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Mental Disorders - Chapter 6 of "Counseling and the Demonic"

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CHAPTER SIX

MENTAL DISORDERS

While there are a number of views on the nature of mental illness, the standard reference of mental disorders in the United States, as we have said, is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (DSM-III-R).[1]

This chapter will examine the basic sections of DSM-III-R, including an overview of the major diagnostic categories and a consideration of the model of man which is implicit in the diagnostic system. The DSM-III-R diagnostic system encompasses three major classes of disorders in terms of cause or etiology.

First, there are many conditions which are clearly caused by physical diseases, such as tumors and strokes. Some of these are

presumably outside the victim's control. Others, such as brain damage resulting from the abuse of alcohol or other controlled substances, are believed to be the result of the person's own actions.

Second are disorders or conditions known or strongly suspected to involve a biological predisposition, such as manic-depressive disorder and various forms of schizophrenia. However, it is believed that the person must be exposed to other factors, such as personal traumas and stressors, in order to develop the disorder.

Third are conditions in which no known or presumed biological factors are involved. These are often called functional disorders. For many of them, which include anxiety and depression, the person is presumed to have little or no personal responsibility in developing the disorder. However, for others of these disorders, personal actions, such as choosing to drink alcoholic beverages or to use a variety of legal or illegal drugs (but without resulting brain damage), may play an important role; examples include alcohol- and substance-abuse disorders (which may occur with prescribed medications as well as street drugs). Initially, we might conclude that these conditions result from sin, but as we shall see, often that is too simplistic an explanation.

If we are to understand the relationship between mental disorders and demonic influence, a basic grasp of the DSM-III-R diagnostic system is of great value. Those who are already familiar with DSM-III-R may wish to skim quickly over this chapter. All of us should remember, however, that mental disorders rarely have simple causes.

Multidimensional Diagnosis

With the publication of DSM-III-R, the diagnostic system adopted a procedure in which each person was to be evaluated on five different dimensions, or "axes," each of which involves a different type of information. The first three of these dimensions constitute the official diagnosis, and include 1) mental disorders, 2) developmental and personality disorders, and 3) physical disorders and conditions. The remaining dimensions include 4) severity of psychosocial stressors and 5) overall

assessment of functioning during the past year; the last two are used primarily in treatment planning and in predicting outcome.

> [The first two dimensions] comprise the entire classification of mental disorders. . . . This separation ensures that consideration is given to the possible presence of disorders that are frequently overlooked when attention is directed to the usually more [obvious disorders of the first dimension].[2]

Obviously, an adequate evaluation of an individual's functioning requires taking into account information from each of these areas. The result is a complex and rather sophisticated system that seeks to encompass the complexity of human functioning.

Clinical Syndromes

The first dimension includes the clinical syndromes such as anxiety, depression and organically induced mental disorders. It is common for individuals to receive a diagnosis on both the first and second dimensions. In such instances, the diagnosis on the first dimension is assumed to be the principal diagnosis which is the focus for treatment unless it is specifically noted that the diagnosis on the second dimension is primary.

Jennifer, whom we discussed previously, would be classified under the clinical syndromes as a Multiple Personality Disorder. This mental disorder has no known or presumed biological cause, and it is unclear whether personal responsibility plays an important role in this condition.

Personality Disorders and Specific Developmental Disorders

The Personality Disorders, such as Paranoid Personality and Obsessive-Compulsive Personality, and specific developmental disorders, such as Mental Retardation and Dyslexia, are diagnosed on the second dimension. Everyone is presumed, from time to time, to show the personality patterns listed here to some degree or other. However, some individuals show these patterns in much more exaggerated and pervasive forms. Often the

Personality and Developmental Disorders result in considerable difficulty in personal-social functioning. Furthermore, some believe that these enduring patterns of responding to people and situations, when present in their more extreme forms, underly many of the mental disorders which are considered on the first dimension. When the person shows such an enduring pattern of disturbance in personality functioning or development, it is diagnosed in addition to, or instead of, clinical syndromes according to DSM-III-R. Also, this dimension "can be used to indicate specific personality traits when no Personality Disorder exists."[3]

A significant source of problems involves difficulty with school adjustment. These problems are categorized as Specific Developmental Disorders, and include reading, arithmetic, articulation, mixed and atypical categories.

Initially it might seem that the Specific Developmental Disorders are not mental disorders. However, there is a strong association between learning disorders, as these are often called, and mental health problems. Data suggests that as many as 80 percent of adolescents receiving hospitalized mental health treatment for substance abuse also show learning disabilities.[4] While one cannot safely conclude that learning disorders produce substance abuse, it seems likely that learning disorders are one of the contributing factors.

