Abstract Problem assessment has always been central to pastoral practice. The notion of pastoral diagnosis emerged in the mid-twentieth century, largely as a practice that emulated psychiatry by linking problems in living to broad theological, spiritual or religious metaphors. Pastoral counselors have never developed a diagnostic system that is consistent or widely accepted by either pastoral counselors or interdisciplinary colleagues. Several factors argue against pastoral diagnosis as a necessary element of practice. These include: (1) the limitations of theological anthropologies that center on human defect, (2) Michel Foucault’s analysis of psychiatric power and the socially constructed nature of psychopathology, (3) contemporary debates about biological psychiatry and the new DSM-V, and (4) evidence that diagnosis can say little about either etiology or what therapy methods will be effective for any specific disorder. Conclusions suggest that it is time to retire the notion of pastoral diagnosis and replace it with a critical pastoral relationship with interdisciplinary diagnosis. This relationship would expose the hidden, often demoralizing, social power of diagnostic practices and highlight multitude pathways to human flourishing.

Keywords: Pastoral diagnosis, pastoral counseling, pastoral theology

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Interview question: “Can you describe how you do pastoral diagnosis?”
Pastoral Counselor response: “Pastoral diagnosis? I’m not really sure I can. I think I do it, but I’ve never really tried to describe it. I guess I try to understand how spiritual issues play out in the problems people bring to therapy.”

My task in this essay was to propose “best practices” for pastoral diagnosis from a theoretical or philosophical position. At first glance this seemed pretty straightforward. Pastoral counselors have long relied on ancient Hebrew and Christian stories, examples from Jesus’ ministry, and traditional practices of spiritual direction to provide diagnostic analogies expressive of human need (Clebsch & Jaekle, 1967; Gerkin, 1997). A modern tradition of pastoral diagnosis emerged in response to twentieth century medicine. This tradition: (1) affirmed the value of religious knowledge about human life in increasingly medicalized pastoral environments, (2) articulated a context for integrating medical/psychological and theological knowledge in acts of care, and (3) claimed a place in a field increasingly dominated by muscular medical-psychiatric-psychological institutions (Denton, 1997; Pruyster, 2005; Ramsay, 1998). However, saying something about pastoral diagnosis in today’s pastoral, medical, psychiatric, and psychological context, is not easy. First, it is hard to locate pastoral counseling as a particular discipline with a specific set of practices. In 2013 the field is no longer unified by a discrete identity, clear paradigm of practice,¹ set of theories, or commonly-accepted theology that was typical of mid-twentieth century pastoral counseling. Second, “pastoral diagnosis” as a notion or discrete practice is elusive. Does it refer to the pastoral identity of the person diagnosing? Does diagnosis of a neuropsychological problem by a psychologist who is also certified as a pastoral counselor qualify as pastoral diagnosis? Is it pastoral diagnosis when a pastoral counselor is required to use the new DSM-V to complete an insurance form? Is pastoral diagnosis a particular kind of diagnosis that represents unique knowledge established through research and common agreement in the field? If so, what

is this knowledge? How was it constructed and by whom? Is it founded in theology? Religion? Specific pastoral practices? Conversations between behavioral sciences and religion? Where is this knowledge codified? What are its norms and how were they established? Is it generally available (like the American Psychiatric Association’s DSM) so other professionals can use it in a more generalized psychotherapy practice?

These questions constrain any contemporary conversation about pastoral diagnosis. So, I begin with three observations. First, pastoral counselors in the second decade of the twenty-first century cannot claim any codified, unified, or generally shared practice of pastoral diagnosis based in widely accepted or empirically tested knowledge. Second, it is also clear that the modern, twentieth-century professional guild of pastoral counselors that might have accomplished this has been replaced by a loose confederation of variously trained and licensed professionals who show little interest in such a task. Third, pastoral counselors making up this loose confederation of variously trained and licensed professionals use a variety of diagnostic frameworks in their clinical practice. Most rely first on the American Psychiatric Association’s Diagnostic and Statistical Manual. This reflects the medical community’s control of diagnosis, especially as it relates to reimbursement for psychotherapeutic services. Many pastoral counselors also rely on discipline-specific assessment, such as couple or family assessment, vocational assessment, and psychoanalytic assessment. Several models of spiritual assessment are available to therapists across disciplines. Starting from these observations, my goal in this essay is to:

- Examine pastoral counseling’s legacy of “pastoral diagnosis,”
• Explore several key theological, philosophical and behavioral science concerns that intersect with historic and contemporary diagnostic practices, and
• Suggest a direction for an alternative vision of how pastoral counselors might relate professionally and ethically to diagnosis in contemporary practice.

Part I: Genealogy

Interview question: “Can you describe how you do pastoral diagnosis?”
Pastoral counselor response: “It seems pretty vague to me. When I was in training we read about it. It seemed like it meant matching psychological diagnoses with theological or spiritual principles. For example, a depressed person might be having a spiritual crisis of faith in the face of loss, or an addict with a chaotic life might be wandering in the wilderness...those kinds of things.”

Anticipation

Most spiritual traditions have stories of rituals, wise men and women, or prophets who discern life-giving from other kinds of “spirits.” For example, my own Judeo-Christian tradition is defined by creation narratives of a deity who discerns between earth and sky, water and dry land, and humans motivated for health and destruction (Genesis 1-4). From creation narratives to the post-exilic prophets, the Hebrew scripture is rich with stories of leaders who, with varying success, discern between what is life-giving and life-robbing in the human spirit. New Testament narratives portray Jesus, the good shepherd or great physician, as one who was expert at discerning and intervening in matters of life-giving and life-robbing human experience. This extended into the early church practices of discipline and guidance. Each period of Christian history claimed standards to assess where God’s spirit was, or more importantly, where it was not, in human behavior and thought. This is evident in narratives of care and healing (Clebsch & Jaekle, 1967), as well as exiled and executed heretics, the Crusades, the Inquisition, Galileo’s imprisonment, Joan of Arc’s burning, and reformers denouncing each other. For better or worse, Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
institutional standards to judge thought and behavior, right or wrong, demonic or God, is woven into the fabric of religious tradition.

