, the experience of generating a moving insight into higher reality, only Boisen did this in the context of a life lived with mental health problems.

Thus, Taylor’s work provides a new way to think about the Church and the chaplain in mental health care, as that place which both witnesses to and supports the possibility that a path to God is possible in the midst of mental illness. It promises a contemporary clinical practice that does not abandon theology and religious spirituality but, instead, focuses on the possibility that each patient might be on a new path to God, in a way analogous to that of Boisen’s life experience.

What this chapter has left undone is the mapping out of what such a clinical approach, specifically one supported by Catholic sponsored health care, might look like. This is the work for Chapter Four and the conclusion of this dissertation.
CHAPTER FOUR:

“RE-MEMBERING GOD”: A MODEL FOR CHAPLAINCY IN CATHOLIC SPONSORED MENTAL HEALTH CARE

This final chapter proposes a new theological model for a contemporary psychiatric ministry of chaplaincy in Catholic sponsored hospitals. It has three parts. Part one begins with a review of why new models are relevant, and summarises this dissertation’s essential findings in terms of models. Part two proposes a “re-membering God” model sourcing it in Henri Nouwen’s strategic use of Boisen and in cultural anthropologist Barbara Myerhoff’s concept of re-membering. Part three concludes with pastoral considerations on the particular relevancy of this model for Catholic sponsored mental health care.

Why another model?

It is indeed legitimate to ask if there is really a need for yet another conceptual model for chaplaincy. Using the work of Robert Dykstra, Chapter One situated how Boisen, Pruyser, and Nouwen are included in the history of pastoral care their respective models: the “Living Human Document,” “The Diagnostician,” and “The Wounded Healer.” However, according to theologian John Neuhaus, models are necessarily specific, concrete and time-limited. For this reason, he continues, it is of critical importance to continually create, and even re-create, them.

While the question is not new, the exploration of models is in fact always new. It is not an academic exercise but a day-to-day struggle to make sense of who we are and what we are doing. Models are crucial to this struggle because, in a very down-to-earth manner, we all live from models.

In this sense, models of practice are as much about expressing core identity as they are about context. The logic here—and the impetus behind this dissertation’s initial exploration of the

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897 Robert C. Dykstra, Images of Pastoral Care: Classic Readings (St. Louis, Mo.: Chalice Press, 2005).
contemporary context—is that when context changes, so too will the models. This way, not only will new models serve as correctives to possible distortions in practice, they also provide new and innovative ways to understand and implement, and may even justify funding for that practice.

**This Dissertation’s Essential Findings in Terms of Contextual Models**

In a broad way, it is possible to review the work of the preceding chapters in terms of four changing contexts that have driven identity and practice issues in the day-to-day struggles of chaplaincy. First, contemporary chaplaincy has become indistinguishable from—and in some ways even unwelcome—among the work of peer multi-disciplinary team members. The introduction of the dissertation specifically highlights Zock’s observation that the chaplain has become a kind of existential counsellor whose spiritual practice is “irrespective of [patients’] religion or philosophy of life.” Chapter Three exposes another side of this contemporary situation: Swinton’s theological friendship challenges so called “generic” spirituality. The work of Zock and Swinton illustrates two very “down to earth” consequences of living within the contemporary clinical dominance of the secular, scientific and medical model. While Swinton’s work most clearly shows how a model’s explicit rootedness in theology does “lead to difficulties” in “the changing understanding of spirituality,” Zock’s work crystallizes the need for a “new theoretical underpinning” and “a new conceptualisation of the profession” of chaplaincy.

Second, Chapters One and Two, which look at the origins of clinical chaplaincy in Boisen, reveal portraits of Boisen that stress that his pastoral practice and research was originally

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901 Neuhaus, 38.

902 John Swinton, e-mail message to author, May 7, 2009.

903 Zock: 137, 139.
meant to attend to religious spirituality in the midst of the mental illness experience, beginning with his own life. In this sense, it can be said that Boisen creatively called attention to a new context for pastoral care: the actual lives and experiences of people living with mental health problems. Pruyser’s and Nouwen’s historical analysis further clarify how early chaplains increasingly seemed to prefer the psycho-social practices of their peer disciplines at the expense of their own theological resources. These authors show how most of Boisen’s original followers ignored Boisen’s own commitment to explicitly religious corporate resources like worship and ritual. Dykstra clearly grasps Pruyser’s concern about this migration in the chaplain’s scope of practice when he comments, “Let ministers be ministers, Pruyser seems to be saying. Let them be theologians.” Nouwen’s clever turn of phrase in his unpublished work actually reframes what became Boisen’s seminal model, the “living human document,” in order to focus on the “living human God.” Together, Pruyser and Nouwen use Boisen to argue for a return to an explicitly theological perspective for chaplains in the clinic of their particular context.

Third, Chapter Three shows how Swinton’s friendship model, based in a theological anthropology, justifies ecclesial, social, and pastoral responsibility for mental health. It argued that Swinton’s work implicitly echoes Boisen’s original call that the Church practice a ministry concerned with mental illness. Moreover, Swinton’s is a contemporary critique and challenge that the Church use its congregations to assist persons living the isolation so characteristic to mental illness.

Finally, Chapter Three also argues that the clinical complications of Swinton’s model reveal what is perhaps the greatest contemporary contextual struggle facing chaplaincy: the very credibility that anyone would believe in religious transcendence at all, be they (in the words of

904 Dykstra, 153.

905 Henri J. M. Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," *The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives* (Toronto: John M. Kelly Library at the University of St. Michael's College, University of Toronto, 1965), 68.

906 For more on how living with mental illness often leads to isolation, in addition to poverty and permanent disability, see The Honourable Michael J. L. Kirby, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, 2006, Final Report of the Standing Senate Committee on Social Affairs, Science and Technology*, 10.2.3, 230.
Taylor) “sane”\textsuperscript{907} or insane. With Taylor, this dissertation argued that belief in religious transcendence is credible but that it is the struggle to find that belief in the midst of mental illness which lies at the root of Boisen’s “new and unprecedented” path to God. This struggle characterises Boisen’s “distinct question.”\textsuperscript{908} While separated by a totally different context, Boisen’s innovation of the clinical chaplain remains remarkably contemporary. In summary, different contextual matters have characterized chaplaincy and its models from Boisen to Swinton. Each period presented its own innovations and challenges, reflecting both flow and tensions at times in the way these models have developed.

\textbf{Towards a New Theological Model in Clinical Practice}

The question remains following Neuhaus and Dykstra: What is the best contemporary model to make sense of today’s struggle for the contemporary chaplain, and specifically in the delimited context of Catholic sponsored mental health care? Any model would need to directly accommodate Taylor’s critical contemporary insight which, when applied to Boisen’s life and work, underscores that it is sometimes credible to believe to God, even in the midst of mental illness. In this final chapter, I suggest a new model where the psychiatric chaplain “re-members God” in clinical practice. This model has two key sources: the primary source arises out of Nouwen’s strategic use of Boisen, especially as published in his book \textit{The Living Reminder} in which he argues that ministry is best considered as a kind of “remembrance.”\textsuperscript{909} The secondary source, particularly this way of spelling “re-member,” is from the work of cultural anthropologist Barbara Myerhoff (1935-1985). Her parsing of the word reflects a social constructivist approach to identity formation, thus making room for others, including God, to be “members” of a person’s identity forming social network.


\textsuperscript{908} David Tracy, \textit{The Analogical Imagination: Christian Theology and the Culture of Pluralism} (New York: Crossroad, 1981), 125.

The Primary Source: Nouwen’s Strategic Use of Boisen

It has already been shown in this dissertation that Nouwen’s many years of studying Boisen rendered only a few published references to him in his major works, and only two articles specifically about Boisen. Chapter Two surveyed this material, introducing for the first time a critical review of Nouwen’s unpublished writing and fragments. It is not my intention to review this material in its entirety here, but to review the core ideas in order to support my proposal for sourcing a “re-membering model” in Nouwen’s treatment of Boisen.

Chapter Two concluded that Nouwen’s essential portrait of Boisen, which had to do with Boisen’s search for relationship and God, needs to be considered as part of Nouwen’s critique of the clinical pastoral training modalities of his day. Nouwen’s core concern was to make more visible and possible the human/divine relationship in pastoral ministry and he used Boisen’s life and work strategically to argue for this.