Physical Disorders and Conditions

As suggested above, it is recognized in DSM-III-R that mental disorders may produce or exacerbate physical conditions such as duodenal ulcers or high blood pressure. It is also recognized that physical conditions, such as hormonal imbalances, a stroke, or AIDS infections, may contribute to mental disorders. Assessment of physical disorders and conditions prompts the examiner to consider this dimension of the person, and to evaluate the interplay between mental and physical functioning; special emphasis is placed on the role of physical factors in the development and treatment of mental disorders.

Severity of Psychosocial Stressors

This dimension requires the examiner to explicitly assess the person's history of stressors in the past year and consider the

role of such historical factors in the presenting complaint. It is believed that stressors may play a role in the development of a mental disorder, in worsening an existing mental disorder, or in recurrence of a former disorder.

The adjustment disorders in particular take into account the level of stress to which the individual has recently been exposed, and are defined in terms of harmful or inappropriate reaction to actual stress experienced in the past three months. Things to be considered as stressors include such experiences as moves, job loss, accident or injury, engagement or marriage, marital conflict or divorce, death, major financial changes, civil or criminal charges, and a host of other events. Stressors are rated on a scale from 1 (none) to 6 (catastrophic). Examples of catastrophic stressors include death of a child or spouse, and being taken as a hostage or placed in a concentration camp.

One example of a factor that might be coded here is the distress caused by the diagnosis of AIDS. In the *Surgeon General's Report on AIDS* it is noted that significant mental-health problems may result from receiving a diagnosis of AIDS:

> Upon being informed of infection with the AIDS virus, a young, active, vigorous person faces anxiety and depression brought on by fears associated with social isolation, illness and dying. Dealing with these individual and family concerns will require the best efforts of mental health professionals.[5]

One of the greatest concerns about widespread testing for AIDS is that a significant number of individuals will be falsely identified as AIDS carriers. Even with an error rate of one in a thousand, if 50 million are tested, 50 thousand will be falsely found to be carriers. The potential mental anguish of this is one of the major dilemmas which must be faced in deciding how to approach the AIDS problem.[6]

Global Assessment of Functioning

The Global (or overall) Assessment of Functioning (GAF) evaluation involves making a judgment about the individual's

overall level of mental health, currently, and during the past year.

> Ratings of current functioning will generally reflect the current need for treatment or care. Ratings of highest level of functioning during the past year frequently will have prognostic significance, because usually a person returns to his or her previous level of functioning after an episode of illness.[7]

In some disorders, such as schizophrenia, a defining criterion is deterioration from a previous level of functioning. Assessment of adaptive functioning for the past year requires the examiner to explicitly evaluate social relationships, occupational functioning, and use of leisure time. Ratings of past and current functioning are made on a scale from 1 (persistent danger to self or others or inability to maintain minimal personal hygiene) to 90 (good functioning in all areas with symptoms absent or minimal).

Overview of Mental Disorders

Table 1 presents a brief overview of the DSM-III-R diagnostic system. Particular attention should be given to the causes or etiology of the various mental disorders as well as to gaining an overview of the kinds of symptoms typical in each major diagnostic group. Though somewhat complex, this information will be important to later discussions of the relationship between mental illness and the demonic.

As a foundational principle, in constructing DSM-III-R it was decided that priority would be given to diagnosing an organic mental disorder over functional disorders whenever the symptoms fit with an organic disorder and signs of organic dysfunction or historical factors supporting an organic diagnosis are present. Organic disorders are those of physical origin; functional disorders, though often similar in symptoms, have no known physical causes. Thus diagnosis of organic depression takes precedence over diagnosis of major depression as a functional mood disorder.

Mental Disorders in DSM-III-R*

I. Clinical Syndromes
   A. Disorders usually first evident in infancy, childhood or adolescence
      1. Disruptive-behavior disorders
      2. Anxiety disorders of childhood or adolescence
      3. Eating disorders
      4. Gender-identity disorders
      5. Tic disorders
      6. Elimination disorders
      7. Speech disorders not elsewhere classified
      8. Other disorders of infancy, childhood, or adolescence
   B. Organic mental disorders
      1. Dementias arising before and during old age
      2. Psychoactive substance-induced organic mental disorders (e.g., organic disorders due to alcohol or narcotic dependence)
      3. Organic mental disorders associated with physical disorders or conditions, or for which the cause is unknown
   C. Psychoactive substance-use disorders (e.g., nonorganic disorders due to alcohol or narcotic dependence)
   D. Schizophrenia
   E. Delusional (paranoid) disorder
   F. Psychotic disorders not elsewhere classified
   G. Mood disorders
      1. Bipolar (manic-depressive) disorders
      2. Depressive disorders
   H. Anxiety disorders
   I. Somatoform disorders (physical disorders without organic causes)
   J. Dissociative disorders (e.g., Multiple Personality Disorder)
   K. Sexual disorders
   L. Sleep disorders
   M. Factitious (faked) disorders
   N. Impulse-control disorders not elsewhere classified
   O. Adjustment disorders
   P. Psychological factors affecting physical condition