Modern, North American pastoral diagnosis is rooted in ancient Christian narratives of care. Pastoral manuals from the Didache (60-120 CE) to those found in today’s seminary bookstores outline procedures used to guide pastoral discernment and action. Until the late nineteenth century, these focused almost exclusively on guiding parishioners toward salvation and moral life. Late nineteenth and early twentieth century medicine, psychology and technology tipped the balance of educated clerical attention away from these concerns and toward cognitive and emotional well-being (Holifield, 1983). What once was madness, moral lapse, or demonic possession became loss of rationality, understood and treated best with medical knowledge rather than spiritual tradition. Emotional distress, once considered a religious issue related to salvation, was associated instead with very earthly, psychological concern for self-actualization. Historian John McNeill observed that pre-twentieth century pastoral care givers

…would be astonished if they could suddenly enter our world of today. They would find themselves in an environment in which their assumptions are ignored by many earnest and highly trained men who undertake the reconstruction of personality damaged by the stresses of life…. [The] territory of the old-time guide of souls…has been absorbed…[by] the empire of medical science. (McNeill, 1951, pp. 319-320)

Medical diagnostic paradigms were central to the development of the early twentieth century clinical-pastoral movement. In The Cure of Souls, Charles Holman (1932) claimed that pastoral ministers must be educated in the “scientific knowledge of human nature.” They must behave like physicians with careful attention to “…sources of infection, conditions that cause
illness, and the measures which must be taken to bring his patient back to health” (Holman, 1932, pp. x-xi). Holman argued for a comprehensive program of religious diagnosis and treatment that would guide all religious work. He lamented that there has been “…no painstaking effort to analyze and classify the types of maladjustment with which the minister deals as has been done with those types of disturbance with which the psychiatrist deals” (Holman, 1932, p. 144). To remedy this he offered a system to understand “sick souls,” a social case-work method for engaging “sick souls,” and a diagnostic guide for assessing individual functioning. His diagnostic frame was forthrightly framed by psychoanalysis and anchored in pastoral discernment of two kinds of “soul sickness:” moral maladjustment and religious maladjustment.

In *Physicians of the Soul*, Charles Kemp (Kemp, 1947) observed that pastoral counseling needed its own theological authority. He traced care from New Testament times to the twentieth century and concluded that psychiatry and behavioral sciences had changed theological anthropology so dramatically that any successful model of care must be both scientific and religious. In particular, care must include a close relationship between ministers, psychiatry and counseling professionals. Though Kemp offered no diagnostic framework, he believed that identifying and classifying human problems was a central pastoral skill. However, pastoral counselors needed to transcend the limitations of medical or psychological sciences and attend also to theology and the practices of the church; to “…life as a whole, in terms of its total context, which includes faith and hope—in other words, God” (pp. 241-242) in order to understand those who are religiously confused, despondent, perplexed or unhappy.

Wayne Oates highlighted theology and religious practice in pastoral assessment. Unlike Kemp, he was highly attentive to the practical intersection of psychiatry and theology. Oates
worked within a psychiatric framework and saw theology and religious life as sources to deepen diagnosis. Playing off of Freud’s claim that dreams were the “royal road” to the unconscious, Oates claimed that scripture was “…the pastor’s ‘royal road’ to the deeper levels of the personalities of his people” (Oates, 1952, p. 60). How a client related to religious life could be used as a diagnostic tool to gather psychological information. By using such tools, “…[a pastor] can get a fairly clear-cut understanding of the life situation of the person with whom he is counseling as well as a feel for the purposive drift of his life energies” (Oates, 1952, p. 63). Oates produced more than 50 books in a half century of professional life. None offer a system for diagnosis. Instead, he (Oates, 1957) modeled practice that paid careful attention to religious dimensions of personality and how religiosity, religious symbol and religious content interacted with psychiatric diagnosis and psychopathology. His work—reflecting his debt to Carl Rogers—shows much more concern for client engagement and a theological frame for practice than for developing a diagnostic system. (Oates, 1970, 1987)

Anchoring the notion

In 1965 psychiatrist Edgar Draper (1965) coined the term “pastoral diagnosis” to describe a parallel he observed between medical psychiatry and pastoral ministry. He argued that the first task of becoming a physician was to become a diagnostician. To enter the medical profession a physician must “…invest his energies in developing his skills in diagnosis for one reason: proper treatment depends on correct diagnosis” (Draper, 1965, p. 25). Diagnosis, he explained, is to know (Greek gnosis) apart (Greek dia), or to distinguish between. In a medical sense, this is to know the difference between one disease and another or to determine the nature of a disease. Pastoral diagnosis, then, is
…an orderly, structured approach to pastoral problems which taps all the resources of the minister, including his compassion (heart) and his objectivity (head). It eventuates in a tentative conclusion as to what the trouble is, opening the way for appropriate action…. [T]he proposition that proper treatment rests on correct diagnosis should serve the pastor as usefully as the physician. (Draper, 1965, p. 31)

In nearly fifty pages of text, Draper constructed a framework to illustrate how psychological and religious/spiritual concerns are juxtaposed to better inform ministry. He showed how pastoral diagnosis is indebted to and linked to psychology but maintains its own identity by focusing on moral life rather than mental health. It is “…uniquely clerical and is molded from the various vectors of human experience that are familiar to the pastor” (p. 68). He proposed a set of useful “vectors” and pointedly avoided a classification system for pastoral diagnosis for two reasons. First, diagnosing clinical syndromes from signs or symptoms should be left to mental health professionals who are “far more enlightened” (p. 70). Second, like Oates, he saw pastoral diagnosis as more of a “spirit of inquiry” about parishioners’ moral life than a systematic way of assessing people.