Nouwen, following Pruyser, located this human/divine priority in Boisen’s research into his own case\textsuperscript{910} which became a kind of template or test case. For Nouwen, Boisen’s intention, in study and pastoral practice, was to alleviate what Boisen saw to be the primary evil of mental illness: alienation from others and from God. Nouwen’s work carefully identified how Boisen considered this alienation to be in the realm of social relationships,\textsuperscript{911} the functional locus of one of Boisen’s key concepts the “fellowship of the best.”\textsuperscript{912}

Nouwen’s unpublished manuscript, “Pastoral Supervision in Historical Perspective”\textsuperscript{913} reflects Nouwen’s assessment that Boisen’s followers had changed, marginalised, and otherwise forgotten Boisen’s intended emphasis with the living human document. Nouwen’s description of the three models characterising training (the medical, the therapeutic, and evangelical protestant) indicated a diminished role for dynamic and theological inquiry. Supervision in these models, he


\textsuperscript{913} Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)."
believed, embraced a kind of professionalism without the struggle of pastoral diagnosis; it replaced theology with the new social sciences, and it simplified the conversion process. Nouwen found conversation about God “vague, undefined, distant... whereas man was concrete, defined and close.”

It was in this document that Nouwen proposed “the experience of the living God or better the living human God.” Nouwen worried that the current models of education failed to form the student ministers into guides capable of helping patients work out their spiritual life, which he understood to be “a dynamic encounter with God.”

Nouwen’s discontent with his own clinical training in psychiatric chaplaincy surfaces here. Nouwen’s second and last clinical pastoral training unit at the Topeka State Psychiatric Hospital, took place in the spring of 1965, the very year he worked on the unpublished manuscript about supervision reviewed above. While he writes that this clinical unit summary document probably reveals more “about the author than about clinical training,” Nouwen hopes that his observations might still have value in so far as his “testimony shows some of the principles on which the training is based.” In a note from March 1965 and titled, “Theology and Clinical Training,” Nouwen asks:

But the question remains in how far the pastor should insist on his theological perspective. In a hospital setting this perspective may be important for the patients and staff as well as for the psychiatric approach. The theological perspective within the healing disciplines can prevent any system from becoming a closed system and can help to consider life as a gift towards which we can only a serving attitude. I only think in terms of the self-concept of the minister and the way he develops his pastoral attitude. Perhaps the most important thing will be to make our implicit theological attitudes more explicit and reflect more the theological implications of what we are doing.

\[914\] Ibid., 68.
\[915\] Ibid.
\[916\] Ibid., 70.
\[918\] Ibid., 63.
Nouwen’s “theological perspective” is unreferenced here, but it is consistent with the teaching Nouwen experienced from Pruyser\textsuperscript{919} during this time at the Menninger Center and documented in Chapter Two of this dissertation. It is interesting to note, however, that Nouwen explicitly expands the value of the theological perspective to include patients and staff, pointing out the way it helps systems of care remain open and not “closed” to the “gift” of life. These observations lend a prophetic quality to Nouwen’s work, especially in light of more contemporary work on what religious commitment offers to the ethos of health care.\textsuperscript{920}

Nouwen’s training concerns became the subject matter of his published work. These themes were developed in detail in Chapter Two, but what is key here is how Nouwen strategically cites Boisen to support his thesis on theological explicitness and implications. In Intimacy, Boisen’s method of sourcing intimacy with God in people’s prayers and people’s actual social relationships is used to argue that the priest is one who is called to research and “remain responsible for God, to keep God alive always changing and always the same, as man himself.”\textsuperscript{921} In Creative Ministry, Boisen is used to support “the continuing search for God in the life of the people we [pastors] want to serve.”\textsuperscript{922} That, Nouwen writes, is why Boisen rejects readymade formulations contained in books and opts instead to work “with living human documents and with actual social conditions in all their complexities.”\textsuperscript{923}

In The Living Reminder\textsuperscript{924} Nouwen makes his last citation—and I would argue his most important—of Boisen in a published book. One might have expected more Boisen citations in


\textsuperscript{922} Henri J. M. Nouwen, Creative Ministry (Garden City, N.Y.: Doubleday, 1971), 63.


\textsuperscript{924} Nouwen, The Living Reminder.
what is the book version of three lectures Nouwen gave in 1976 to the International Conference of the Association for Clinical Pastoral Education and the Canadian Association for Pastoral Education in Detroit, Michigan. One might have also expected some mention of Nouwen’s long study of Boisen. But Nouwen invokes Boisen, “the father of the Movement of Clinical Pastoral Education,” once only to ground his idea that ministry can be understood as a process of remembrance.

For Nouwen, the concept of remembrance has both ancient theological and modern social science sources, each pointing to the importance of recollection and the healing power of memory. Nouwen briefly cites Abraham Heschel’s work, *Man is not Alone,* where it is suggested that “much of what the Bible demands can be comprised in one word: Remember.” He also cites the Christian author Nihls Dahl who writes that the task of the first apostles was to “make the faithful remember what they have received and already know – or should know.”

Nouwen is effectively retrieving the Jewish and Christian traditions of zikka rôn (Nm 10.10) and anamnesis. The latter, from the Greek, means “remembrance, commemoration, memorial, re-presentation in the sense of ‘making present’ once again in the here and now.” Nouwen’s analysis employs this meaning to highlight how current human experience relates to divinity’s presence and salvific action. He points out how this approach allows “time to be converted from *chronos* into *kairos.*” Similarly, in Judaism, the ritual remembrance of core feasts in its history is not mere recollection, not a recalling of the events as something past.

925 Ibid., 23.
Nouwen writes, “for Israel, remembrance means participation.” At issue is the making present the very same love of God which historically brought redemption such that it remains “a living force which sustains us in the present.”

Nouwen argues that this remembrance is “also the message which forms the core of our lives as ministers of the gospel of Jesus Christ.” Seen this way, what appear to be “a series of randomly organized incidents and accidents” become an opportunity to “explore God’s work in our lives,” not just individually but collectively over time. For Nouwen, the minister must not lose “touch with that reality with which we are called to connect ... the presence of God.”

Thus, Nouwen retrieves a rich theological and liturgical deposit of both Judaism and Christianity in order to argue for a revitalized memory of God in the everyday life of people who suffer.

In the therapeutic approaches contemporary to his time, Nouwen underscores how the social sciences were already revealing that painful and suppressed memories need to be carefully remembered not forgotten. Left alone, he writes, they can “become independent forces that can exert a crippling effect on our functioning as human beings.” Nouwen cites Max Scheler’s *On the Eternal in Man* to suggest “remembering is the beginning of freedom from the covert power of the remembered thing or occurrence.”

Nouwen uses Boisen strategically in his analysis of these contemporary therapeutic trends about memory. Nouwen reminds his readers that Boisen “pleaded for” a dynamic understanding the lives and behaviours of the “living human documents” in care, one “which offers insight into the many psychic forces by which painful memories are rejected.”

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932 Ibid., 38.
933 Ibid., 38-39.
934 Ibid., 39.
935 Ibid., 25.
Nouwen does not develop the details here, but he is implicitly referring to Boisen’s idea of restoring “the individual to right relationship” with God by attending to the “actual social conditions in all their complexity.” Chapter One developed Boisen’s complex understanding of the isolation he understood to characterise some psychically distressed patients. Boisen considered such patients as being “afraid to tell” or share what troubled them. Thus what complicated their situation, Boisen thought, was that they never socialised their problem. Rather their memories and ideas remained stuck within the suffering patient, often experienced and interpreted as a kind of condemnation. For Boisen, the distinctive role of the minister was to “help the soul in jeopardy to a solution on the level of the abiding and universal,” that is to find “forgiveness and restoration to the fellowship of that social something we call God.”

The strategic value of Nouwen’s invocation of Boisen here is that it draws attention beyond a clinical approach that remains only with the psychological and emotional dynamics of the individual sufferer. Chapters One and Two argue that while both Nouwen and Pruyser situate Boisen’s too simplistic analysis of the religious meaning of mental illness, they affirm, nevertheless, the breakthrough quality of his intention and how this contributes to a broader more holistic clinical approach, inclusive of the theological perspective. Nouwen invokes this again with the idea that ministry “offers space in which the wounding memories of the past can be reached and brought back into the light without fear.”