II. Developmental Disorders and Personality Disorders
   A. Developmental Disorders (usually first seen in childhood)
      1. Mental retardation
      2. Pervasive developmental disorders (e.g., infantile autism)
      3. Specific developmental disorders (e.g., dyslexia)
      4. Other developmental disorders
   B. Personality Disorders

III. Physical Disorders and Conditions

IV. Severity of Psychosocial Stressors

V. Overall Assessment of Functioning

Table 1

*Adapted from American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM – III – R)

A second foundational principle is to give priority to diagnosis of more pervasive disorders, even though symptoms associated with a more specific or "isolated" disorder also are observed. For example, if schizophrenic symptoms are present along with chronic mild depression, technically known as dysthymic disorder, schizophrenia is diagnosed since chronic mild depression often accompanies schizophrenia.

In the next section we will examine several mental disorders in DSM-III-R to illustrate the interactions among biological, psychological, social, and spiritual factors in mental disorders.

Examples of Mental Disorders

Mental Retardation

One of the most prominent classes of disorders among children is mental retardation. This disorder involves general intellectual functioning which is significantly below average, associated with or resulting in deficits or impairments in adaptive behavior beginning before age eighteen. Low intelligence test scores and inability to live independently and meet the normal social responsibilities expected of the child's age and cultural group are the primary criteria.

Causes "may be primarily biological, psychosocial, or an interaction of both."[8] Numerous biological causes of retardation have been discovered. Among these are Down's Syndrome or Trisomy-21, Tay-Sachs disease, phenylketonuria, cretinism, hydrocephaly, and severe shortage of oxygen during the birth process. In general, mental retardation stemming from biological causes is moderate to profound, thus diagnosis generally occurs at birth or in the first few months of life.

About 75 percent of the cases of retardation are only mildly severe. In the majority of these, no clear biological factor can be identified, though biological causes cannot confidently be ruled out. Mild retardation is believed to result from one or more of three factors: 1) genetic causes; 2) environmentally influenced biological factors, such as malnutrition and lead poisoning; 3) psychosocial causes, such as relatively deprived early-childhood environment and learning experiences.

Conduct Disorders and Oppositional Defiant Disorder

Conduct Disorders are defined as a "persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated."[9] The conduct is more serious than the ordinary mischief and pranks of children and adolescents; it includes stealing, aggression, lying, cheating, truancy, property destruction—such as setting fires—rape, extortion, mugging and other such things.

Conduct Disorders are divided into two types, depending on whether the person engages in such activities alone (solitary) or with others (group). There is little firm evidence that biological factors play a role in these disorders, though it is known that such difficulties tend to run in families.

The Oppositional Defiant Disorder lacks the serious violation of the rights of others found in the Conduct Disorders, but includes acts of defiance, negativism, and hostility directed primarily toward parents and other adult authority figures. Denial is common; the person justifies the conduct and does not view himself or herself as acting inappropriately. Temper, moodiness, and the use of drugs, alcohol, and tobacco are common in this condition.

In conduct and oppositional disorders, biological factors are presumed to play at most a minor role. The primary causes are generally presumed to be psychological and socioemotional. Spiritual factors may also be important in these disorders. They may reflect overt sinful conduct. Also, there is the possibility that some of these patterns of behavior could be due to demonic influence.

Organic Mental Disorders (Axis I)

Organic Mental Disorders involve a known or presumed biological cause that can be demonstrated from a review of the individual's history, physical examination, or laboratory testing. For Organic Mental Disorders there should be a corresponding diagnosis of a physical disorder or condition. Physical brain disorder is the primary diagnosis, while the mental-disorder diagnosis describes the way in which the brain injury manifests

itself in mental/psychological functioning. "The essential feature of all these disorders is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain."[10]

Organic Mental Disorders may result from a host of biological causes, including the effects of aging, toxic effects of prescription drugs, alcohol or substance abuse, brain tumors, strokes and hardening of cerebral arteries, brain injuries, infections, and nutritional deficiencies or excesses. The symptomatic manifestations are quite diverse, including such features as delirium, delusions, hallucinations, impaired judgment, dementia, amnesia, apathy, lethargy, incontinence, psychomotor impairment, anxiety, and depression.

