Jesus the village psychiatrist: A summary

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ABSTRACT

This paper was a response to a panel discussion on the author's book, *Jesus the village psychiatrist*, published by Westminster John Knox Press, Louisville, KY, 2008 which formed part of the Society of Biblical Literature's Psychology and Biblical Studies Section, 21–24 November 2009, New Orleans, LA. The response consisted of an explanation of somatoform disorders, a summary of the book and the following case studies: the case of Fraulein Elisabeth, the case of paralytics, the case of blind persons, the demon-possessed boy, the case of the woman with a haemorrhage, the healings of lepers and the woman who cared for Jesus. The paper concluded with a discussion on words and their power to cure. It illustrated how symptomatology had changed from paralysis in the 19th century to chronic fatigue in the first half of the 20th century to stress today.

INTRODUCTION

A common feature of the somatoform disorders is the presence of physical symptoms that suggest a general medical condition but which cannot entirely be explained by a general medical condition, by the direct effects of a substance, or by another mental disorder (such as panic disorder). The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to factitious disorders and malingering, the physical symptoms are not intentional (i.e. not under voluntary control). Please consult appendix 1 for more information on somatoform disorders.

In *Jesus: A psychological biography* (Capps 2000; cf. Capps 2002) I devoted a chapter to Jesus' role as a healer and discussed several of the healing stories as being illustrative of the effects of anxiety. I focused specifically on paralytics (Mk 2:1–12; Jn 5:1-9), the blind (Mk 8:22–26; Mk 10:46–52), the possessed boy (Mk 9:14–29), Jairus' daughter (Mk 5:21–24) and the haemorrhaging woman (Mk 5:24–34). In *Jesus the village psychiatrist* (Capps 2008) I focus on the same healing stories, but employ *The diagnostic and statistical manual of mental disorders* (DSM-IV) (American Psychiatric Association 1994) to make the case that all of these healings involved somatoform disorders (primarily somatization disorder and conversion disorder). I provide evidence that blindness, paralysis, seizures and death-like symptoms were common in the 19th century and that the psychiatric community at the time generally referred to these patients as suffering from 'conversion hysteria'. I suggest that if the psychiatrists, who were severely criticised by Albert Schweitzer ([1913] 1948) in *The psychiatric study of Jesus*, had not focused on Jesus' own alleged pathologies (they used terms like 'psychic degenerate', 'paranoid psychotic' and 'religious paranoid') but had instead viewed him as one of their own and focused on the persons he healed, they would have recognised the similarities between these persons' pathological symptoms and the ones they themselves were treating. Contrary to popular belief these psychiatrists criticised by Albert Schweitzer were not Freudian but pre-Freudian.

CASE STUDIES

The case of Fraulein Elisabeth

In the 1890s Freud began to feel that he could help patients with physiological symptoms (such as the paralysis of an arm or leg) by encouraging them to talk about when the symptoms began, what was going on in their lives at the time and so forth. In the case of Fraulein Elisabeth in *Studies in hysteria* (Breuer & Freud 1957:135–181), a woman had suddenly developed leg pains that prevented her from walking. After she was examined, in order to find out if there was a physiological cause and nothing was found, Freud began to ask her when the paralysis began, finding that it occurred shortly after the death of her sister. As he continued to talk with her he discovered that she had been going on long walks with her sister's husband while her sister lay ill in bed. A deep affection between herself and her sister's husband began to develop and the thought began to develop in her mind (perhaps unconsciously) that if her sister died he would be free to remarry. As it was customary at the time for a widowed man to marry his wife's sister, this thought was not mere fantasy. As she stood by her sister's bedside, mixed feelings would well up inside her. Elisabeth grieved for her sister but she could not suppress thoughts for herself and her future. Her leg paralysis began after her sister died and Freud surmised that this was due to the fact that her friendship with her sister's husband began during their long walks together. When this interpretation was presented to her she resisted it at first because she felt guilty, but as time went on she accepted the interpretation and the paralysis consequently began to disappear. At that point Freud told her that she should not continue to think about marrying her sister's husband but rather find another man, for, if she were to marry her sister's husband, she would continue to feel guilty. At the conclusion of his case study, Freud relates that he had been invited to a dance and watched Elisabeth swirling about the floor with another man to whom, he was later told, she was engaged.