As stated by pastoral psychologist and Jesuit, Kevin Gillespie, “Nouwen wanted more than psychological answers to the real questions of the day.” This is evidenced in the direction Nouwen takes in the text right after citing Boisen. Of the contemporary challenges

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941 Ibid., 185.
942 Ibid., 268.
943 Ibid., 281.
944 Ibid., 268.
facing the clinical pastoral care of his age, he asks: “Has the great emphasis on the complex psychodynamics of human behaviour not created a situation in which ministers have become more interested in the receiver of the message than in the message itself.”[^947] This retrieves Nouwen’s earlier training report about the theological “self-concept”[^948] of the minister. He brazenly asks if in the emphasis on professionalism ministers are not stuck halfway, identifying more with the “psychologist and psychiatrist than to the priest?”[^949] At issue in Nouwen’s distinction between the “receiver” and the “message” is his concern that ministers are failing to live out of their fundamental theological identity of remembrance. He suggests they are identifying with other disciplines where the “concrete” person is the primary subject matter. Such a self concept makes human dynamics the primary concern, or scope of practice. When this happens, Nouwen argues, the focus is not open to theology and such ministers get “in the way of the experience of God.”[^950]

To reflect further on this problem, Nouwen introduces a reference to the Great Commandment (Matt 24:34-40) in *The Living Reminder*. Nouwen’s analysis openly explores whether ministers have given up the idea that they are fundamentally reminders of God for others. He cautions that “we [ministers] must continually remind ourselves that the first commandment requiring us to love God with all our heart, all our soul, and our entire mind is indeed the first;”[^951] that is, it is first for ministers too.[^952]

In this text, Nouwen’s use of the second commandment is carefully developed in the context of “professional” service to others as neighbours which “during the past several decades may have led us to put too much confidence in our abilities, skills, techniques, projects, and

[^950]: Ibid., 29.
[^951]: Ibid., 31.
[^952]: Nouwen’s later work will develop this theme further. See for example his Christological and mystical focus in Henri J. M. Nouwen, *In the Name of Jesus* (London: Darton, Longman and Todd, 1989).
programs.\textsuperscript{953} Nouwen means by this that “over the years we have developed the idea that being present to people in all their needs is our greatest and primary vocation.”\textsuperscript{954} His point is that the idea that chaplaincy is best understood as mainly being present with others who are ill or distressed has tended to obfuscate the primary or first commandment, being with God.

The practical tension in living both commandments is how to understand the commandments’ priority relationship. Nouwen suggests pastoral ministry has mostly tended to emphasize service to the neighbour over commitment to God, while sometimes arguing for balance between the two expectations. But Nouwen notes, the first commandment is more radical. [Jesus] asks for a single minded commitment to God and God alone. God wants all our heart, all our mind, and all our soul. It is this unconditional and unreserved love for God that leads to the care for our neighbor not as an activity which distracts us from God or competes with our attention to God, but as an expression of our love for God who reveals himself to us as the God of all people.\textsuperscript{955}

Nouwen carefully indicates that “it is indeed true that God may meet us in the neighbour”\textsuperscript{956} but an overemphasis or distorted understanding of service can lead to confusion between the two relationships. For Nouwen the love of neighbour flows from God’s love to us.

The first commandment receives concreteness and specificity through the second; the second commandment becomes possible through the first. The first and second commandments should never be separated or made mutually exclusive, neither should they be confused or substituted for the other.\textsuperscript{957}

It is valuable to remember that Nouwen’s lecture and book began by proposing that the work would be a careful exploration of the way professional service challenges what ministry has to do with prayer and spirituality. Remembrance is Nouwen’s way to resituate ministry’s connection with spirituality, where the latter means “a spiritual connectedness, a way of living

\begin{footnotes}
\item[953] Nouwen, \textit{The Living Reminder}, 29-30.
\item[954] Ibid., 30.
\item[955] Ibid., 31.
\item[956] Ibid., 32.
\item[957] Ibid., 32.
\end{footnotes}
united with God.”

Nouwen’s citation of Boisen situated just before this reflection on the great commandment, is therefore contextually significant. Nouwen’s reference to Boisen’s careful concern about the role of painful memories and personal crisis is meant to locate spiritual connectedness at what Boisen called “the level of the abiding and universal,” God.

Nouwen concludes The Living Reminder by drawing attention to the fact that the twofold parts of professionalization, expertise and proclamation, “can never be separated without harm.” For Nouwen, the answer to the question from the other health disciplines like psychiatrists, psychologists, medical doctors, “Tell me how you are different from us?” lies in the chaplain’s foundational identity in the great commandment. The chaplain proclaims and has expertise in how people connect with God, beginning with his or her own lived experience with God, all in the practice and study of “the communal relationship with God.”

Nouwen’s practical way to identify the specific difference in the practice of chaplains from that of other disciplines is that the chaplain as minister is tasked “to continuously make connections between the human story and the divine story.” For Nouwen remembrance is a kind of “practice which inscribe[s] a habitus—an orientation and inclination toward the world, aimed at a certain telos.” Nouwen’s answer seems to anticipate both Zock’s and Swinton’s critiques about contemporary chaplaincy. To Zock’s problem of an indistinguishable practice,

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958 Ibid., 34.
960 Nouwen, The Living Reminder, 76.
961 Ibid.
962 Ibid., 32.
963 Ibid., 24.
964 This emphasis on practice as habitus and telos is borrowed from Smith and Smith’s use of Alasdair MacIntyre’s definition of a practice: “By a ‘practice’ I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.” Alasdair C. MacIntyre, After Virtue: A Study in Moral Theory, 2nd ed. (Notre Dame, Ind.: University of Notre Dame Press, 1984), 187. Cited by David Smith and James K. A. Smith, Teaching and Christian Practices: Reshaping Faith and Learning (Grand Rapids, Mich.: W.B. Eerdmans Pub. Co., 2011), 8,9.
Nouwen stressed the centrality of a personal experience explicitly made available as a public belief in God, put in service for others in the practice of making connections between the concrete human story in the clinic and the divine story. Nouwen’s attention to the particular relationship between a person’s story and the divine story also challenges the idea of generic chaplaincy. Nouwen is particular: the specifically Christian contribution to chaplaincy is that the chaplain is a living reminder of Christ, and, when viewed from the larger Judaeo-Christian tradition, he or she is a witness to God. The minister proclaims that such a connection can exist starting—as it must—with his or her own life. Hence the “living” part in *The Living Reminder* the chaplain can be in the clinic. Furthermore, as part of a larger community of practice, that chaplaincy has standards which reflect and are constantly debated by a tradition that still believes and practices this approach.

The core issue remains how remembering God, as the special dimension chaplaincy addresses, is conceptually integrated into the overall framework of clinical care. What is the best way to structure a clinical discipline or practice model that remembers God in the clinic? Nouwen’s *The Living Reminder* offers a partial insight. Nouwen is keenly aware that new ways of thinking about science will always call out for more integration between the disciplines.

One of our most challenging tasks today is to explore our spiritual resources and to integrate the best of what we find there with the best of what we have found in the behavioural sciences.  

*The Secondary Source: Barbara Myerhoff’s Work on “Re-membering”*

In this section, I will develop how Nouwen’s remembrance model can be integrated with the secular cultural anthropological work of Barbara Myerhoff. This integration is original in that neither Nouwen nor Myerhoff use each other’s work, but both are influenced, among others, by the Holocaust related works of Elie Wiesel, the Jewish studies of Abraham Heschel, and the interviews of Hiroshima survivors by Jay Lifton. They also share an interest in aging.

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965 Nouwen also develops this theme in *The Wounded Healer*: “The Minister is the one who can make this search for authenticity possible, not by standing on the side as a neutral screen or an impartial observer, but as an articulate witness of Christ, who puts his own search at the disposal of others.” Henri J. M. Nouwen, *The Wounded Healer: Ministry in Contemporary Society*, 1st ed. (Garden City, N.Y.: Doubleday, 1972), 99.

966 Nouwen, *The Living Reminder*, 76.
differentiated mainly in Myerhoff’s longer commitment to its study. Chronologically, Myerhoff’s study of the elderly began about the time Nouwen co-wrote the text for *Aging: The Fulfillment of Life.* While Nouwen moved onto other interests as was his pattern, Myerhoff continued to focus on the elderly for the rest of her life.

For Myerhoff, this investigation would produce an Academy Award winning documentary film in 1976 and a book in 1978, both titled *Number Our Days.* This has been praised for its ethnographic breakthroughs, as well as for such seminal conceptualisations as “definitional ceremonies” about the role ritual and storytelling play specifically among the Jewish elderly she studied. Victor Turner, in the introduction of this book, considered it “in the vanguard of anthropological theory.” This was mostly because Myerhoff turned her research gaze not only on her own “nation of birth, but also to her Jewish heritage,” thus doing anthropology locally, among one’s own people. Turner also celebrated her work’s abundance of verbatim transcripts, narratives she used through her research “to show us the very processes through which her subjects weave meaning and identity out of their memories and experiences.”

Myerhoff used the term remembrance—a term she borrowed from Victor Turner who also wrote it with a dash or hyphen—as in “re-membering.” She defines the word this way:

To signify this special type of recollection, the term “re-membering” may be used, calling attention to the reaggregation of members, the figures who belong to one’s

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970 Ibid., xiv.
971 Prior to this, Myerhoff’s interest was more classically anthropological. For example, she studied the Huichol Indians of the Sierra Madre Occidental of Mexico. See Barbara G. Myerhoff, * Peyote Hunt: The Sacred Journey of the Huichol Indians*, Symbol, Myth, and Ritual Series (Ithaca [N.Y.]: Cornell University Press, 1974).
972 Turner, xv.
life story, one’s own prior selves, as well as significant others who are part of the story. Re-membering then, is a purposive, significant unification.973

Myerhoff saw a use for the concept as a way to think about the role memory played in the elderly she was studying. Her insight was that “re-membering” reflected a social constructivist role in identity formation, especially when that identity was at risk of being lost or forgotten. The dash therefore was meant to draw attention to how a person may “add” back those historically constitutive “members” of his or her social circle who were at risk. The foundational building block of this approach is based in her idea that “being is a social, psychological construct, made, not given.”974 Consequently, for her, it is impossible to conceive of being human at all—and especially the challenges life brings to elderly—without accounting for the fundamental role relationality plays.