A recent addition to organic mental disorders is dementia due to the AIDS virus. In the *Surgeon General's Report on AIDS* it is noted that "mental disease (dementia) will occur in some patients who have the AIDS virus before they have any other manifestation such as ARC or classic AIDS."[11] A recent newsletter for mental-health professionals elaborates:

> Recently it has become apparent that, in addition to psychological reactions and organic brain conditions resulting from opportunistic infections, some people with AIDS show symptoms of other types of neurological damage. HTLV-III directly infects some cells in the brain. . . . central nervous system involvement may be extensive in some patients. Some symptoms that appear to be psychologically caused may in fact be organic in origin and degenerative in course.[12]

It is clear that the immediate cause of the Organic Mental Disorders involves some malfunction of the brain. However, even in these disorders, personal responsibility may play a significant role. For example, personal choices regarding life style and behavior are involved in the substance use or abuse which results in certain organic disorders; similarly, the personal choice to engage in promiscuous sexual activity may result in contracting AIDS. In other instances, the action of persons other than the patient/client is involved, for example, when

head injuries are the result of assault and abuse. In still other instances, such as disorders caused by aging or infections, no personal responsibility seems to be involved. These three patterns correspond to personal sin, the sin of others, and sin in the world. Finally, some believe that patterns of conduct which lead to organic mental disorders, such as substance abuse, may be the result of demonic influence.

Mood Disorders

Mood refers to a prolonged emotional condition that colors all the person's mental life. It may be predominantly depressive or elated, or these two may alternate in a cyclic pattern. In their fully-developed form, both elated and depressed mood may be associated with disturbances in thinking and loss of reality contact, but the mood disturbance occurs first and is presumed to be primary.

Ahmed Ahmed came to a large East-coast city, took the largest suite of rooms in the most expensive hotel, and presented himself as a prince from a rich, Middle-East oil kingdom. He brought an entourage of several other guests who took nearby suites, all on his tab. They invited a number of prominent people from the town, and began a party which went on for several days. As the bill mounted, the hotel manager became uneasy and requested payment. Soon he discovered that Ahmed was an impostor, that he had no money, and thus could not pay the bill. Charges were pressed, and Ahmed was arrested. At the arraignment his attorney claimed that Ahmed was unaware of what he was doing, and thus could not be held responsible due to insanity; Ahmed was experiencing a manic disorder (a clinical syndrome diagnosed on the first dimension).

Obsessive Compulsive Disorders

Obsessive Disorders are recurrent thoughts, ideas, images or impulses that the person professes not to desire and finds repugnant, yet reports he or she is unable to resist. Compulsions are repetitive behavioral rituals performed to produce or prevent some event or situation; however, the person recognizes that the activity has no relationship to the event or is clearly excessive.

Leila Leila was a mild-mannered woman in her late fifties.

She came to me on referral from another counselor for help with a compulsive pattern of washing herself. When I first saw her our appointments were at 6:00 P.M. In order to be ready on time, Leila rose at 5:30 A.M. to begin her shower and get dressed. She spent all day washing and rinsing her body, inch by inch. Yet she could not complete the task and make it to our appointment on time.

A recent convert to a charismatic faith, Leila struggled with the belief that her problem was the result of sin, or of demonic influence. She prayed for deliverance, and attended healing meetings in which others prayed for her; yet she experienced no change.

My goal in working with her was to change the habit patterns that made up her washing ritual. We worked on using the soap to lather up only once during each washing; on dressing herself completely after washing rather than washing after donning each article of clothing; on shutting off the water and beginning the next task, rather than washing again when she touched the faucet due to fear that she was now contaminated.

Leila was obsessive-compulsive. There were spiritual dimensions to her problem as well, involving reluctance to carry out some aspects of her wifely duties in the home, resentment toward her husband, and ingratitude toward God for allowing her to experience this difficulty. These were addressed, along with a focus on practical behavior changes.

Leila found it hard to accept the view that her problem was partly psychological, not merely spiritual; so long as she viewed it as spiritual she believed that all she could do was pray and believe that God would heal her. This made it easy for her to justify doing nothing herself. I encouraged her to pray and believe, but also to work as God enabled her, to promote the healing process through her own diligent efforts. As she did so she gradually made progress.

