INTERNISTS OF THE MIND OR PHYSICIANS OF THE SOUL: DOES PSYCHIATRY NEED A PUBLIC PHILOSOPHY?

by Don Browning

Abstract. Although psychiatry is interested in what both body and mind contribute to behavior, it sometimes emphasizes one more than the other. Since the early 1980s, American psychiatry has shifted its interest from mind and psyche to body and brain. Neuroscience and psychopharmacology are increasingly at the core of psychiatry. Some experts claim that psychiatry is no longer interested in problems in living and positive goals such as mental health, happiness, and morality but rather has narrowed its focus to mental disorders addressed with psychotropic drugs. In view of this trend, psychiatry needs to confront two questions in social philosophy. If it is no longer directly concerned with health and happiness, how does it relate to these positive goals? And how does it relate as a medical institution to religious institutions, schools, and other organizations that directly promote health, happiness, morality, and the purposes of life? It is not enough for psychiatry to renounce its moral role; its practices still shape cultural values. Psychiatry should take more responsibility for developing a public philosophy that addresses these issues.

Keywords: culture; immediate luminousness; William James; Immanuel Kant; mental health; moral fruitfulness; morality; narrative identity; neuroscience; philosophical reasonableness; pragmatism; psychiatry; psychotherapy; public philosophy; religion

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Psychiatry can be viewed as a medical specialty concerned with mental health. Because it is a practice within the general field of medicine, psychiatry justifiably has assumed that a vital link exists between body, mind, and psyche. However, at times in its history psychiatry has tended to

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emphasize either body or psyche as the privileged point of access into its subject matter. Although in this essay I concentrate on psychiatry as it has developed in the United States, I would like to think that it contains insights relevant to other parts of the world where psychiatry has developed along different paths.

Eric Kandel points out that prior to World War II psychiatry in the U.S. had firm roots in biology and experimental medicine. During and after that war, however, psychiatry began to assimilate the insights of psychoanalysis, largely abandoned its biological roots, and started treating mental disorders and somatic illnesses such as hypertension, asthma, and gastric ulcers as consequences of emotional conflicts best addressed through psychotherapy (Kandel 1998, 155, 457). Although Sigmund Freud had separated psychoanalysis from neuroscience by the time he had written *The Interpretation of Dreams* ([1903] 1938), academic psychiatry in the U.S. waited until the decades between 1940 and 1970 to have its romance with the talking therapies that addressed psyche as a distinct realm of emotionally charged meanings.

It is common knowledge that since the early 1980s American psychiatry has again shifted away from the psyche to the brain and body. Neuroscience is increasingly the core of psychiatry. As early as 1985, Jerrold Maxmen in his book *The New Psychiatry* felt compelled to announce that no longer were the psyche, problems of living, and the talking therapies at the center of psychiatry. Psychiatry had narrowed its focus; it had ceased being interested, he claimed, even in mental health. In a footnote commenting on the purpose of psychiatrically run community mental health centers (CMHCs) he asserted that they primarily provide treatment for mental disorders. They do not provide mental health, since nobody knows what mental health is. Certainly a more accurate term for CMHCs would be Community Mental Disorder Centers, but that might not induce anyone to seek their services. Semantics aside, the first-line providers of community mental health are hairdressers and bartenders; only their failures go to the CMHCs (Maxmen 1985, 217). Psychopharmacology that addresses the hard-core mental illnesses, plus DSM-III (*The Diagnostic and Statistical Manual of Mental Disorders*, 3d ed.) diagnostic codes, Maxmen argued, have made psychiatry at once more scientific and more humble. He claimed that the talking cures are only one among a battery of possible interventions, and with regard to their use Maxmen believed that psychiatrists were not better in addressing with psychotherapy the problems of life than psychologists, social workers, or ministers (1985, 20–22). Psychiatrists do not know what mental health is, he contended, and they certainly do not know the purpose of life or the nature of human happiness.

Maxmen may have overstated the directions of the new psychiatry, but if he is reasonably accurate it follows that this medical specialty is left with at least two interrelated quandaries. First, if psychiatry is primarily about

overcoming mental disorders and about neither mental health nor happiness, how does it relate to these more positive goals for living? Second, how does psychiatry as a medical institution relate to other institutions in our society, such as religion and morality, that customarily have specialized in realizing health, happiness, and the purposes of life? It is not enough for psychiatry to renounce responsibility for these areas of life, as Maxmen suggests that it should. As is the case with the other secular professions of law and education, psychiatry in the U.S. has had enormous culture-making power. This is likely true in other modern societies as well.