A life, then, is not envisioned as belonging only to the individual who has lived it but is regarded as belonging to the world, to progeny who are heirs to the embodied traditions, or to God. Such re-membered lives are moral documents and their function is salvific.975

It is critically important to understand that Myerhoff’s concern is rooted in the experiences of radical loss and marginalisation among a subordinated group. The subtitle of her celebrated work captures this: A Triumph of Continuity and Culture among Jewish Old People in an Urban Ghetto.976 She described the threat facing her research group of elderly Jews of eastern European origin this way:

What Sir Thomas Browne said in 1685 [sic] is still true: the threat of oblivion is “the heaviest stone that melancholy can throw at a man.” When people are very old, separated from progeny, bearers of traditions that will pass away with them, and not sure that anyone—neither God nor their fellows—will remember their names or pass on the knowledge that they have existed, then they face a death that

974 Ibid., 233.
975 Ibid., 240.
976 Myerhoff, Number Our Days.
surpasses a normal separation from life: then they face the possibility of oblivion. 977

Myerhoff argued that “re-membrance” is the antidote to oblivion because it brings unification and renewal to what is at risk of being dismembered.

Myerhoff readily admitted that Freud’s now classic understanding of loss and the completion of mourning, which includes de-cathexis, 978 requires that those who are “left behind develop a new reality which no longer includes what has been lost.” 979 Myerhoff’s breakthrough insight, however, was that the “full recovery from mourning may restore what has been lost, maintaining it through incorporation into the present.” 980 It is in this sense that re-membering brings back a certain sense of order where it was at risk of becoming disordered, dis-membered and forgotten.

In a most interesting verbatim at the end of her seminal book Myerhoff documents her own response to Schmuel, an elderly Jewish man, who was concerned that all this re-membering might have had unexpected consequences. He believed the celebrity and fame Myerhoff’s work received through the Academy Award had unintended, even unhealthy outcomes including a certain self aggrandizement among the survivors. He asked “They go directly from one made up world to another, to Hollywood. Is this sanity?” 981 Myerhoff responds:

No one can say the publicity hasn’t brought them genuine benefits, Schmuel. And not only to them—to me too, and others who know about them. You of all people should be pleased. Look what happened because of the remembering and the re-telling. The dreams, the bobbe-myseh, the memories – all still alive and circulating. 982 [emphasis added]

977 Barbara G. Myerhoff, "Re-Membered Lives," *Parabola* 5, no. 1 (1980): 74. (The date 1685 should be 1658.)

978 For an review of the importance this concept has in traditional grief theory, see Therese A. Rando, *Grief, Dying, and Death: Clinical Interventions for Caregivers* (Champaign, Ill.: Research Press, 1984), 76-78.

979 Myerhoff, "Re-Membered Lives," 77.

980 Ibid., 77.

981 Myerhoff, *Number Our Days*, 277.

982 Ibid., 278.
This citation repeats Myerhoff’s central point: remembering saves the world—people’s worlds—from oblivion. It allows the lost party to be added back; and even if there is a risk of some exaggeration in the remembering or a consequence of it, this can be managed. The process allows the surviving party’s current existence to be reconstituted by the re-membering, the making present, of former relationships.

Myerhoff’s idea of a re-membering that returns what might have been lost in the past to the present has itself experienced a renaissance in contemporary loss theory and, subsequently, in clinical care. It provides a helpful conceptual framework for how the deceased person can be invited back into the present and current social world of the griever. This conceptual renaissance began with the late narrative theorist and therapist Michael White (1948-2008), in his 1988 article “Saying Hullo Again: The Incorporation of the Lost Relationship in the Resolution of Grief.” White identified how grief work can involve the reconstruction of a new socially constructed world which includes what was lost, only differently than before. White then systematized and expanded Myerhoff’s ideas beyond just grief work, with the concept of “re-membering conversations” which:

1. Evoke ‘life’ as considered as a ‘membered’ club, ‘identity’ as an ‘association’ of life.
2. Contribute to a multi-voiced sense of identity, rather than the single-voiced sense of identity which is the feature of the encapsulated self that is the vogue of contemporary western culture.
3. Open possibilities for the revision of one’s membership of life: for the upgrading of some memberships and for the revoking of others ...
4. [Richly describe] the preferred accounts of identity and knowledge of life and skills of living that have been co-generated in the significant memberships of people’s lives ...
5. [Illustrate that] re-membering conversations [are] not about passive recollection, but about purposive engagements with the significant figures of

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one’s history, and with the identities of one’s present life who are significant or potentially significant. 984

Some in pastoral care have capitalized on White’s reclamation of Myerhoff. One American CPE supervisor describes the value this way. Re-membering Conversations was used to reposition or reclaim a significant deceased person in a client’s narrative frame. In this conversation the client is first asked to share the [deceased] person’s contribution to the client’s life. Then they are asked to talk about their own identity through the eyes of the person (out of Barbara Myerhoff’s theory that identity is a public and social achievement, not a private, individual one). Next they are asked to talk about their contribution to the person’s life. And, finally, they are asked to talk about the implications of that for the deceased person’s identity. I have often worked with people around the first two questions, but I observed how real movement happened for people when they engaged the final two as well.985

To “Re-member”: A Clinical Theological Application for Chaplaincy

While this application to the grief work that chaplains might carry out is very important, I focus now on the application of Myerhoff in terms of re-membering ‘God.’ Myerhoff is relevant here because contemporary clinical practice, for the reasons articulated in this dissertation, risks forgetting God in the clinic and makes irrelevant any clinical psychiatric chaplaincy primarily religiously rooted in the human/divine relationship. In practical terms, the contemporary reality for God and chaplain in the secular, scientific, and medical paradigm is the “oblivion” 986 of which Myerhoff spoke.

I propose to interpret Myerhoff in a new way, to reflect a theological application of her re-membering as a means of retrieving God and a distinctively religious meaning to chaplaincy. That is because, as Myerhoff scholar Marc Kaminisky writes, she “was conscious of her role as a secular intellectual.” He suggests she fits the definition of the same provided by Edward Said:


The secular intellectual works to show the absence of divine originality, and on the other side, the complex pressure of historical actuality. The conversion of the absence of religion in the presence of actuality is secular interpretation.987

My work intentionally pushes beyond this secular scope in a way that answers Nouwen’s invitation to integrate the best of what is found in the sciences with our theological resources.988 I suggest that Myerhoff can actually be used to reverse Said’s so-called “conversion of the absence of religion in [to] the presence of actuality.” My way forward proposes a clinical methodology—“a re-membering God” practice for the chaplain—that attends, assesses, and assists with religion’s potentially meaningful presence in the clinic. My work does this in at least four ways.

First of all, Myerhoff’s re-membering approach, applied theologically, offers an inclusive clinical model which does not impose a religious spirituality—one where the ultimate value or Person is God or a transcendent reality—where there is none. Rather it offers a socially constructed framework within which to conceptualise and articulate how for some patients God is or may be a constituent part of their identity in the midst of their illness experience. In this model, what is at issue is clarity about God’s function in identity formation and support. Placing an emphasis on the social and functional is consistent with the portraits of Boisen revealed in this dissertation, even when the limitations in Boisen’s approach are recognized. As David Steere writes, the important practical research question Boisen identified has to do with how the idea of God works in people’s lives:

Whether we accept his particular findings or not, Boisen opened a door to the empirical study of theology that we can ill afford to ignore in the future. If the idea of God does not function this way, how does it?989

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988 Nouwen, The Living Reminder, 76.

While clinical inquiry in health care, especially mental health care, will always need to attend to pathological uses of God, just as it does when there is pathology in other social relationships and manifestations, the practical value in this approach is in its creation of space for a clinical practice where God and theology might also be a helpful dimension or perspective for the patient. Applied this way, Myerhoff offers a way to re-member God in the clinic in terms of the social network of support that illness threatens to dis-member. God now becomes a potential member of the social network.