Somatoform Disorders

The main features of this group of disorders are physical symptoms suggesting physical disorders (hence, somatoform) for which there are no positive medical or laboratory findings. The physical symptoms are a response to psychological stress or

personal and interpersonal conflict rather than to real physical trauma or disease.[13]

Somatoform Disorders may take the form of preoccupation with an imagined physical defect. Or they may manifest themselves in an exaggerated concern over minor imperfections in bodily appearance, general physical complaints involving one or more of the major organ systems (such as gastrointestinal complaints or heart palpitations), loss or alteration in physical functioning (such as weakness in the arms or chronic pain in the absence of any adequate physical explanation), or exaggerated complaint about normal aches and pains.

While superficially similar to some aspects of demonic influence, in most instances it seems likely that Somatoform Disorders are physical reactions to psychological distress. They illustrate the interaction of psychological and physical functioning.

Dissociative Disorders

The central element in Dissociative Disorders is loss of personal identity and integration which is not due to organic brain syndromes. Disturbances may occur in identity, consciousness, or motor behavior, though disturbance in motor behavior must be accompanied by disturbed consciousness to fit this disorder.

Multiple Personality is a Dissociative Disorder which involves the presence of distinct personalities or personality states which alternate in the dominant role, usually suddenly, and with distinct personality patterns associated with each.

> The **belief that one is possessed** by another person, spirit or entity may occur as a symptom of Multiple Personality Disorder. In such cases the complaint of being "possessed" is actually the experience of the alternate personality's influence on the person's behavior and mood. However, the feeling that one is "possessed" may also be a delusion in a psychotic disorder, such as Schizophrenia, not a symptom of a Dissociative Disorder [emphasis in the original].[14]

The popular accounts, *The Three Faces of Eve*, and *Sybil* are based on Multiple Personality Disorders.[15] Jennifer, described

in chapter 5, is an example of multiple personality. Multiple personality is the mental disorder that most closely resembles demonic possession. As we shall see later, some believe that demon possession sometimes occurs in persons with multiple personality.

Sexual Disorders

Sexual disorders involve a wide variety of disturbances in which psychological factors are the presumed cause. Disorders of sexual functioning for which the cause is physiological are not included in DSM-III-R.

Early editions of DSM-II included homosexuality as a specific mental disorder. In later editions it was deleted, although the context clearly implied homosexuality was a mental disorder (a footnote reveals that a vote of the American Psychiatric Association resulted in this change). A later section of this chapter addresses homosexuality in some detail.

Factitious Disorders

In Factitious Disorders, physiological or psychological symptoms are intentionally produced or feigned by the individual. There is a compulsive quality about these acts which suggests that they are deliberate and purposive, but the individual uses them toward ends which he or she is unlikely to consciously choose. When physical symptoms are present they may seem so real that the person has repeated hospitalizations for medical care.

Factitious Disorders may mimic either psychological or physical illnesses. Examples of factitious disorders include complaints of dementia, psychosis, false pregnancies, dizziness, rashes, or abdominal complaints. Virtually any form of physical or psychological complaint may occur with this disorder. It usually is recognized and diagnosed because of the extreme frequency of complaints, the absence of tissue pathology, and/or the inconsistency of symptoms.

Emily Emily saw her enterologist repeatedly with complaints of uncontrollable diarrhea. Although repeated on several occasions, all of the diagnostic tests yielded negative results. Subsequently, it was discovered that she was obsessed

with maintaining her weight below 106 pounds. Anytime it exceeded this level she took large doses of laxatives to purge herself of the food which she had consumed and thus reduce her weight. The laxatives accounted for the diarrhea. Emily's disorder is classified as factitious, though not all Factitious Disorders involve physical symptoms.

Whether or not we consider excessive use of laxatives sinful, Emily clearly was responsible for producing her own problems. Moreover, she misled her doctor regarding how the symptoms came about, though it is not clear whether she herself was aware of the relationship between her habits and the symptoms. Some might consider Emily to be under demonic influence. Certainly, she had made maintaining her 106-pound figure a false god to which she paid repeated homage.

Psychological Factors Affecting Physical Condition (Axis I)

This classification is used where psychological factors cause a physical illness or make it significantly worse. Judgment is involved, but this can often be easily recognized when physical symptoms repeatedly begin with or become more severe following identifiable psychological stressors. In the past these have often been called psychosomatic or psychophysiological disorders. Headaches which occur following interpersonal conflict fit this classification. Other examples include lower back pain, migraine and tension headaches, duodenal ulcers, ulcerative colitis, and many others.

All of us have heard the expressions: "She's a pain in the neck." "He's a hothead." "You make me sick." These statements reflect the fact that our minds and bodies interact. While the spiritual dimension of this class of mental disorders is often ignored, McMillen, in his book *None of These Diseases* makes a strong case for the conclusion that many physical and mental disorders involve spiritual issues such as unforgiveness, bitterness, hatred, and worry.[16]

Issues from a Christian Perspective

As was shown in the foregoing discussion, the DSM-III-R diagnostic system is complex and multifaceted. It attempts to

account for all of the complexity of mental disorders as they are currently viewed by practitioners from a variety of disciplines and theoretical perspectives. It includes three major classes of disorders in terms of cause or etiology: genetic and biological factors, psychological factors, and personal-social factors.