British psychoanalyst Frank Lake (1965) took a quite different approach to pastoral diagnosis. His ponderous text Clinical Theology turns Draper’s assumptions upside down. Pastoral counselors do not need a separate system of diagnosis. Instead, ministers should be highly trained in psychiatric diagnosis. By developing an intimate familiarity with the “disordered contents of the unconscious mind” (Lake, 1965, p. xxv), clinical theologians (ministers) can evaluate the “evil contents” that alarm psychiatric patients. According to Lake, the psychiatrist and the clinical theologian cover the same ground of human misery. Both equally
rely on psychiatric “truth.” Drawing from Wesleyan theology, Lake suggests that a competent clinical theologian will compare psychiatric truth with the theological principle of Christ’s normality. Competent psychiatric diagnosis becomes an avenue for the Holy Spirit to sanctify and purge troublesome, unconscious content. Pastoral diagnosis is indelibly welded to psychiatric practices and nosology. Lake was critical of the American clinical pastoral movement precisely because it maintained a boundary between psychiatry and theology. Where Draper avoided a classification system in favor of a “spirit of inquiry,” Lake filled nearly 1,300 pages with dense description of psychoanalytic diagnostic categories and corresponding theological analysis. Draper overtly rejected “clinical theology” as undermining both pastoral counseling and psychiatry.

Edgar Draper coined the term “pastoral diagnosis,” but psychologist Paul Pruyser (1976) popularized the concept with his publication of *The Minister as Diagnostician*. Pruyser expanded Draper’s work by constructing a coherent rationale for pastoral diagnosis as a religious practice at the intersection of mental health and ministry. He made a clear distinction between pastoral diagnosis, a function of clergy, and medical or psychological diagnosis. At the same time he gave pastoral diagnosis credibility by inviting it to the case consultation table at The Menninger Foundation. Note how thoroughly Pruyser anchored pastoral diagnosis in clerical bedrock:

Who has ever heard of ministers being engaged in *diagnostic* work?....The pastor will gladly help his people in trouble, benefiting from the diagnosticians, but he will surely not consider himself an expert in diagnosis…What if they want to place themselves in a pastoral-theological rather than a medical, psychiatric, legal, or social perspective? What
if they wanted to be in several professional hands at the same time? [This] would make the pastor a diagnostician of a special kind. (Pruyser, 1976, pp. 9-10)

For Pruyser, pastoral diagnosis was separate from psychiatry or the behavioral sciences. It was firmly tied instead to religion and theology—ministry’s “basic science.” “Rather than imitate medical and psychological methods and categories, the pastor can guide distressed counselees and parishioners into making assessments of themselves in terms relevant to the religious perspectives they share and the implied contract between pastor and counselee.” (Pruyser, 2005, p. 371)

Pruyser broadened the clerical, clinical-pastoral paradigm of the mid 1970’s and provided a systematic analogical connection between the practice of medical psychotherapy and pastoral counseling. This connection legitimized an institutional place for pastoral counseling—the authority to diagnose stands hand-in-hand with the authority to treat. Pastoral diagnosis also came to the institutional foreground of pastoral counseling. Pastoral counselors were now expected to “do” pastoral diagnosis, though concrete standards for this practice were far from universal and generally left to the individual counselor’s or training program’s creative imagination.

Pastoral counseling texts published in the 1980s and 1990s showed two broad diagnostic attitudes. One trajectory never speaks directly of diagnosis. Instead, these texts show how pastoral counselors can use theological reflection to examine a client’s behavior, thought, emotion, and religious location and describe religious or spiritual themes that might be addressed in counseling. Examples include William Oglesby’s (1980) Biblical Themes for Pastoral Care, Archie Smith Jr.’s (1982) The Relational Self, Edward Wimberly’s (1990) Using Scripture in Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
A second trajectory reflects formal diagnostic practices. These typically grew from a correlational model of theological reflection. Clinical and theological sources converged in a diagnostic frame to describe client experience and guide intervention. The pastoral counselor’s task was to assess religious themes, spiritual pathologies, and spiritual dimensions of psychopathology that require treatment. Theological language and spiritual metaphor became tools to observe matches between religious/spiritual problems and problems in living. In its clearest form, discernment relied on a religious diagnostic schema that juxtaposed religious and psychotherapeutic language and produced seamless dual diagnoses and clinical strategies. Several examples show the diversity this trajectory produced. In the 1980’s Carroll Wise brought together ego psychology and theology to propose a set of “…criteria for the purpose of evaluation, criteria that are concerned with ego processes” (Wise, 1980, p. 105), informed by the redemptive atmosphere of pastoral psychotherapy. Wayne Oates’ work straddles the two streams. His early work was clearly influenced by the first trajectory of diagnosis, but his later work, particularly *Behind the Masks* (Oates, 1987) is much more diagnostically sophisticated and comes close to anticipating a clinical theology. In the early 1990s, Valerie DeMarinis (DeMarinis, 1993) constructed an elegant model of pastoral assessment that used feminist developmental psychology and feminist theology to guide diagnosis. Larry Kent Graham (Graham, 1992) engaged liberation theology and family systems theory to build an elaborate, contextual system of pastoral assessment. In the late 1990s, Donald Denton (Denton, 1997) constructed a pastoral diagnosis system that juxtaposes the diagnostic language of the DSM-IV.
with religious issues that frequently arise in pastoral counseling. (For example, a DSM Axis I diagnosis of Adjustment Disorder with Depressed Mood might be juxtaposed with an Axis I Religious Diagnosis of Ethical guilt.) Nancy Ramsay (Ramsay, 1998) provided an approach to pastoral diagnosis that moved beyond traditional categories of pathology to include sensitivity to a broad spectrum of contextual variables. Her approach was a refined and highly conceptual way of reflecting theologically on client assessment, goal setting, and selecting client interventions.

Though the diagnostic systems proposed in this second trajectory are diverse, they all produce the same tensions. All are hierarchical. That is, the client does not have access to psychological and theological knowledge possessed by the professional pastoral counselor. Like medical diagnosis, pastoral diagnosis is a professional activity that rarely invites the client into full participation. This can objectify clients, participate in diagnostic reductionism, support medical and psychological assumptions that oppress clients, and disconnect theological reflection from the broader life of faith communities.