Secondly, the identification and enhancement of ever stronger interpersonal networks is a reason many health care disciplines include community building initiatives as part of their clinical mental health care. As shown in Chapter Three, this was a main concern in disciplines such as social work where there is now clinical encouragement and support regarding the friendship formation possibilities in the lives of patients. While Swinton’s chaplain as friend created clinical boundary issues, the outcome that patients could benefit from developing stronger social networks for themselves was never at issue. Furthermore, Myerhoff’s theoretical andanthropological work clearly supports enhanced community connections. Taken together, this model offers an important resolution to the critical boundary issue of Swinton’s chaplain as friend model raised in the last chapter. This model delimits the clinical methodological focus; it is not specifically about the chaplain’s friendship with the patient, per se, but the role of the chaplain in clinically attending to, assessing, and assisting with the patient’s relationship—even friendship when that is the case—with God.

Thirdly, this dissertation briefly introduced narrative therapy to show how White’s adoption of Myerhoff’s “re-membering” metaphor into “re-membering conversations” reintroduced Myerhoff’s idea into a contemporary psychotherapeutic practice. White’s structural conceptualisation for the kinds of questions which support “re-membering conversations” offers specific promise to the kinds of clinical interventions that chaplains might employ. This is because White’s work in narrative therapy offers clinically adaptable ways to explore and

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strengthen how God might appear as a “member” of concern for the patient in clinical conversation. More than ten years ago, marriage and family therapists Thomas D. Carlson and Martin J. Erikson addressed aspects of this when they wrote an article titled “Re-authoring Spiritual Narratives: God in Person’s Relational Identity Stories.” Their particular research, which documented a case study example, suggested that God can have a “constitutive effect”\textsuperscript{991} in the lives of some patients. Unfortunately, their work on this topic has not generated significant response in the literature. But given the current scholarship trend which seeks to integrate spirituality into the variety of psychotherapies\textsuperscript{992}—and especially this dissertation’s use of Taylor and its reclamation of Boisen’s innovation to argue that belief in God can be credible and meaningful even in the midst of mental illness—this narrative way of “re-membering God” offers new possibilities for integration. Importantly, in addition to offering a structure for a conversation about God that chaplains can use, it also offers a way of thinking about clinical intervention that is easily understandable to chaplaincy’s multi-disciplinary peers.

An approach built on a re-membering conversations approach might also offer a corrective to the clinical trend by chaplains towards immanence and existential counselling identified in the introduction of this dissertation. This was part of what Canadian clinical pastoral supervisor Peter VanKatwyk noted in his 2008 article, “God Talk in Therapeutic Conversation,” namely that “in clinical [pastoral] education the emphasis has been on self-talk and relationship-talk rather than God-talk.”\textsuperscript{993} This was also Zock’s concern about the split identity of the chaplain.\textsuperscript{994} This experience was featured into Nouwen’s concern that conversation in his clinical training about God became “vague, undefined, distant... whereas man was concrete, defined and


\textsuperscript{994} Zock.
close. This model explicitly calls on chaplains, for whom theology is traditionally an aspect of expertise and relevance in regards to reality, to be actively engaged in the kinds of clinical conversations that re-member God for the benefit of the patient who suffers. As Nouwen points out, the chaplain as minister is tasked “to continuously make connections between the human story and the divine story.” Re-membering conversations offers a social and dialogical structure for that kind of theological work that to happen.

Finally, this theological application of Myerhoff finds statistical support. According to Canadian sociologist and researcher Reginald Bibby, the prevalence of positive belief in God or a supreme power among the Canadian adult population averages 81%. Significantly, that statistical amount has not changed in 20 years ending in 2005. In terms of gross average, four out of five members of the general population entering health care clinics believe in God. A smaller but more focused study by Baetz and others included research about the prevalence of belief in God among a cohort of hospitalised and online mental health patients. It determined that 71% believed in God. Even if the number is only in the 70th percentile, the statistic points to a critical consideration: over the course of treatment for this sizable cohort, what role does the patient’s relationship and belief in God play in this cohort’s illness experience? Adapting Myerhoff offers a way of understanding God in social networks, a dimension that could otherwise be missed as having any bearing on clinical practice.

995 Nouwen, "Pastoral Supervision in Historical Perspective (Unpublished Manuscript)," 68.
996 Nouwen, The Living Reminder, 24.
997 From 1985 to 2000, the statistical range for belief in God is 84% to 81%. Reginald Wayne Bibby, Restless Gods: The Renaissance of Religion in Canada (Toronto: Stoddart, 2002), 140. In 2005, Bibby found that 82% [Yes, definitively (49%) and Yes, I think so (33%)] believe in God or a supreme power. Reginald Wayne Bibby, "Canada’s Dataless Debate About Religion: The Precarious Role of Research in Identifying Implicit and Explicit Religion," Implicit Religion, North America 12, no. 3 (2009): 264. These statistics are slightly higher in the US. Recent statistics (2011) indicate belief in God in the 80% percentile. When the question asked is “Do you believe in God or a universal spirit?” the rate increases to 92%. Frank Newport, "More Than 9 in 10 Americans Continue to Believe in God" http://www.gallup.com/poll/147887/Americans-Continue-Believe-God.aspx [accessed February 29, 2012].
999 Such a clinical approach can be conceived of as an attitude or what Pruys called “perspective.” Carl Elliot, in a presentation of Wittgenstein’s later philosophy, suggests that “taking a certain attitude towards events,
These four practical approaches outline the contribution that Myerhoff’s work of re-membering offers as a model for chaplaincy. Importantly, it identifies a scope of practice for the chaplain, permitting clarity for the clinical exploration, when appropriate, of the existence, content, and impact of a patient’s belief in—and relationship with—God in their illness and healing trajectory. This inclusive practice is reminiscent of Pruyser’s critical work, explored in Chapter One, about the diagnostic process, and the importance of pastoral assessment. From Pruyser, it is also important to remember that such a process is not simply about attending to explicit references to God in a person’s belief system. More than “God-Talk,” he argued that what is needed is “theological alertness.” In this, he is correct because, as Pruyser taught, after Boisen’s innovative work, religious data does not always appear in predictable ways. As also argued in Chapter One, Pruyser recognised this as a key breakthrough of Boisen’s. Before Boisen, “The old question was: Which are the significant data of religious experience? The new question is: which data of experience are of religious significance?” This shift means plumbing all experience for data of religious significance. Re-membering God, as a model for clinical chaplaincy, affirms that the practical assessment “of the religious dimension of a patient is an extremely difficult business,” and is often clinically missed. It must be expertly and carefully sought after and diagnosed.

The “re-membering” model also opens wide the kinds of therapeutic encounter possible for the cultivation of those practices which, over time, might assist the patient in their suffering. I am thinking here, for example, about the facilitation and research of those prayer/meditation practices which are increasingly showing themselves to be clinically indicated for improved

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1001 Pruyser, A Dynamic Psychology of Religion, 12.
wellbeing. This kind of inquiry opens up the potential for a practical integration of people’s religious approach to their illness and suffering. Myerhoff’s attention to those members who help constitute the social identity of the sick person, her social constructivist approach, also critically calls forth consideration of the communities of support which need strengthening. These are, as Swinton has made clear, sometimes people’s communities of faith. As such, clinical chaplains have the opportunity to play an important role in making clinical centres better integrated with community resources, and assist with discharge planning as well by identifying early on in clinical admissions the social networks that assist a patient’s relationship with God and others.

“Re-membering God”: Pastoral Implications for Catholic Sponsorship

As identified in the introduction of this dissertation, Boisen’s was a challenge to both the clinical psychiatric establishment of his day and to the pastoral care practice of the Churches. Remaining within the boundaries of this dissertation, it is the purpose of this last section to reflect on the pastoral contributions this proposed “re-membering God” model offers the Church, particularly the Roman Catholic Church’s mental health ministry. The intention here therefore is to operationalise this new knowledge to the particular context of Catholic sponsorship.

It has been shown, that “sponsorship of a health care ministry is a formal relationship between an organization recognized by the Catholic Church and an apostolic work, for the sake of sustaining and promoting the Church’s mission.” For the Roman Catholic Church, health care is ministry, which is to say that “it is first and foremost a work of the Church that is rooted

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in the healing mission of Jesus.” Furthermore, this dissertation has also noted that, in the province of this author, Roman Catholic board governance is responsible for half of Ontario’s mental health hospitals. Boisen could never have imagined that psychiatric facilities might actually be governed by Church sponsored boards. This makes the application of his work with the Roman Catholic sponsorship system a particularly interesting context. In this section, I would like to suggest that the proposed “re-membering God” model offers at least three significant and distinctive pastoral contributions to such a sponsorship structure.

First of all, the application of Myerhoff within a social sciences’ construct partially answers John Shea’s question: “How is the ultimate religious perspective embodied in concrete organizational structures and specific programs?” Clinically, with this model, Catholic sponsored institutions can demonstrate that, as part of best scientific and medical care, patients also have at their disposal the clinical resources to “re-member God” as a member of their social network, in the midst of their mental illness experience.