Because humans are complex beings in whom biological, psychological, and personal-social aspects are in continuous interplay, these factors interact in a variety of complex ways in producing mental disorders. For example, there is evidence that at least in some instances involvement in substance abuse is as much the result of mental disorders as the cause of them; many individuals use alcohol or drugs as a form of self-medication for depression, anxiety and other mental disorders.[17] There is even one passage in Proverbs that appears to support this practice (see Proverbs 31:4–7).

Further, while the initial decision to consume alcohol or to use drugs is presumably voluntary, once the process has begun there is strong evidence that the probability of that person's becoming a problem drinker or drug abuser is significantly influenced by biological factors which are presumed to be genetic.[18]

The Role of Sin

Sin in the World By this point it should be quite clear that one cannot responsibly dismiss all of the mental disorders included in DSM-III-R by saying with Adams that the problem is sin.[19] At least not if one means *personal* sin.

Yet, in another sense the problem is indeed sin. First, the presence of sin in our world as the result of the Fall, and the resulting distortion of the whole created order, caused death in its many-faceted forms to be passed to all men (Rom. 5:10–21). Without sin in the world there would be neither physical nor mental illness. Moreover, in the world to come these will be abolished (Rev. 21:1–4). Thus, *in the sense that all evil is the result of sin in the world, mental disorders are the result of sin;* but mental disorders are not necessarily the result of the sufferer's personal sin. Mental disorders may be the result of sin in the world, the sin of others, and/or personal sin.

Personal Sin As we have already seen, personal-social life style is sometimes a major factor in mental illness. Thus it seems

true that *at least in some instances mental illness is the result of personal sin.*

The Sin of Others There is another possibility as well. *In some instances, mental illness is the result of being sinned against.* The child who is brutally beaten by an unloving parent with the result that serious brain damage is sustained, the chronic depressive who was the victim of repeated psychological and sexual abuse, the car-accident victim who was hit by a drunk driver: these are the victims of the sinfulness of others.

Often it is not possible to distinguish among sin in the world, personal sin, and the sinfulness of others as influences in a given mental disorder unless the person's history is well-known. For example, organic brain syndromes can be produced by a vicious assault or by completely accidental injuries.

The presence of brain damage may go undetected for years if the effects are mild to moderate, or develop gradually. Senile dementia may illustrate such a pattern in which repeated minor strokes or coronary blood clots produce brain atrophy and progressive loss of functioning which may not be detectable by current medical techniques, or which may only recently be detectable by the development of sophisticated procedures (such as positron emissions tomography and magnetic resonance imagery).

It is important to remember that the simple fact that no medical problems are diagnosed does not satisfactorily rule out physical causes (the effects of sin in the world) as the basis of a given mental disorder. Our knowledge in these areas is, unfortunately, still very limited. Medical diagnosis is subject both to limited knowledge and human fallibility.

Another example of this confusion between physical and psychological sources of mental disorders occurs in the area of "irritable bowel syndrome," a condition that fits under the classification, "Somatization Disorder"; presumably the disorder is a result of anxiety or "nerves." Recent research has shown that a number of medical disorders can produce an "irritable bowel." Previously, due to inadequate knowledge and diagnostic capabilities, persons with these diseases were diagnosed as having Somatization Disorders. Among the causes of misdiagnosed gastrointestinal disorders are food allergies,

such as allergic reactions to milk (galactosemia, or lactose intolerance), reactions to gluten and cane sugar, and a parasitic infection of the digestive tract known as ghiardiasis. Also, gastrointestinal complaints sometimes develop as side effects of necessary medications.[20]

Spiritual Well-Being

There is much in Scripture to suggest that a healthy relationship with God should result in better mental health and physical well-being.[21] In the past few years a body of literature has begun to develop which points to this precise conclusion from a scientific perspective as well. Psychologists Craig Ellison and Raymond Paloutzian developed the Spiritual Well-Being Scale as an index of spiritual health. Research with this scale indicates that spiritual well-being is positively correlated with many indicators of physical and psychological health, such as self-esteem, satisfaction with family life, and sociopsychological adjustment to seminary. Similarly, spiritual well-being has been found to be negatively related to many indicators of physical or psychological difficulties such as depression, loneliness, aggressiveness, elevated blood pressure, complaints of chronic pain, and being overweight.[22]

With the goal of making assessment more complete, and in light of the findings on spiritual well-being, perhaps we should consider adding an additional dimension to the DSM-III-R coding, thus providing for evaluation from a Christian perspective. This dimension would assess spiritual condition. It could address such questions as whether the person professes any religious faith, importance of religion to the individual, frequency of church attendance, frequency of personal devotionals, and any recent changes in the person's religious life. Use of the Spiritual Well-Being Scale or some similar instrument might also be helpful.