**Contemporary practice**

The notion of pastoral diagnosis has changed substantially since 1965. Most pastoral counselors today would reject both Draper’s and Pruyser’s definitions. First, clerical identity is no longer central to professional pastoral counseling. Very few pastoral counselors practice as parish clergy. Second, few believe with Pruyser that their basic science is limited to religion or theology. Third, pastoral counselors have worked hard for professional parity—the right to practice on equal ground with other mental health professionals. This has shifted their attention away from ecclesial concerns and toward practices required by insurance panels and state licenses. Medical-psychological diagnosis using the Diagnostic and Statistical Manual (now in Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
its Firth Edition) is central to these practices. It is notable that the DSM-IV (1994) provided some interstitial diagnostic space (V-codes) for spiritual issues. Some pastoral counselors interpreted this as making room for pastoral sensibilities in interdisciplinary practice. Others experienced it as medical-psychological colonization of pastoral practice by defining spiritual conflict as a mental disorder. Editors of the new DSM-V paid more attention to and specific definitions for spiritual diagnosis.

While it appears that DSM editors are making increasing space for diagnosis of spiritual issues, pastoral counselors have had little, if any, influence in this medical-psychological process. Spirituality is normalized as a psychological process in ways tangential to historic pastoral theological concerns. Pastoral counselors may offer a useful aesthetic language to describe religious and spiritual contexts, but it is psychiatry (Peteet, Lu, & Narrow, 2011; Sperry, 2001; Verhagen, Van Praag, Lopez-Ibor, Cox, & Moussaoui, 2010) and psychology (Aten & Leach, 2008; Miller, 2000; Pergament, 2007; Shafranske, 2006) that define the norms for spirituality and grant spiritual diagnosis professional legitimacy. Psychiatric colonization of spirituality functionally relegates “pastoral” to a niche market of folk with religious questions.

In sum, a generally accepted descriptive nosology for pastoral diagnosis has not materialized in a way that influences today’s pastoral counselors or the contexts in which they work. Unlike other disciplines, pastoral counselors share no standard of practice for a method called pastoral diagnosis. Seminaries, universities and training programs that teach pastoral diagnosis are diverse and seem to share a common approach. They offer courses based in personality theory, family systems and psychiatric nosology (DSM) augmented by religious and theological reflection on the process of diagnosis, client relationships, and the psychology of Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
religious content. Supervision focuses on accurate assessment of psychopathology and problems in living. Spiritual and religious issues are important contextual concerns that influence pathology and treatment. My own study (Townsend, 2009, 2011) suggests that certified pastoral counselors today rarely use pastoral diagnosis separate from mental health diagnosis as a distinct practice. When they do, pastoral diagnosis is vague and used post hoc to help explain psychiatric diagnosis or enrich the therapeutic relationship. For most, pastoral diagnosis lurks around the boundaries of a niche psychotherapy practice as a “value added” option to conventional psychotherapy practice.

Part II: Hermeneutics of practice

Interview question: “How is pastoral diagnosis important to your practice?”
Pastoral counselor response: “I think it should be very important. I was trained to think diagnostically in two directions—one, psychologically, and two, pastorally. We spent a lot of time thinking through how psychological pathology corresponded with spiritual or theological pathology. Ideally, the two should be integrated. In practice, though, everything seems to rest on psychological diagnosis. Psychologists and social workers on staff don’t really care about pastoral diagnosis—some say it’s just a word game that describes psychological problems in religious language. So, mostly pastoral diagnosis falls by the wayside. My supervisors used to tell me to expect that. The fact that the two are integrated in me informs my treatment.”

At this point I laid this essay aside to consider my ambivalence about pastoral diagnosis. Nine months of brooding resulted in a set of questions, a set of observations about pastoral diagnosis and a proposal for “best practices.”

Questions

Is there a need to say anything at all about “pastoral diagnosis” in 2013? Do pastoral counselors have any real need for such a practice, or is the notion an interesting historical footnote that has little actual impact for most pastoral counselors? In today’s multidisciplinary, multicultural context how would pastoral counselors show that “pastoral diagnosis” is credible, Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
legitimate and not limited to particular theologies, faith traditions or pastoral counselors’ imaginations? Can pastoral counselors offer observable, definable and empirically verifiable data necessary to form a pastoral nosology to name and sort people’s spiritual or religious pathology? Would “pastoral diagnosis” defined any other way have any meaning at all in the medical-psychological context in which most of us work? Is there any particular merit for forming such a system? Will this sort of “diagnosis” help as pastoral counselors seek public voices and interdisciplinary legitimacy?

**Observation: Theological anthropology**

For pastoral clinicians, diagnosis embodies belief about the nature, meaning and situation of persons seeking care. These beliefs guide clinical imagination. They ground causal explanations and suggest curative action. Historically, pastoral counseling has anchored its anthropology in modern or liberal protestant theologies (for example, Paul Tillich, Reinhold and Richard Niebuhr, Emil Brunner, Karl Rahner, and Rudolph Bultmann). Theologian David Kelsey shows that these theologies share a common anthropological theme: They understand humanity primarily through modern theology’s “turn to the subject.” That is, they highlight self-reflective rationality. The human person is a rational, acting subject who becomes fully actualized only by proper self-choosing in an internal struggle with untruth, inauthenticity, despair, or meaninglessness. These theologies are anthropocentric. They are “…exhaustively concerned with human failure, an exclusively intrahuman defect or distortion…that is in need of correction” (Kelsey, 2009, p. 118).

This theological lens provides a powerful analogy for pastoral diagnosis. The Genesis Fall is observed by a rational, knowing God. This God employs divine knowledge to rightly...
diagnose the specifics of human depravity (pervasive sin). Correct diagnosis guides interventions to correct this indelible defect through the Law, the Prophets, the Christ event, the sacraments of the church, and the hope of *parousia*. This theological frame lends authority to a defect-centered approach to counseling and hierarchical practices of diagnosis. Kelsey points out that there is a cost to this theology and its associated practices. Our vision of both God and the human person is truncated. Humans are a problem to be repaired; God is limited to the One who redeems. We miss a far more nuanced and contextual (not to mention religiously plural) understanding of both God and humanity. We miss the mystery that God relates to ALL that exists, and that God values relationship with humans far beyond the limits of defect and repair. More specifically, when human becoming is focused in defect and individual choice, spirit is reduced to freedom and moral choice. This sets the stage for two serious problems: (1) dualism and the notion that all the important stuff in human life (e.g. spirituality) is internal to the human psyche/self’s struggle to overcome inherent defect; and (2) a vision that a struggling human is not fully human (that is, humanity is not actualized) until right choices overcome defects of inauthenticity, despair and meaninglessness. Physical, social and contextual factors are pushed to the margins in favor of self-centered, intrapersonal conflict. Any life-sustaining relationship (with God or another person) that does not directly relate to self-actualization is overlooked. According to Kelsey, these anthropologies tend also to underestimate contextual realities such as one’s location in a material world, one’s relationship to embodied physicality and the powerfully constructive force of social relationships.