Freud believed that these somatoform disorders resulted from repressed sexual desires (as in the case of Elisabeth) or the infliction against oneself of the desire to act aggressively against another person or persons. He believed that if the root causes of these desires are uncovered and acknowledged, the physiological symptoms would disappear, especially if the person found another, more constructive way to express or redirect these desires.

He also believed that words have the power to cure. These may be the words that the patient speaks, such as when Elisabeth acknowledged that she had affectionate feelings for her sister's husband and that she *did* think the guilty thought that if her sister died, she could have her sister's husband. These may also be the words that the therapist speaks, as for example when Freud said to her that she must relinquish her thoughts of being her sister's husband's wife and find someone else. In Freud's *Introductory lectures on psycho-analysis* he writes:

> *Nothing takes place in a psycho-analytic treatment but an interchange of words between the patient and the analyst. The patient talks, tells of his past experiences and present impressions, complains, confesses to his wishes and his emotional impulses. The doctor listens, tries to direct the patient's processes of thought, exhorts, forces his attention in certain directions, gives him explanations and observes the reactions of understanding or rejection which he in this way provokes in the patient. The uninstructed relatives of our patients, who are only impressed by visible and tangible things – preferably by actions of the sort that are to be witnessed at the cinema – never fail to express their doubts whether 'anything can be done about the illness by mere talking.' That, of course, is both a short-sighted and an inconsistent line of thought. These are the same people who are so certain that patients are 'simply imagining' their symptoms. Words were originally magic and to this day words have retained much of their ancient magical power. By words one can make another blissfully happy or drive him to despair ... Words provoke affects and are in general the means of mutual influence among men.*
>
> (Freud 1966:19–20)

I suggest that even as Jesus cured somatoform disorders, especially somatization disorder and conversion disorder, he healed primarily through words (but also touch). An especially important feature of conversion disorder is implied by the very term 'conversion', which is

> *derived from the hypothesis that the individual's somatic symptom represents a symbolic resolution of an unconscious psychological conflict, reducing anxiety and serving to keep the conflict out of awareness (primary gain).*
>
> (American Psychiatric Association 1994:453)

Thus, the fact that Fraulein Elisabeth suffered paralysis in her legs and not her arms was symbolically meaningful. This was also true in the case of those whom Jesus cured and his success in curing them was due, significantly, to the fact that he understood this to be the case.

The case of paralytics

Why would persons who are relatively young become paralysed, especially in their legs? I suggest that if they were being forced to work in menial positions in which they were systematically demeaned, they would be reluctant to walk to work. Paralysis would mean that they could not work. When Jesus learned that a man who was paralysed had been lying beside the pool for 38 years and that his method for getting well was completely ineffective, Jesus asked the man whether he really wanted to be able to walk. This was a reasonable question to ask. When the man said that he did, Jesus commanded him to pick up his mat and walk. Immediately, his symptoms disappeared and he could walk. This suggests to me that he had suffered from conversion disorder which

> *involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.*
>
> (American Psychiatric Association 1994:445)

I believe that Jesus' instruction that if someone asks you to walk one mile, walk two, has relevance to the psychological factors that underlie paralysis. Paralysis might develop because one resented the fact that one was under the control of another, especially when this other person treated oneself in an abusive manner. By walking two miles, one deprives the other of the feeling that he or she is in control. By and large, paralysis would fit the idea that physical symptoms are the redirection of aggressive desires from the object of one's aggression onto oneself instead.

The case of the blind

As with paralysis, it is unusual that a relatively young person suddenly becomes visually impaired. If older people become blind due to macular degeneration, this should not be true of younger persons. I suggest that a person may become blind because he experiences guilt for wanting to see what he is not supposed to see. If families lived in very small quarters, fathers and brothers would need to learn *not* to look at their daughters and sisters while they were undressing. Similarly, in village life, a man would need to learn *not* to look lustfully at another man's wife. These sexual desires could, then, lead to blindness. If one cannot see, one cannot be tempted. When Jesus encountered a blind man who wanted to be able to see, he healed him but then instructed him *not* to return to the village where he had been living but to return to his home village. Why? I think this was because Jesus knew that the man was subject to temptation in that village, perhaps because he had 'eyes' for another man's wife.