Even with provision for assessing the person's spiritual condition, the use of the DSM-III-R diagnostic system, or any similar classification scheme, poses unique problems from a Christian perspective. Recognition of this does not mean that we should reject the diagnostic system; indeed, to do so would likely create more problems than it would solve. However, the added

spiritual dimension must be accounted for in some fashion. Another major problem we must address involves the relationship of demonic influence to this classificatory system; further discussion of this issue is presented later.

HOMOSEXUALITY

The place of homosexuality in the *Diagnostic and Statistical Manual* illustrates some of the complexity of the diagnostic classification system. As noted earlier, in the first two editions of the manual, homosexuality per se was viewed as a mental disorder. However, in 1969, in a controversial decision, the American Psychiatric Association voted to remove it as a mental disorder. For a time the section on homosexuality was replaced with a new category, that of "Sexual Orientation Disturbance [Homosexuality]":

> This is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This classification is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality *per se* is one form of sexual behavior, and with other forms of sexual behavior which are not by themselves psychiatric disorders, is not listed in this nomenclature.[23]

This new category was merely inserted in context following the introduction to sexual deviations which defined sexual deviation:

> [such are] sexual interests [which] are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism.[24]

This definition of sexual deviations clearly implies homosexuality to be abnormal. A footnote was appended, acknowledging the inconsistency.

Some have argued that this change in the diagnostic system was basically a political act. They believed that homosexuals had effectively lobbied to have themselves declared normal. It is rumored that at least one person charged that the voting on this decision was rigged. Regardless of the merits of this allegation, it is clear that there are diverse views about both the morality and the psychological status of homosexuality.

Although homosexuality is perhaps one of the more obvious examples, there is controversy about a number of the other categories included in the diagnostic system as well. That controversy, in part, resulted in the recent publication of DSM-III-R. Even so, disagreements remain; controversy about the revisions in DSM-III-R had made the news even before it went to press.[25]

The diagnostic system involves values, and bears evidence of disagreement about those values. Many are inclined to view mental disorders as categorically distinct from medical disorders. However, it is not wise to make too much of that distinction. Medical diagnosis is also based on values, most specifically the value that it is good to be well and bad to be ill or injured, and worse yet to die. One feature that distinguishes physical medicine is that there tends to be greater agreement about its values.[25] But even they are not universal, as is demonstrated by the fact that civil suits try to decide whether a child should receive surgery despite the objections of parents who are Christian Science practitioners. Similar value controversies arise over other medical and bioethical matters. In these instances the dispute is sometimes over the fact of illness; equally often it is over the wisdom of treatment even when the presence of illness or injury is undisputed.

Because of the controversy regarding homosexuality, further comments about a Christian view of homosexuality may help to illustrate some of the issues raised here.

First, in a recent review, John Money shows that disturbances in hormonal levels prenatally and shortly after birth may result in internal genital organs, external genital organs, or both internal and external organs which are inconsistent with the sex chromosomes at a genetic level. Thus, at a biological level it is possible for both masculine and feminine characteristics to

coexist in a single organism, and to do so in a variety of ways. Fortunately, such anomalies are relatively infrequent.[26]

In addition to anomalies of physical structure, discrepancies may also occur between sexual structure and sexual behavior patterns. A variety of discordant behavioral patterns may be fostered by abnormalities at the biological level. These include behavioral tendencies toward homosexuality and bisexuality.

The steroid hormones such as prednisone and medrol are examples of commonly prescribed medications which can affect sexual development. It seems likely that exposure to steroids during crucial developmental periods may dramatically alter external genitalia and/or the brain-controlled predispositions influencing sexual behavior. However, it is doubtful that this factor, by itself, accounts for the current level of homosexuality. Homosexuality is a complex issue at both the biological and social levels.

In addressing the religious/moral aspects of sexuality, several things need to be acknowledged at the outset. First, God made humans as sexual persons, and pronounced that sex within the God-given limits of marriage is "holy and undefiled" (see Hebrews 13:4; cp. 1 Cor. 7:1–4).

Second, God set explicit limits on the overt expression of sexuality. Homosexuality, fornication, adultery, bestiality, and a wide variety of other sexual behaviors are clearly prohibited by Scripture (Exod. 20:14; Lev. 20:10–23; 1 Cor. 5:1–7; 6:15–19).