These kinds of anthropologies have guided pastoral counseling and pastoral diagnosis. They wear thin, however, in the scrutiny of multicultural awareness, human sciences, and new
philosophical anthropologies. Feminist theologies, liberation theologies, Queer Theology, polydox theologies, and a variety of other postmodern theologies propose far more varied, nuanced and contextual notions of what it means to be human, how self and meaning are constructed, where and how human soul and spirit are located, and how human trouble and alienation are to be understood. These positions require any pastoral practice—including diagnosis—to be accompanied by careful attention to how practices:

- construct or embody a defining theological statement;
- attend to theological and social locations;
- account for individual, cultural, gendered, sexual, ethnic, religious and social class difference; and
- activate culture-specific knowledge (e.g. human sciences) that exerts power over particular human bodies and privileges particular cultural visions of human life and meaning.

Nancy Ramsay (Ramsay, 1998) addressed many of these critical elements in her treatment of pastoral diagnosis. However, she did not go far enough in challenging the practice’s anchor in modern theology, its modern evolution from psychiatric methods, and the meaning-constructing nature of the practice itself. Two examples below illustrate why contemporary pastoral counselors must critically examine any specialized practice of pastoral diagnosis. First, a brief description of Michel Foucault’s analysis of psychiatric power shows how diagnosis is an instrumental mechanism of social control. His work is important for several reasons: it poses a serious challenge to modern anthropological assumptions, it is the foundation for several emerging postmodern theologies, and it is the basis for postmodern approaches to psychotherapy.
(for example, Narrative, Solution-Focused, Collaborative) that now inform many pastoral counselors. A second example rests in contemporary controversy about the DSM-V. This controversy is important because modern notions of pastoral diagnosis structurally mirror psychiatry’s diagnostic practices. Problems arising from psychiatry are likely to be reflected in pastoral counseling practice. Both these examples illustrate how diagnosis is a practice that constructs social meaning and is tied to particular anthropological assumptions, political mechanisms of power, and distinct cultural histories.

**Observation: Foucault’s analysis**

Michel Foucault showed how mental health disciplines are part of a cultural technology of power that constructs norms to define, segregate and classify human experience. Power is created when social discourse forms and accumulates knowledge about a social problem. Those who experience the problem are objectified and examined. This produces a “domain of knowledge” to explain and regulate the bodies and behavior of those identified as problematic (Foucault, Rabinow, Hurley, & Faubion, 1997). For example, psychiatric discourse created knowledge that redefined deviance as illness rather than “criminal,” “possessed” or “delinquent.” This knowledge was set in the context of major social changes between the Middle Ages and modernity.

Perhaps more importantly, Foucault’s analysis unmasked the illusion that “mental illness” was discovered through an objective, incontrovertible scientific process. He showed us instead how mental illness was constructed in response to culturally-specific and questionable social and ethical commitments. Psychiatry (representing the mental health disciplines) claims knowledge to predict and control the social problem of the “madman,” “monster,” “delinquent” Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
and “masturbating child” (Foucault, 2003). Though the notion “mental illness” borrows from a medical metaphor, it lacks foundation in organic, pathological process. Rather, it is a category of knowledge/power that “…has its reality and its value qua illness only within a culture that recognizes it as such.” Mental illness is illness “…only insofar as it is a form of behavior that is not integrated by that culture” (Foucault, 1987, pp. 60, 62). Diagnosis of a mental illness expresses a deception: it keeps us from seeing ourselves in the one locked up or treated. Put another way, psychopathology “…is the final outcome of all that is wrong with a culture” (Henry, 1963).

Diagnosis relies on normalization. This mechanism is political. It defines the center and margins of society. It subdivides social space by constantly observing the difference between those who are normal (healthy) and those who are not (the ill). It works by “…establishing and fixing [individuals]…of assigning places and defining presences….” (Foucault, 2003, p. 46). Normalization creates knowledge and then distributes the power of that knowledge differently based on personal characteristics. Mental health professionals create and exert knowledge/power by discriminating continuously between healthy and pathological individuals, groups, and ideologies. Though their power is expressed as medical knowledge, the norms that create psychopathology are based in deviation from administrative regularity, family obligations and social standards rather than organic pathology. Foucault observed that

…there is a sort of explosion of the symptomatological field that psychiatry undertakes to cover in pursuit of every possible disorder of conduct. As a result, psychiatry is invaded by a vast range of conduct that had previously been accorded only a moral, disciplinary, or judicial status. Any kind of disorder, indiscipline, agitation, disobedience,
recalcitrance, lack of affection, and so forth can now be psychiatrized. At the same
time…psychiatry becomes firmly anchored in a medicine of the body...one that is
cconcerned with all conduct…. (Foucault, 2003, pp. 161-162)

To wield such defining power, psychiatry had to: (1) codify “madness” as illness, (2) establish
norms to pathologize conduct (behavior, thought and emotion), (3) provide a system of
classification (diagnosis), (4) offer explanations for why certain individuals are not (or cannot
be) disciplined to live within norms, and (5) establish protocols for correction. This technology
promised to protect society and lent mental health practice the authority of medical knowledge.³