Ralph Waldo Emerson, the 19th-century essayist, was sexually attracted to another student, Martin Gay, when he was in his early twenties. Emerson would write in his journal about how Gay looked at him with apparent longing. During this time, Emerson temporarily lost his eyesight. Many Bostonians were suffering from tuberculosis at the time and this could affect the eyes. Emerson's physician performed eye surgery on him, but this did not change the situation. What did help him was leaving Boston to work in the fields of Indiana for several months. I believe that the change of scene enabled Emerson to gain some needed psychological distance from the sexual tensions he was feeling at that time in his life. If his physician had inquired, as Freud would have done, into his personal struggles at the time, he would probably have concluded that Emerson was suffering from conversion hysteria (now called conversion disorder).

The demon-possessed boy

I believe that the symptoms of the demon-possessed boy (which included kicking with his feet and foaming at the mouth during a seizure) reflect self-directed aggression. Since it was his father who brought the boy to Jesus, it is very likely that the object of his aggression was his father. Why? Because sons were usually under their mother's care and instruction until they reached the age of twelve, at which point their fathers would take over. Typically, their fathers treated them harshly and this would have been especially true in Galilee because the Galileans had a long tradition of training their sons to fight in defence of the homeland.

Unlike a younger boy, a teenage boy would be strong enough to cause his father physical harm if he lashed out at him. In addition, he was old enough to curse his father. I am of the opinion, therefore, that the boy's symptoms (kicking and foaming at the mouth) are self-directed violence. Since Jesus was a man who was able to command the boy's respect, my guess is that the boy was able to respond to Jesus in a way that he could not respond to Jesus' disciples.

The case of the haemorrhaging woman

I believe that the haemorrhaging woman suffered from somatization disorder. One of the diagnostic criteria for this disorder is the presence of a sexual symptom, one of which may be excessive menstrual bleeding. The doctors (those who would have applied known medical techniques) had not been

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able to help her. This very fact suggests to me that her problem was a psychosomatic one. I believe that Jesus' declaration, '[D]aughter, your faith has made you whole', was powerful because it affirmed her and also conveyed, as it were, a paternal blessing, an expression of what Andries van Aarde (1997) has termed 'father-like performance'.

In 'The Galilean sayings and the sense of "I"' Erik H. Erikson (1981) says that this is 'the decisive therapeutic event in the Gospels' and suggests that Jesus' feeling that 'the power had gone forth from him' (Mk 5:30) when the woman touched him is suggestive of the transference of energies to which Freud drew attention in his views on the curative process. I draw on Freud's 1912 essay on 'The dynamics of the transference' (Freud 1963) to explain what makes the story of the woman with the haemorrhage such a powerful illustration of the importance of the role of transference in the curative process. I emphasise in this regard that such transference reflected an aptitude for trust in the woman and that Jesus did not betray her trust by exploiting her transferential feelings of love for purposes that were inimical to the goal of curing her of the haemorrhage.

The case of Jairus' daughter

The story of Jairus' daughter is interwoven with that of the haemorrhaging woman and it seems significant that she is 12 years old while the woman had been haemorrhaging for twelve years. The fact that the daughter was at marrying age is also important. In Jesus' day she may well have been thought to be suffering from hysteria, which was considered to be due to the fact that, without a fetus, her womb could wander upwards and affect her respiratory system (therefore, the basic issue here was sexual). Significantly, Jesus declares that she is not dead but sleeping. I take this statement seriously. In the 19th century women who were considered hysterical (today they would be considered to be suffering from somatization disorder) would take to their beds for long periods of time and develop death-like symptoms. This happened to Alice James, the sister of William and Henry James, on many occasions. When she in fact died, William cautioned Henry in a cablegram to make sure that this was not another hysterical attack. Jesus cured Jairus' daughter by reaching out his hand, calling her 'little girl' and inviting her to get up. As in the case of the haemorrhaging woman, his words to them were inherently empowering. It was as if he had assured her that she could face the challenges of becoming a woman.

The healing of lepers

There are two stories in the Bible that relate Jesus' healings of lepers (Mk 1:40–45 and parallels; Lk 17:11–19). In the Hebrew Bible leprosy is sometimes attributed to divine judgement for sinful behaviour and sometimes not. This, to me, suggests that some cases of leprosy were sexually transmitted infections (STIs) such as herpes, syphilis and gonorrhoea, which, like the modern equivalents to leprosy cited by biblical scholars (psoriasis, seborrhoea dermatitis and fungal skin infections), involve blisters, rashes and skin ulcers (I was led to the insight that leprosy might be a STI while reading a tabloid article about Hillary Clinton's fears that her husband's alleged STI might be transmitted to her).