Furthermore, in terms of better practice initiatives, Catholic sponsored hospitals can distinguish themselves as being centres of excellence which seek to better understand how belief in God—in all its manifestations—is best managed in the midst of mental illness. In particular, through a sustained application of this model, Catholic sponsored hospitals could become the knowledge capitals for better research about this aspect of health, and about the current best practice options for integrating belief in God in the provision of mental health care. This kind of difference could make an important contribution in the kind of care that distinguishes Catholic facilities.

Such a “re-membering” research and clinical practice also offers a way to fulfil two of the ten criteria identified by the Catholic Health Association of Canada in its Health Ethics Guide as “tangible signs” for Catholic hospital identity: “a culture that supports Christian ethical

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values and spiritual beliefs” and the “promotion of spiritual/religious care.” Such a practice reflects Canon Lawyer Frank Morrissey’s insight that one of the markers of Catholic identity requires evidence on “how the spiritual care of persons is integrated into the overall care program.”

Secondly, implementing the “re-membering God” model is one way Catholic sponsored health care can demonstrate historical continuity with “an ultimate identity that relates it to the divine source.” The problematic was engaged in detail in Chapter Three, particularly in light of Parker Palmer’s ideas about “functional atheism” and McCormick’s prophetic question about American Catholic health care in the 90s under managed care: “Does not the claim of distinctiveness dissolve in the reality of practice?” The central contribution here is that the model offers Catholic sponsored mental health care a measurable and evidenced way to demonstrate how the scope and nature of the clinical practice in place in its facilities reflects its foundational identity.

Clearly, the issue of foundational Catholic identity is broader than just what chaplains in such hospitals are doing, but a chaplaincy focus does offer some important perspective and measurement opportunities. Chaplaincy as a discipline, as this dissertation shows, has post-Boisen tried to fit into the changing landscape of health care, sometimes to the point of losing its historical religiously transcendent focus. As argued by Elaine Graham, “pastoral theology may in part be an enquiry into what it means to be human, but its traditions also insist upon a Divine or

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1010 Morrissey, 9.


transcendent dimension to human affairs and Christian practice.”1014 What I identify here is that through this theological adaption of Myerhoff, it is possible to specifically re-imagine the integration of distinctly religiously spiritual chaplaincy that can attend to the appearance of God in the clinic. The argument I am proposing recognizes it as a critical part of a Catholic health care system.

Thirdly, in providing a concentrated focus on the distinctively theological role of the psychiatric chaplain and inclusion of a clinical practice friendly to God in Catholic sponsored mental hospitals this dissertation does not intend to imply that the larger continuum of spirituality should be unaddressed in psychiatric and other health care. Limiting focus on God and religious transcendence in this dissertation is a corrective rather than exclusionary strategy. In fact, there is every reason to suggest that Catholic healthcare should be a leader, perhaps even a “friend”—to re-interpret Swinton’s term in a new way1015—in the provision as well as research about spiritualities which are not specifically religiously spiritual.

In fact, this kind of consideration raises another practical issue for the design of spiritual care services in Catholic institutions. Zock’s observes that much of contemporary chaplaincy is indistinguishable from the other disciplines.1016 When this insight is applied to “re-membering God” it would seem to confirm the birth of a new kind of spiritual discipline, what Zock called

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1014 Elaine L. Graham, Transforming Practice: Pastoral Theology in an Age of Uncertainty (Eugene, OR: Wipf and Stock, 2002), 88.

1015 The new idea here is to potentially re-interpret “friendship” as a hermeneutic for the Catholic faith based hospitals’ clinical encounter with spiritualities different from those of the Catholic tradition. In a few recent and admittedly preliminary articles, Canadian systematic theologian John Dadosky explores two principal and complementary ecclesologies in the context of Vatican II. First, there is the very familiar and officially endorsed “communion” ecclesiology, and second, there is what Dadosky calls “friendship” ecclesiology. The central idea of the first ecclesiology is that it accounts well for relationships within the Church, ad intra; but Dadosky argues, only the friendship model can account for relationships with what is “Other” that is “Christian confessions, cultures, religions, and secular culture,” which are technically outside the official Church. John Dadosky, "Towards a Fundamental Theological Re-Interpretation of Vatican II," The Heythrop (2008): 746. These kinds of relationships, he suggests are best referred to as being ad extra, and may disclose God in new ways. Applying Dadosky to clinical care, the research question is to consider faith sponsored mental health care ministry as having both ad extra and ad intra aspects. See Dadosky, "The Official Church and the Church of Love in Balthasar's Reading of John: An Exploration in Post-Vatican II Ecclesiology," Studia Canonica 41, no. 2 (2007): 453-471; Dadosky, "The Church and the Other: Mediation and Friendship in Post-Vatican II Roman Catholic Ecclesiology," Pacifica 18, no. October (2005): 302-322; Dadosky, "Towards a Fundamental Theological Re-Interpretation of Vatican II," 742-763.

1016 Zock: 137.
the “existential counsellor.” If so, new practice and program design models are needed to reflect that the broad continuum of spirituality permits different and complementary care initiatives. Rather than have chaplaincy fit into a strictly existential discipline—an option I suggest ignores the integrity and origins of Catholic sponsorship and Boisen’s inspiration of clinical psychiatric chaplaincy in the first place—there exists an opportunity for clinical collaboration between a retrieved religiously spiritual meaning for chaplaincy and new forms of spiritual counselling.

Such a collaborative approach involves honestly engaging the full continuum of spirituality, including the religiously spiritual, but moves away from reductionist “professional stereotypes” about chaplaincy by other disciplines, or worse by chaplains themselves. Pruyser identified this latter kind of problem more than 40 years ago. He was concerned by the lack of integration by psychiatric chaplains of theological and religious perspectives. He asked, do their actions “proceed from a peculiar tacit assumption, namely that theological ideas become inoperative in the face of serious mental turmoil?” Pruyser’s point was never to replace excellence in psychiatric interventions with some kind of miraculous faith healing, but only that it is possible to assess the same “complex personal problems” from “several different perspectives at once.” Pruyser’s goal was to move toward a more integrated multi-

1017 Ibid., 138.
1018 For an example of an integrative model (in this case with palliative care) which attempts to parse out different spiritual care interventions and the professions which might assist, see C. Puchalski and others, “Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference,” J Palliat Med 12, no. 10 (2009).
1020 Pruyser, The Minister as Diagnostician, 51.
1021 Paul W. Pruyser, "The Minister as Diagnostician," The Perkins School of Theology Journal Winter 27, no. 2 (1973): 3. Such a view is also reflected in the Canadian Conference of Catholic Bishops' 1983 pastoral message on sickness and healing, “New Hope in Christ.” Commenting on what should characterise Catholic and indeed all health care, it states: “Such care should include consideration for the spiritual needs of people. Healing best takes place in an atmosphere of love and understanding which includes reconciliation with oneself and with others. Thus, to rely on faith without medicine would be irresponsible, but to rely on medicine without faith would also be inadequate.” Canadian Conference of Catholic Bishops, "New Hope in Christ: A Pastoral Message on Sickness and Healing," (Ottawa: 1983), 12, sec. 37.
disciplinary model where the theological perspective is recognised as having a valid place in the clinic.

It is likely that the even greater challenge today is in truly modeling an integrated system of the variety of all the spiritual supports contemporary patients are seeking. The burgeoning interest in spirituality’s relationship among the allied health care professions (like social work, occupational health etc) offers important opportunities for inter-professional collaboration and referral. Such considerations also raise creative, inter-professional and important educational opportunities for experts in religious spirituality to assist in the training of these allied disciplines, and vice versa, in the training of chaplains.

Finally, by way of identifying the larger conceptual possibilities of such a model for Catholic sponsored mental health care, I think it is important to recall briefly my position as articulated in Chapter Three: regarding Taylor’s understanding of contemporary spirituality and the role of the Church. There I argued that the Catholic sponsored health system [and other faith based hospital systems for that matter] may well be the only discourse partner in contemporary culture capable of engaging and offering witness that belief in God is a credible option in the contemporary world. The point here is not to reject the application of this idea as an option within secular hospitals, but rather—if Taylor is correct—that the mainstream narrative of secularization simply makes this option in secular hospitals harder to effect at this time.

Also from Chapter Three, I identified the importance of Taylor’s observation that the Church ought to be that kind of place “in which human beings, in all their difference and disparate itineraries ... [can come]... together”\textsuperscript{1022} including the careful and curious discernment by the Church of those “new and unprecedented itineraries.... opened by pioneers who have discovered a way through the particular labyrinthine landscape we live in, its thickets and trackless wastes, to God.”\textsuperscript{1023} The critical issue here is that in order to re-member God, the Church must, like Boisen, search in new and unfamiliar territories.