Foucault’s analysis exposed a truth game: Mental health professionals use socially
constructed knowledge as medical fact to enact social discipline--that is, to correct deviance.
This power relies on three interacting techniques: Hierarchical observation, normalizing
(2008), these techniques of power are focused in “…the doctor [or therapist], the person who
organizes everything and really is in fact…the core of this disciplinary system” (Foucault, 2008,
p. 22). Liberation is promised through the therapeutic relationship. It is a relationship of
subjugation and discipline. The doctor/therapist’s gaze (hierarchical observation) obtains “…an
exhaustive capture of the individual’s body, actions, time, and behavior” (Foucault, 2008, p. 46)
and submits them to normalizing judgment. Central to this gaze is the “examination,” the
codified system of questions and observations that focuses normative judgment, results in
indelible written reports, and offers a schema for a client to “progress” toward “normal.” The
examination accumulates knowledge/power. It transcribes the character of an individual “him” or
“her” into a “case;” it combines into one whole “the deployment of force and the establishment
of truth” (Foucault, 1977, p. 184). By so doing, it justifies and documents placing a body into a cell. This prison image allows Foucault to borrow Jeremy Bentham’s concept of the panopticon to show the penetrating and corrective quality of psychiatric power. While modern mental health practices released those who thought and acted differently from physical chains, Foucault suggested that they were released into a far more powerful and insidious bondage—normalization and the mechanisms of psychiatric power. One could be released from chains, but one cannot easily be released from the totalizing nature of psychiatric power.

Diagnosis is a central player in psychiatric power. It assumes: (1) control of normalizing knowledge; (2) the ability to objectify clients and know them better than they know themselves; (3) the ability to “subjectify” or attribute character to individuals who think, feel or act in particular ways; (4) the knowledge to predict and explain individual differences; and, (5) possession of knowledge to correct deviations from “normal.” Though Foucault’s analysis focuses on mental health practice, he observed that psychiatric power is closely connected to the “pastoral function” of religious traditions, especially in pastoral counseling and guidance (Foucault, 2003, pp. 167-199; 2008, p. 174 ff; Foucault, Gros, Ewald, & Fontana, 2005, pp. 331-412). Pastoral counseling uses the same technologies of power as psychiatry. The “pastoral function” assumes and creates normative knowledge. Pastoral practice employs hierarchical observation and normative judgment through control of doctrine and religious practices. The knowing gaze of the pastor in preaching, teaching and especially counseling and guidance observes and corrects deviation. Most telling are pastoral practices of confession and confidential pastoral conversations which assure social control through ever-present observation and pastoral presence.
Foucault’s analysis shows that diagnosis—pastoral or otherwise—is never benign or unambiguously benevolent. It creates knowledge/power. It imposes precise norms, marginalizes whole classes of individuals and justifies technologies of correction. It is part of a cultural technology of power.

**Observation: DMS-V**

When considering best practices for pastoral diagnosis, the controversies about the new (May, 2013) DSM-V loom large. Work on this manual began in 1999 as a collaborative effort of the American Psychiatric Association and the National Institute of Mental Health. Eight years of research resulted in five further years of committee work to draft new diagnostic criteria. This process highlighted sharp controversies within the psychiatric community about research methodologies, the value and epistemological foundations of classification systems, economic conflict of interest with pharmaceutical companies, political tensions related to any DSM categorization (but especially the DSM-V), and the boundaries and limitations of psychiatric diagnosis. These controversies are complex and passionate (Frances, 2009, 2010b; Phillips, 2010; Sadler, 2010). A brief review of this psychiatric tension helps frame the question of best practices for pastoral counselors.

One leading critical voice in this controversy is Allen Frances, M.D., former chair of the department of psychiatry at Duke University School of Medicine, collaborator on the DSM-III and chair of the DSM-IV revision committee. He voiced deep concern about methodological procedures used to develop the DSM-V, the claim that the new DSM would represent a “paradigm shift” in psychiatric nosology, and how the new manual would influence public health
and psychiatric practices. The heart of much of his critique is centered in the fundamental nature of psychiatric diagnosis. Most branches of medicine rely on a diagnostic system grounded in demonstrable organic etiology, which is then directly linked to specific methods of treatment related to etiology. Psychiatry, however, relies on what Frances describes as a sloppy, primitive classification system grounded solely in symptom description (Frances, 2010a).

Frances defines himself as a critical realist who recognizes that it is necessary for mental health professionals to make interpretive judgments. He also acknowledges that the move from DSM-II to DSM-III was a substantial advance for psychiatry. It reduced psychiatry’s diagnostic reliance on psychoanalysis and pointed toward a revolution of biological psychiatry. Underlying this shift was an assumption that mental disorders were real. They existed “out there” and were available for scientific study. New technologies in neuroscience, imaging, and genetics would finally be able to define the etiologies and pathogenesis (and hence treatment) of mental pathology. Unfortunately, the results of the hoped for psychiatric revolution have been disappointing. Frances points out that biological psychiatry has failed to document the real (biological) existence or explanation for any mental disorder. Schizophrenia, for example, has been the object of intense research for more than 50 years with no evidence of a prototype “schizophrenia” waiting to be discovered. Researchers are not even close to genetic or neurobiological explanations. Instead, schizophrenia appears as a group of disorders—perhaps hundreds—which make defining the “disease” and its boundaries practically impossible and probably arbitrary. The more psychiatry learns about schizophrenia, the more it resembles a heuristic and not a disease. Akil and colleagues (Akil, 2010) make a similar observation about depression. Twenty years and hundreds of millions of dollars of depression research have
produced no major breakthrough in diagnosing or treating depression. Frances draws the following conclusion:

There can be no dramatic improvements in [diagnosis] until we make a fundamental leap in our understanding of what causes mental disorders. The incredible recent advances in neuroscience, molecular biology, and brain imaging that have taught us so much about normal brain functioning are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even 1 [one] biological test is ready for inclusion in the criteria sets for DSM-V. (Frances, 2009, p. 4)

Critical realism leads Frances to conclude that when it comes to defining mental disorders, or the conditions under which people qualify for a mental disorder, we enter a “world of shifting, ambiguous and idiosyncratic word usages. This is the fundamental weakness of our field.” (Frances, 2010a, p. 22) He further suggests that classification of mental disorders will continue to be little more than a collection of fallible limited constructs seeking, but not finding, elusive truth. At best, diagnosis is a call to action with immense and unpredictable outcomes.