Third, God calls us to forsake sexual lust, the tendency to dwell on and be preoccupied with sexual thoughts and fantasies (Matt. 5:27–32). It is important to distinguish between being attracted to or "falling in love" with members of the same sex and being overtly involved in sexual intimacies. It appears that it is at this point that the role of sexual socialization becomes vital in a person's conforming to the God-given standards for sexual conduct. Although some persons are biologically predisposed to be attracted to other persons of the same sex, they can learn to control their impulses, thus conforming to godly standards; these same principles apply to those attracted to members of the opposite sex to whom they are not married (1 Cor. 6:9–11).

In light of the findings of Money and his colleagues it appears that some people, at least without the benefit of modern

surgery, fail to develop complete external genitalia, and thus may be incapable of heterosexual intercourse; perhaps these are those whom the Bible describes as "eunuchs who were born that way." Others may have their sexual organs altered by men, often for cruel and inhumane reasons; these are "eunuchs who were made eunuchs by men" (Matt. 19:12).

Finally, some may find themselves, by reason of hormonal or social influences, attracted to members of the same sex. In order to live a godly life, these may find it necessary to forsake sexual intimacy for the kingdom of God. This group, in most respects, is comparable to those with heterosexual interests who eschew marriage for the sake of God's kingdom (see 1 Corinthians 7:24–40).

As we have seen, some may find themselves attracted to members of the same sex for reasons over which they have little or no control. To the extent this is true, we must view this as the effect of sin in our world, or, in some instances, the effect of the sin of parents or influential others, but not of personal sin on the part of the individual. However, when the individual chooses to satisfy his or her sexual impulses outside of the marital relationship, the problem is sin whether the transgression is heterosexual or homosexual. It is to this matter that Scripture speaks. By contrast, DSM-III-R is concerned with all the psychological dimensions of sexual-identity problems whether or not they result in illegal or sinful acts, provided they are a source of concern to the individual.

In light of the above, for those charged with the care of troubled persons it is too simplistic to dismiss the problem of homosexuality with the simple statement that the problem is sin.

Summary

In this chapter we have examined the diagnostic system for mental disorders in DSM-III-R. It is a complex system which takes into account biological, personal, and social factors that cause mental disorders, and considers a highly diverse set of symptomatic manifestations. Disorders are diagnosed on five dimensions, including mental disorders, personality disorders, physical disorders, severity of psychosocial stressors, and global assessment of functioning during the past year. In addition, it

was suggested, a sixth dimension might be helpful to assess spiritual functioning, since the spiritual dimension presumably interacts with the physical and psychological dimensions.

Issues considered in diagnosis include the specific symptoms, their severity and duration, presumed causative factors, history of prior functioning, age of the individual, presence of other mental or physical disorders, and a number of other things. It was suggested that mental disorders are too complex to be dismissed as simply the result of personal sin, although personal sin, sin in the world, and the effects of the sin of others each may result in mental disorders. Finally, homosexuality was examined as an example of a disorder that involves a complex interaction among physical, social, and spiritual factors.

Mental disorders may be caused by genetic influences; they may be the result of accident, injury, disease, or exposure to substances on a voluntary or involuntary basis; they may result from clearly identified physiological malfunctions. Other mental disorders, many of which are attributed to psychological factors, are of unknown origins. Some disorders are associated with acts which are considered crimes in most states.

Value considerations are important in determining which behaviors will be labeled as mental disorders.[27] This is a well-recognized, if uncomfortable, aspect of mental disorders. The controversy over the insanity plea as a defense in criminal trials is one example of its practical implications. While Scripture is normative in establishing the nature and scope of sin, and for all true theology, it was not intended to define the limits of other disciplines, even those which most closely relate to its subject matter. For example, although the Bible contains a great deal of historical and geographical information, it is neither a history nor a geography text. In a similar manner, the Bible is not a diagnostic tool for mental disorders. DSM-III-R is designed to be just such a tool, however imperfect. While fault can be found with DSM-III-R from a number of perspectives, including a Christian one, we would do well to emulate mental-health professionals in using this system until a better one is developed to replace it. The diagnostic system simplifies communication among counselors, whether Christian or non-Christian, and

among members of different professions, such as social workers, physicians, and counselors. Often, several persons need to communicate together about a single counselee, and the DSM-III-R system helps.

One of the thornier problems of the diagnostic system is the relationship of demonic influence to the various classifications. At first impression it might appear that there is no place for demonic influence. We shall turn to this issue in some detail in the next chapter.