\textsuperscript{1022} Taylor, 772.
\textsuperscript{1023} Ibid., 755.
Chapter Summary

Starting with his own life, Boisen creatively called attention to a new context for pastoral care: the actual lives and experiences of people living with mental health problems. For this, he created psychiatric chaplaincy. This dissertation’s model of “re-membering God” simply points to the Church’s belief and practice that God is somewhere to be found in that context. It is at once research about pastoral care, and the provision of pastoral care by chaplains in the clinic. It proposes an attitude that welcomes diversity of expression about spirituality, inviting conversation and discernment about how God appears in the midst of mental illness. It does not expect or impose belief about God among its patients or even its staff. Rather, the model offers Roman Catholic sponsored boards an opportunity to search for relief for the kind of suffering that can characterise living with mental health problems, while also witnessing to their belief. After all, Boisen’s challenge was not only to the psychiatric establishment, but to his Church and he implored them to get involved in mental health.1024

In conclusion, this chapter proposes a new theological model for clinical psychiatric chaplaincy in the delimited context of Catholic sponsored mental health care. By following Nouwen’s strategic use of Boisen in the context of remembrance, it suggests that the mental health context is also an opportunity to “explore God’s work in our lives.”1025 In this sense, it has suggested a return to the priority relationship Nouwen underscored in the Great Commandment when he strategically cited Boisen. The argument here is that this priority relationship is not just for the chaplain, but can inspire Catholic mental health care practice and its governance. In this approach, health care outreach is as Nouwen says, “an expression of our love for God who reveals himself to us as the God of all people.”1026 Rather than being limited by a specific religious spirituality, this chapter argues in fact that the religious particularity of Catholic health care is at the source of its most important contributions to alleviating suffering in the provision and management of medicine, especially mental health care.

1025 Nouwen, The Living Reminder, 25.
1026 Ibid., 31.
CONCLUSION

More than ten years ago British mental health Chaplain John Foskett openly appealed for a return to the origins of clinical psychiatric chaplaincy as envisioned by Boisen, a detail included in the introduction of this dissertation. Foskett, having witnessed a real but unaddressed spiritual searching among those living with mental illness with whom he worked, chose to remind pastoral counsellors that they had forgotten their roots in Boisen and mental health care. Indeed, Foskett’s caution remains relevant.

For the most part those with severe mental health problems have been ignored and made redundant in either developing their own spirituality or being allowed to make their contribution to the moral and spiritual maturity of their communities. A rediscovered pastoral and spiritual counselling movement would make a real difference in recovering what is being lost and ignored.1027

The original motivation for this dissertation also began ethnographically, rooted in my own encounters as a psychiatric chaplain with people who were living with mental health problems. In the introduction, I recalled the forensic patient who said: “In my experience, talking about this, about God, only leads to one thing: more medication.” Despite the clear evidence of pathological tendencies, some of his ideas about God’s place in his life were genuinely comforting to his suffering, and some even showed evidence of spiritual development. Much of what he had to say, however, ended up being ignored or pathologised by a clinical psychiatric system that at the time was unable to discern and attend to the difference. The critical work of this dissertation suggests, to the contrary, that it is possible, important, and indeed vital that mental health care find a way to value

insights into suffering and salvation elicited by accounts of vulnerability and illness whilst being able to distinguish those forms of mental illness that express themselves in religious delusion and distorted spirituality. ¹⁰²⁸

This dissertation suggests that the achievement of such clinical intentionality is at even greater risk when chaplaincy fails to bring theological questions to clinical practice. Dutch pastoral theologian Hetty Zock’s observation that chaplains have become existential counsellors who focus “on the search for meaning and life orientation of all the clients/patients/residents irrespective of their religion or philosophy of life”¹⁰²⁹ is pertinent here. For a variety of complex reasons—including the credibility that “a sane person could believe in God”¹⁰³⁰—chaplaincy’s migration to a more “secularized spiritual care service”¹⁰³¹ has come at the price of its particular, historical, and unique theological contribution to clinical care. This was not Boisen’s intention when he first became a clinical psychiatric chaplain.

As chaplain in an institution for the insane, the writer is dealing constantly with the mentally ill. He is seeking to interpret the experiences of his patients not merely from the standpoint of current psychiatry but also from the standpoint of the student of religion. ¹⁰³²

This dissertation applied literary research to retrieve a distinctive religiously spiritual meaning to Boisen’s innovation of the clinical psychiatric chaplain in relation to current theory and practice. In the specific context of Catholic sponsored mental health care, this dissertation proposed a model of “re-membering God” that offers, thanks to a clinical theological application


of Myerhoff’s anthropological work, a conceptual framework to practice a theologically rooted clinical chaplaincy within the multi-disciplinary team.

It was possible to reach this conclusion after presenting the ways in which Boisen’s innovation was first explored and later adapted by Pruyser and Nouwen. This was further developed through critical conversations with Swinton and Taylor. In the first place, Pruyser is responsible for the rediscovery and reclamation of the innovative and biographical genius in Boisen’s creation of the psychiatric clinical chaplain. Nouwen’s insights on Boisen—hitherto mostly archived and under-studied—offered a means to recast Boisen’s seminal contributions concerning alienation, mental illness, and the search for the “living human God.” Swinton’s contemporary work on friendship, while not without clinical challenges, echoed Boisen’s original intentions. This is especially true in the way that they both are clearly committed to supporting an ecclesiological dimension for mental health care. Finally, reading Boisen through Taylor’s recent philosophical work clarified how Boisen can be seen as an important pioneer in the contemporary search for God among those living with mental health problems. Indeed, it was for this reason that this dissertation argued that Roman Catholic sponsored mental health care offers one way that the Church can be a pastorally welcoming, or to use Swinton’s term, a “friendly” place for such patients.

Two overt limits to the research of this dissertation remain, however, and each one points to a direction for future scholarship and research. First, while this thesis proposes a model that re-members God “back” into the psychiatric clinic, it has not been my intention to argue specifically that “aspects of religious and spiritual involvement are associated with desirable mental health outcomes.” This limitation follows my agreement with Pruyser and Nouwen that Boisen’s genius was not in the way he equated better mental health outcomes with certain religious experiences. My research in the area of religion, spirituality and mental health is, I

1033 Henri J. M. Nouwen, “Pastoral Supervision in Historical Perspective (Unpublished Manuscript),” The Henri J.M. Nouwen Archives and Research Collection in the Special Collections and Archives (Toronto: John M. Kelly Library at University of St. Michael’s College, University of Toronto, 1965), 68.

1034 John Swinton, Spirituality and Mental Health Care: Rediscovering a ‘Forgotten’ Dimension (London: Jessica Kingsley Publishers, 2001), 68.
believe, consistent with theology professor Joel James Shuman’s and psychiatrist Keith Meador’s argument that “those who commend religion for its health benefits face some serious conceptual difficulties.” Accordingly, this thesis narrowed its exploration and adaption of Boisen to address a more fundamental purpose: the mapping out of a way that the religiously spiritual dimension—which this thesis has defined as part of the larger spirituality continuum—might be acknowledged and engaged in clinical psychiatric care via the chaplain, particularly in the context of Catholic sponsored care.

Further research and practical innovation are required, given the recent evidence that religious and spiritual conversations are not happening as frequently as patients might like. Indeed, there is great debate, sometimes even reluctance, among the health professions concerning who should be leading them and how they ought to be engaged. While the literature generally favours a more robust discussion about an integrated clinical practice open to spirituality and religion, there is a particular need for additional scholarship by chaplains and leaders of Catholic health care for whom the religious/spiritual dimension ought to be an area of expertise. Without this new scholarship chaplaincy will remain an “absent profession” and

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Catholic health care risks ignoring one of its primary resources: the “theological candor”\textsuperscript{1040} that motivates it to consider health care as ministry in the first place.

The second limitation is the cluster of boundary issues that this thesis identified in the clinic, following Swinton’s model of chaplain as friend. Nevertheless, it affirmed that his concern for friendship—including his concept of the congregation as friend—echoes Boisen’s challenge that Church ministry must focus on the theological and pastoral issues related to isolation in mental illness. Mental illness is a predictor of marginalisation from society at large. As argued by the 2006 Final Report on Mental Health, Mental Illness and Addiction by the Standing Senate Committee on Social Affairs, Science, and Technology, \textit{Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada}, research indicates that for people living with mental illness “the prognosis [is] bleak: permanent disability, isolation and poverty.”\textsuperscript{1041}

Negative reactions such as “abandonment and shunning” create a sense of marginalisation that is experienced by an astonishing 60\% of people living with mental problems who actually seek counselling from within religious congregations.\textsuperscript{1042} Families of persons living with mental illness also experience problems, including being “nearly invisible within the congregation.”\textsuperscript{1043} A Church congregation’s awareness of its members’ concerns is complex. Without focusing specifically on mental health issues, Bibby’s research suggests that a major challenge for North American congregations is being “aware” of congregants’ needs. Among Catholics who have even a marginal relationship with the Church, 63\% “report that their Church was unaware of what they were going through.” The “unawareness figure” among Protestant

\textsuperscript{1040} Allen Verhey, \textit{Reading the Bible in the Strange World of Medicine} (Grand Rapids, Mich.: Eerdmans, 2003), 27.