A second related concern about the DSM-V is that it introduces a number of new diagnoses and lowers the threshold for several disorders established by DSM-III and IV. Critics insist that proposed new disorders, (such as Psychotic Risk Syndrome, Minor Neurocognitive Disorder and Binge Eating Disorder) and lowered thresholds for disorders such as Attention Deficit/Hyperactivity, Autism Spectrum Disorder and grief-related depression blur boundaries between normal and pathological. By redefining normal variations in thought, emotion, and
behavior as mental illness, the DSM-V will exacerbate an over-diagnosis problem created by the DSM-IV. Critics see three serious potential problems:

- **Redefinition** encourages wholesale imperial medicalization of normality by “…applying the term ‘mental disorder’ to the expectable aches and pains and sufferings of everyday life” (Speigel, 2010). This could be a huge windfall for pharmaceutical companies paid for by false-positive patients who should never have entered the mental health system. Just as important, medicalization implies diminishing tolerance for imperfection and normal variability. It also suggests reduced faith in personal responsibility and human resilience.

- **New diagnoses and lowered thresholds** increase the potential for unintended consequences, particularly false epidemics. Frances points to his own complicity as chairperson of the DSM-IV in creating three false epidemics. (Frances, 2009, 2010a) A seemingly harmless change of a “word or two” about Autism and Attention Deficit Disorder resulted in an epidemic of false positives for both disorders. Adding Bipolar II coalesced with the interest of pharmaceutical companies and became an “enormously popular” diagnosis. Prescription rates for drugs that have serious side effects jumped dramatically, and rates of childhood Bipolar Disorder increased forty fold. A simple editorial change in Paraphilia NOS created a “forensic nightmare” that resulted in extended sentences for sexual offenders. Changes in diagnostic criteria quickly show the political dimension of the diagnostic enterprise.

- **Finally, biological psychiatry** is committed ontologically to the idea that mental pathology exists. It also assumes that there are qualitative differences between mentally
disordered and “mentally healthy” people and between discrete mental disorders. However, without a foundation in biology or organic pathology, mental illness is instead defined by

…what clinicians treat…what educators teach and insurance companies pay for…. [D]iagnostic classification is the result of historical accretion and accident without any real underlying system or scientific necessity. The rules for entry have varied over time and have rarely been very rigorous. Our mental disorders are no more than fallible social constructs (but nonetheless useful ones if understood and applied properly).”

( Frances, 2010a, p. 23)

Critics of the DSM-V point out that these facts necessitate great care (even conservatism) for any attempt to recalibrate thresholds or create new categories of illness. Such action can easily blur the boundaries between normal variation and illness.

Proponents of DSM-V changes respond to critics by vigorously defending the studies, methodologies and procedures that guided thirteen years of DSM-V development. Many claim a “liberal” position that any risk of over-diagnosis is offset by a more inclusive mental health safety net and faster medical response to those developing mental illness or suffering from problems not yet diagnosable.

A striking footnote runs through the DSM-V debates. The most frequent users of all DSM versions are researchers and neophyte psychiatrists and psychotherapists. Full-time experienced clinicians are less likely to see DSM diagnoses as important to treatment, even though such diagnosis looms large for health insurance payment, disability and forensic evaluations, and meeting bureaucratic requirements. In actual practice, a descriptive nosology
that cannot tie disorders to specific social or biological etiological factors has little to offer treatment. Schizophrenia and depression provide examples that resonate throughout the discussion: Nearly a century of research shows that there may be several hundred social and biological pathways leading to any of the schizotypies identified in the DSM-IV-TR, and perhaps an equal number influence any depressive disorder. The most precise description of symptoms says nothing about how a disorder developed; neither does it predict which of a multitude of possible treatments will benefit any individual client.

Six decades of research has shown that psychotherapy is effective. However, that same research also shows that “psychotherapy does not work the same way as medicine….Bluntly put, the existence of specific psychological treatments for specific disorders is a myth” (Duncan, Miller, Wampold, & Hubble, 2010, p. 28). Rather, results show that a wide variety of treatments are effective for any constellation of client problems. Instead of accurate differential diagnosis, the most critical factors for positive outcomes in therapy are (1) a therapist who has a coherent rationale for treatment she or he believes in, (2) a client who accepts this rationale and expects treatment to be effective, and (3) a good working alliance in the therapy relationship. These factors are also active in how and if psychotropic drugs are effective in treating any particular disorder or set of client problems (Sparks, Duncan, Cohen, & Antonuccio, 2010). Taken together, the evidence suggests that therapists must give up belief that clients are carriers of diagnosable illnesses best treated by specific interventions. This is best replaced with a collaborative, contextual approach to therapy that ties therapeutic effectiveness to a remoralizing, resource-enhancing and motivating relationship with a therapist who can be both supportive and challenging. “The therapist’s procedures are important but become effective largely by
contributing to the formation and development of this relationship in the patient’s experience (Duncan et al., 2010, p. xxi).

**Part III: Best practices for pastoral counselors**

*Interview question: “How is pastoral diagnosis important to your practice?”*
*Pastoral counselor response: “I guess I have to be honest. I haven’t thought about pastoral diagnosis for years. I’m not even sure what it means anymore. When I think diagnosis, I think DSM-IV-TR. I try to assess people’s spiritual problems, but if you asked me to ‘pastorally diagnose’ one of my clients, I’d be at a total loss. Is there a manual now that tells you what the diagnoses are and what criteria to use?”*

**Realities**

- Any practice of care or counseling requires some kind of frame to assess problems, guide treatment and observe outcomes.

- If pastoral counselors are to work or be reimbursed for services in North American, medicalized contexts, they must (at least for the foreseeable future) have some expertise in DSM and other psychologically-based diagnostic procedures.

- Pastoral counselors are expected to have something uniquely “pastoral” to offer their clients and interdisciplinary colleagues.