That leprosy might have sexual connotations is supported by the fact that laws concerning leprosy in Leviticus 13–14 are preceded and followed by laws concerning menstruation after childbirth (Lv 12), as well as semen emissions and the menstrual period (Lv 15). Therefore, stories about the healing of lepers might be the male counterpart to the healing of the haemorrhaging woman. In any event, lepers with STIs would be the most dangerous of all lepers as they could infect other humans to a more damaging degree than those with fungal infections and they would almost certainly be viewed as sinners and not innocent victims of a disease. They would be ostracised (forced to live in the desert) because no respectable father would want them around his daughter and no husband would tolerate a leper near his wife.

The woman who cared for Jesus

The epilogue focuses on another 'decisive therapeutic event' in the Gospels, one in which Jesus was the object of special care. This is the story of the woman who poured a costly jar of ointment on Jesus' head. I suggest that this story is directly connected to the discussion in the previous chapter of the 19th-century view of the hysterical woman and, more specifically, to the suggestion that the diagnosis of histrionic personality disorder might, in certain cases, be its contemporary analogue. This is a story of excess, an extravagant display, having all the earmarks of a histrionic bid to be the centre of attention for one brief moment. The woman's action evoked a predictable response from everyone gathered there – 'What a waste!' and 'How inappropriate!' – everyone, that is, except Jesus himself. He came to her defence: '[S]he has done a beautiful thing to me' (Mk 14:6 RSV) and '[W]hat she has done will be told in remembrance of her'. Accustomed to being the caregiver, the one who went about from village to village curing others, Jesus, on this occasion, was the grateful receiver of a beautiful act of caring, so beautiful that he thought of it as the anointing of his body for burial. I see this story as another example of transference in which Jesus' response was profoundly appropriate.

CONCLUSION

Words have the power to cure

In looking back at Freud's (1966) statement that

> *words were originally magic and to this day words have retained much of their ancient magical power. By words one can make another blissfully happy or drive him to despair.*
>
> (Freud 1966:19–20)

I would like to state that Jesus was not a magician. Unlike the magicians of his day, who employed incantations, Jesus used real words. He understood that words indeed have power.

Some might think that taking the view that the persons whom Jesus healed were suffering from somatization disorders minimises his power to cure. They may feel that this is especially true in the case of the raising of Jairus' daughter. However, one could argue that the very opposite is instead the case. After all, mental and emotional disorders do not lend themselves to easy cures. These disorders can be controlled or their effects can be minimised, but typically only through a variety of resources, including medication, counselling, cognitive restructuring, the help of support groups, self-monitoring and so forth. If mental illnesses are so resistant to modern curative efforts, the fact that Jesus *could* cure these disorders, to me, is more impressive than if these individuals were, for example, suffering from muscular deterioration (paralytics) or macular degeneration (the blind). Furthermore, the fact that Jesus healed those who were demon-possessed implies that, in their case, the cause of the illness was *not* physiological.

I realise that the interpretations offered here raise all sorts of questions relating to the effectiveness of faith healers; questions that I am not competent to answer. I do believe, however, that the DSM-IV makes an important distinction between somatization disorders, on the one hand, and factitious disorders and malingering on the other. In somatization disorders, the physiological symptoms are real, not feigned and the individual has no voluntary control over these symptoms.

Changing symptomatology

In *From paralysis to fatigue: A history of psychosomatic illness in the modern world*, Edward Shorter (1992) shows that the most typical symptom of somatization disorder in the 19th century (paralysis) began to give way in the first half of the 20th century to 'chronic fatigue'. Patients would complain of being excessively tired (and typically attribute it to a viral infection). In our day, stress is the

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more common term. The DSM-IV recognises that it is sometimes difficult to differentiate between somatization disorder (which manifests in several physical symptoms) and depressive disorder (which may have similar physiological complaints).