\textsuperscript{1042} Matthew S. Stanford, "Demon or Disorder: A Survey of Attitudes toward Mental Illness in the Christian Church," \textit{Mental Health, Religion & Culture} 10, no. 5 (2007): 448.

\textsuperscript{1043} Edward B. Rogers, Matthew Stanford, and Diana R. Garland, "The Effects of Mental Illness on Families within Faith Communities," \textit{Mental Health, Religion & Culture} 15, no. 3 (2011): 308.
Churches may be considerably lower, at 26%, but mental illness still presents considerable challenges to these congregations as well.

Swinton’s congregational focus therefore offers an important subject for future research and even innovation in health promotion. It suggests that Catholic sponsored mental health centres would be wise, as would secular sponsored hospitals for that matter, to develop community health strategies in order to partner creatively with local multi-faith religious congregations. Such an outreach would not only enhance the hospitals’ cultural and religious competency but also enhance local faith communities’ abilities to support their members and their families who live with mental health problems. Such an outreach could also contribute to better clarifying how health and its promotion can be conceptualised as having something essential to do with “membership,” including group memberships like congregations.

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1047 Wendell Berry, Another Turn of the Crank: Essays (Washington, DC: Counterpoint, 1995), 86-109. Especially noteworthy in Berry’s work is his concern about how the medicalization of health care “isolates and parcels us out.” Ibid., 88.

1048 One particular consideration here needs to be how “re-membering” can be an action of the “caring community” of the Church to unite people who are marginalized. This application of “re-membering” has been advocated by pastoral theologian John Patton, particularly in chapter two of Pastoral Care in Context. John Patton, Pastoral Care in Context: An Introduction to Pastoral Care, 1st ed. (Louisville, Ky.: Westminster/John Knox Press, 1993). He also writes “re-membering” with hyphen, referencing two sources. Parker Palmer used it for re-building broken down communities, an idea Patton develops in the way a community can be the context for remembering to care for others. Patton locates this source in the address that Palmer gave to the American Association for Clinical Pastoral Education conference in 1987. His second source is the work of feminist family therapist Deborah Luepnitz. She hyphenates the word to reference the importance of gender issues and to guide people “in the important activity of not forgetting that we are all capable of both action and reflection, and that we separate the two at our social and personal peril.”Deborah Anna Luepnitz, The Family Interpreted: Feminist Theory in Clinical Practice (New York: Basic Books, 1988), 275. Cited by Patton, 51. Patton uses Luepnitz to underscore a person’s agency in the concrete reality of “family, Church, or a larger social structure,” including the choosing of new “roles, functions, and opportunities.”Ibid., 52. Where my employment of “re-membering” is different than Patton’s is that I adapt Myerhoff to draw attention to the act of clinically recognizing God as a potentially meaningful member of...
As Nouwen put it when writing about his training experience as a clinical psychiatric chaplain, “perhaps the most important thing will be to make our implicit theological attitudes more explicit and reflect more the theological implications of what we are doing.”\textsuperscript{1049} This is especially important because, as this dissertation has explored, it is true that “God sometimes comes up when we get sick”\textsuperscript{1050} and not always in pathological ways among those who live in the “little-known country”\textsuperscript{1051} that Boisen called mental illness. And so, in a way faithful to Foskett’s call to return to Boisen, it can be said with Myerhoff: “Look what happened because of the remembering.”\textsuperscript{1052} Boisen’s pastoral and research insight concerning the idea and place of God in the clinic does not have to come to an end, especially in a psychiatric chaplaincy practice in a Roman Catholic sponsored health care system. When Parker J. Palmer spoke at the Association for Clinical Pastoral Education conference in 1987, he addressed memory with a linguistic assertion that speaks to the heart of this dissertation, when he said:

The opposite of remember is not to forget, but to dismember. And when we forget where we came from ... we have in fact dismembered something.\textsuperscript{1053}
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Appendix

Photocopy of Nouwen’s Record of his Meeting with Boisen in August 1964

The following three pages are reprinted with permission of The Henri J.M. Nouwen Legacy Trust.
In August, 1964, I visited Anton Boisen in Elgin State Hospital, close to Chicago, Illinois.

It was a very intense experience. My great admiration for Boisen, based on his writings and the stories of many who had known him, caused me to expect some sort of impressive, solemn surroundings in which I would find him. Completely the opposite occurred. After a long walk through the somber corridor of the mental hospital someone brought me to a little room behind the dining hall, where I found him in a wheelchair.

A poor, not very clean little room. A bed, a table and two bookcases filled with books and old-looking papers. Besides the wheelchair there is hardly room for another chair. Total lack of privacy. There is no door in the room--only a screen door, and the noise of dishwashing in the kitchen and cleaning in the dining room mixed with sounds of modern music intrudes in every conversation.

Anton Boisen himself, however, was different. He was very friendly and he kept expressing his thankfulness to the hospital, where he could stay after he had stopped his work as a chaplain. His language was slow and often difficult to understand. He expressed his own irritation that he was not able to put his thoughts in better words and said things like "I am stupid.... I cannot say what I want to say. This is the best way I can explain it".

Most remarkable were Boisen's direct and open questions to me: What do you think about the Messianic claim of Jesus? Who is God? What influence do you think that the nuclear power has on the idea of God? Will this world survive? By these many intrusive questions he kept me close to him and didn't allow me to leave, although Chaplain Sullivan had told me that I should not stay too long.

Who is God? What is your answer? Boisen challenged me to a straight and open answer. When I asked him the same question he replied: "God is the internalisation...."
of the highest values of our social relationship, and Jesus Christ is the man in which the apostles found these highest values represented". He spoke about his own theology as a liberal theology. It was clear that these questions were very real and personal for Boisen. He showed an obvious preoccupation with the end of the world and his own personal death. Sullivan told me that the idea of suicide was often in his mind and that he felt that suicide might have been his highest religious act. It seemed that he used his visitors to find an opportunity to test his feelings and ideas and to establish a communication in which he could find some answer.

The fact that I was a priest intrigued him, especially in relation to celibacy. Also, here were very strong personal overtones which suggested many unresolved sexual problems. He alluded to this also when he told that it had been very difficult for him to decide how many details he should describe in his autobiography, "Out of The Depth". Sullivan told me that Boisen's sister prevented many parts of "Out of The Depth" from being published. So much was cut out by her that the editor nearly refused publication. Boisen's sister was very afraid for the good name of her family and did not seem to get along too well with her brother Anton.

During this conversation I tried to find also some answers for the many questions I had in mind when I entered Boisen's room. Although Boisen himself took over the initiative in the discussions he nevertheless answered many questions. The first question was how far John Dewey had influenced A. Boisen. The answer was clear. Boisen did not study Dewey directly. Dewey's influence on Boisen happened indirectly, especially by G. Coe, W. James and Starbuck.

Much influence on his thinking and especially on his health was attributed by Boisen to S. Freud. He considered Freud as the most important help in his recovery process. Eastman brought Boisen into contact with the writings of Freud. Boisen wrote a 25 page letter to Eastman after which Eastman sent him "The
Introductory Lectures" of Freud. This was immediately following Boisen's psychotic crisis. Since then Boisen tried to read as much as possible of the works of Freud. Boisen remarked: "If I had been born earlier, things would have turned out completely different". Boisen thought himself lucky that he got to know Freud at the right time.

When I asked about Cabot's influence on Boisen, Boisen immediately referred to Cabot's book, "Differential Diagnosis" in which Cabot discusses his case-method. It became clear that the case-method, which was Boisen's favorite training tool, came from Cabot and I was impressed by the fact that Boisen mentioned this book and not his more ethical studies. Sullivan told me that Boisen did not have any written manual for his case-studies but that he used an outline, which was mostly used by his students.

At the end of my visit Boisen gave me a copy of his book, "Hymns of Hope and Courage". With much effort and fumbling Boisen signed the book for me.

When I left I was very thankful that I had had the opportunity to meet this man whose suffering had become a source of creativity. The condition in which I found him showed clearly that his basic suffering never completely left him. Two years ago he had a new psychosis and he had lived since then on the borderline of reality. Especially when he became tired, the psychotic contents came more to the surface: his fear of a nuclear war, his many death-thoughts and his never completely solved love affair with Alice. He still idealized her who only wanted to be left alone and he still suffers from his puritanistic fears. But seeing a man so closely and being able to experience how a deep wound can become a source of beauty in which even the weaknesses seem to give light is a reason for thankfulness.