**Proposition**

I now return to one of the questions posed in Section II. Do contemporary pastoral counselors have any real need for a practice called pastoral diagnosis? On one hand, the notion is part of our history. On the other hand, there is no evidence that pastoral counselors today have any substantial interest in investing the time, research, money or collaborative capital necessary to establish a widely accepted diagnostic system with interdisciplinary credibility. Pastoral diagnosis is inescapably linked to psychiatry conceptually and historically. Perhaps more than Sacred Spaces: The E-Journal of the American Association of Pastoral Counselors, 2013, vol.5
psychiatry, which still hopes for biological foundations for its nosology, pastoral diagnosis would always be a system of fallible social constructs lacking any direct relationship to treatment methods. Forty years ago Pruyser (1976) warned pastoral counselors to be skeptical of psychiatric diagnostic systems and avoid emulating them. It is clear today that any such system would be plagued by the same deeply embedded ethical and practical problems that confront contemporary psychiatry. These concerns raise serious questions about whether pastoral counseling, faith communities, clients or the interdisciplinary mental health community would be well served by any system of diagnosis that expands the potential for medicalization of religion or spirituality, particularly in the light of psychiatry’s colonization of spirituality in the DSM-IV and V.

I propose that the time has come to retire the notion of a specialized “pastoral diagnosis” in favor of “pastoral engagement with interdisciplinary diagnostic practices.” There is little to lose in this exchange. There is no evidence that attempts to construct a system of pastoral diagnosis have had much influence on either the field or on therapeutic outcomes. What little evidence we have suggests that few pastoral counselors in practice today claim to use it or claim to know how to do it (Townsend, 2009, 2011). What pastoral counselors do in everyday life is engage with interdisciplinary diagnosis (DSM, family systems, social work, etc.) appropriate to their vocational location. In this space, for better or worse, we pastoral counselors participate in systems of power that act on human bodies, shape human minds, allocate resources of care, and make life-defining distinctions between people. This power works by pathologizing human differences. This, as David Kelsey (Kelsey, 2009) points out, blinds us to multitudes of pathways leading to human flourishing. Best practices for pastoral counselors, then, would be critical.
pastoral engagement with self, clients and colleagues that challenges the truth claims of socially constructed diagnostic frameworks, exposes systems of power expressed in any act of diagnosis, and discloses how diagnostic power works on bodies, minds, spirits, and communities in specific contexts. This engagement takes the shape of a public theological voice that unapologetically asks: (1) how social forces of marginalization, alienation and demoralization participate in any individual diagnosis of psychological, social or spiritual pathology; (2) how this particular diagnosis expresses intolerance for difference and robs meaning from personal experience; (3) how this particular diagnosis obscures, undermines or disguises client resources and strengths; (4) who benefits (personally, professionally, financially) from this particular diagnosis; and (5) what effect will this particular diagnosis have on the client’s flourishing and the well being of his or her community? These questions are also apropos of any pastoral assessment that uses religious or spiritual metaphors, themes or categories to sort client experience and identify religious or spiritual pathology.

Practice of critical pastoral engagement deconstructs misleading truth claims expressed by medicalized care. These claims often obscure pathways to human wholeness. This deconstruction creates space for more hopeful interpretations of human problems and differences that coalesce with what we now know about effective therapy. Clients are not carriers of discrete diagnosable illnesses that warrant precise intervention. Instead, there are many complex paths leading to client problems and there are innumerable paths leading toward human wholeness. Consequently, any act of diagnosis must be assessed for how it participates in stimulating client hope and a remoralizing therapeutic relationship. As best practice, critical pastoral engagement would reject hierarchical assignment of diagnosis by a clinician in favor of full collaboration.
between clients and counselor. This means that pastoral counselors and clients talk about what problems mean in a particular context. Recognizing that any DSM diagnosis are socially constructed interpretations of classes of human experience, counselors work with clients to examine how diagnosis (or a particular diagnosis) will improve her or his life and facilitate a therapeutic relationship. It may be that a diagnosis will allow access to care or medication not otherwise available. It may be that a diagnosis can provide relief by normalizing troublesome experience. It may also be that a diagnosis needed for an insurance claim (or to justify treatment in a particular clinic) may have immense unforeseen consequences for sense of self, marriage, family relationships, future vocational opportunities, or access to public office or religious service. Critical pastoral engagement requires full disclosure and equal access to diagnostic power.

**Conclusion**

Diagnosis is here to stay, at least as long as our culture prefers medicalized explanations of human difference and deviation from social norms. Pastoral counselors must participate in diagnosis if they are to be culturally relevant or survive professionally. However, this participation does not require pastoral counselors to have their own system of pastoral diagnosis that mirrors, competes with, or enhances psychiatric diagnosis. Instead, best practices require pastoral counselors to be vocal colleagues in interdisciplinary contexts. A pastoral voice will engage all practices of diagnosis in a critical way that exposes their immense power, highlights alternative pathways to human wholeness, and advocates for care expressed in positive, remoralizing therapeutic relationships.

References


Historically, pastoral counseling was limited to ordained clergy with specialized psychotherapy training who were endorsed to specialized ministry by their denominations. This clerical description was normative for AAPC certification through the mid-1990s.

One noteworthy exception is psychologist Ken Pergament (Pergament, 2007) who acknowledges consultation with psychologist/pastoral counselor Carrie Doehring. Conversely, psychiatrist Lyn Sperry (Sperry, 2001) laments that pastoral counselors have focused on psychotherapy models to the neglect of religious and spiritual priorities.

Foucault does not dismiss neurological and other organic explanations for some mental symptoms. His analysis does question, for instance, how neurological differences are compared to social norms and interpreted as “normal” or “pathological” rather than “different.” However, he is particularly concerned to show how psychiatric/medical knowledge/power works to classify social and physical deviation (such as homosexuality, opposition to one’s parents, ADDHD, odd thinking, deep emotional swings) as a mental illness with all the unsubstantiated neurological assumptions and social consequences that accompany such a diagnosis.

Bentham proposed that social control could be established by structuring authority and observation. For example, a prison could be built around a central observation tower (a panopticon). This allowed an observer continuously to see every action in every inmate’s cell. Control relied on the fact that inmates would never know when they are being observed and so must act as if they were always observed. Control is distanced from physical restraint and becomes a matter “…of mind over mind.” (Bentham, 1995, p. 95)