In any event, Shorter's conclusion that 'the development of psychosomatic symptoms can be a response to too much intimacy or too little' (Shorter 1992:323) is well worth our attention. So, too, is William James's ([1892] 1992) essay 'The gospel of relaxation' in which he contends that Americans 'are weakened by all this over-tension' (James 1992:824) and cites a comment by a Scottish psychiatrist that Americans have a tendency to 'live like an army with all its reserves in action' (James 1992:829). I believe that Jesus, who said that his yoke is easy and his burden is light, would endorse 'The gospel of relaxation' (see also Capps 2009).

Please consult appendix 2 for more information.

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APPENDIX 1

The somatoform disorders

A common feature of the Somatoform Disorders is the presence of physical symptoms that suggest a general medical condition (hence, the term 'somatoform') but which cannot entirely be explained by a general medical condition, by the direct effects of a substance, or by another mental disorder (e.g. panic disorder). The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to factitious disorders and malingering, the physical symptoms are not intentional (i.e. under voluntary control). Somatoform disorders differ from 'psychological factors affecting medical conditions' in that there is no diagnosable general medical condition to fully account for the physical symptoms (American Psychiatric Association 1994). The somatoform disorders include:

- Somatization disorder (historically referred to as hysteria or Briquet's syndrome) is a poly-symptomatic disorder that begins before the age of thirty, extends over a period of years and is characterised by a combination of pain, gastrointestinal, sexual and pseudo-neurological symptoms.
- Undifferentiated somatoform disorder is characterised by unexplained physical complaints, lasting at least six months, which are below the threshold for a diagnosis of somatization disorder.
- Conversion disorder involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.
- Pain disorder is characterised by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to play an important role in its onset, severity, exacerbation, or maintenance.
- Hypochondriasis is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions.
- Body dysmorphic disorder is the preoccupation with an imagined or exaggerated defect in physical appearance.
- Somatoform disorder, not otherwise specified, is included for coding disorders with somatoform symptoms that do not meet the criteria for any of the specific somatoform disorders.

APPENDIX 2

Epilogue

After *Jesus the village psychiatrist* was published, two books relating to the topic have been brought to my attention. One is *Psychology, religion and healing* by Leslie D. Weatherhead (1951). Weatherhead focuses on the healing technique involved in the healing stories in the Gospels and classifies them into three categories: (1) cures which involve the mechanism of suggestion, (2) cures which involve a more complicated technique and (3) cures which involve the influence of a psychic 'atmosphere' or the 'faith' of people other than the patient.

The other book is *Disease and healing in the New Testament* by J. Keir Howard (2001). Howard was a physician trained in England who held a senior post in the University of Otago Medical School in New Zealand before embarking on theological studies leading to his ordination as an Anglican priest. Although he endorses the view held in my book that most of the conditions confronting Jesus were somatoform disorders, he believes that blindness was not one of these conditions. He is of the opinion that it is much more probable that the blind persons treated by Jesus suffered from advanced cataracts (extremely common in the Middle East) and that Jesus treated them through the use of manual couching, a procedure that remains very popular among village healers today. It involves using a needle to push down the crystalline lens of the eye (pers. comm. 12 October 2008). Dr Howard has also written a monograph titled *Medicine, miracle and myth in the New Testament* (2010).

Another book that is relevant to the topic is Mary Kilbourne Matossian's (1989) *Poisons of the past: Molds, epidemics, and history*. In my summary of *Jesus: A psychological biography* (Capps 2002) I noted that Matossian argues that food poisoning due to

contaminated grains explains why one village could experience an epidemic and another village in the same general vicinity would not, thus virtually ruling out a virally transmitted disease. She also notes that among the more severe symptoms would be skin eruptions, bleeding from bodily orifices and central nervous system disorders (including delirium, stupor, convulsions, depression and disorientation). Her argument has relevance to 1st-century Palestine and thus to Jesus' role as a village psychiatrist in that food poisoning may cause physical symptoms found in leprosy and mental aberrations found in demon possession. The fact that food poisoning may occur in one community but not in an adjacent community would support belief in localised demonic agencies.

Finally, Thomas W. Seat II, a student in my class on 'The minister and mental illness', has written a paper titled 'Jesus' academy of village psychiatry: Peter's imitation of Jesus' curative methods in Acts 9:36–43'. Seat suggests that the healings attributed to Peter in Acts 3:1–10 and Acts 9:32–43 involved somatization disorders. He focuses especially on the raising of Tabitha, noting parallels between this and the story of Jesus' healing of Jairus' daughter.

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