The frameworks these professions use to conceptualize their practices reflect back onto society, indirectly shaping understandings of life, its goals, and its purposes. For instance, if the legal profession holds that law, like the marketplace, primarily should be ordered by rational-choice economic considerations, a calculative and material view of life may spread to those sectors of society that are touched by lawyers, courts, and legislatures. By analogy, if psychiatric practice reduces psyche to brain and biology, this profession may unwittingly flatten life to these material forces, making both morality and religion difficult to conceptualize. This could happen to some extent even with Maxmen's generous gesture of referring most cases dealing with problems of living to nonmedical psychotherapists. Without developing specific concepts or understandings of health and the good life, how would psychiatry know how to trust the contributions of these other therapeutic resources?

In summary, Maxmen's solution leaves psychiatry without ways to position its work in relation to other conceptualities, institutions, and traditions concerned with positive concepts of health, purpose, and responsibility. In addition, it must be acknowledged that since Maxmen wrote his book psychiatry has not restricted its use of psychopharmacology to the disorders of schizophrenia and clinical depression. All kinds of people in U.S. society suffering from varying degrees of stress are given psychiatric help by altering the functions of their brains rather than by changing their habits and attitudes toward life. Hence, the view of human nature assumed by this intervention may be spreading broadly throughout our society.

The Expansive View of Psychiatry

The expansive view of psychiatry that identified it with psychoanalysis and psychotherapy did have its difficulties. In various ways this view, at least in the U.S., made much of psychiatry into a positive culture with religious and ethical overtones. In retrospect, it is clear that psychiatry was not philosophically prepared to occupy such a vaunted quasi-religious role in our culture as it sometimes did during the 1960s and 1970s.

Philip Rieff's 1966 summary of Freud's view of mental health around the idea of "psychological man" illustrates my point. Skeptical of both the

releases of the id and the loyalties of the superego, or what Rieff called "communities of commitment," psychological man was also both depressed and consoled, according to Rieff, by Freud's near-cosmological theory of the life and death instincts (1966, 117). There were indeed religious overtones in the dual-instinct theory held by the later Freud and his more orthodox followers (Freud 1963a). On the other hand, Erik Erikson's concept of mental health as "generativity" resonated strongly with positive models of moral selfhood found in the teleological tradition of philosophy associated with Aristotle and Thomas Aquinas (Browning 1973).

Furthermore, as I argued in my book *Religious Thought and the Modern Psychologies* (Browning 1987), Erikson saw the comforting love of a parent as something of a metaphor for a deeper cosmological security implicit in the core of experience, especially experience with the family. Object-relations theory in general, with the exception of Melanie Klein, seems riddled with deep metaphors suggesting an ontology of generosity and trust. The later theories of Heinz Kohut (1977) exhibit a similar ontology of trust. For instance, in rejecting Freud's image of life built around the idea of Guilty Man, Kohut believed that his self-psychology implied a view of life he summarized with the concept of Tragic Man. Whereas Guilty Man lives in a world of strife and conflict between the generations, Kohut's Tragic Man lives in a fundamentally harmonious world of mutual self-actualization between the old and the young, a world very similar in feel and tonality to the vision found in the humanistic psychologies of Carl Rogers, Abraham Maslow, and other psychologies of fulfillment (Browning 1987, 223–24). My point here is not to argue for either the validity or the usefulness of any of these concepts but rather to demonstrate how easy it is for psychological and psychiatric concepts to slide over into ethics, ontology, and religion, even when their proponents assume they are stating them in completely neutral terms.

I can imagine shivers of discomfort moving through my psychiatric readers when I ascribe such blatant ethical and quasi-religious horizons to theorists who have so profoundly influenced the history of their profession. I could, however, give even more examples. These writers are full of positive images of mental health and human fulfillment and packed with deep metaphors suggestive of ontologies or worldviews of comfort or discomfort, warmth or coldness, trust or distrust. It is more difficult to avoid this level of thinking in the human sciences than Maxmen thinks. Implicit ontologies of life and views of human fulfillment can sneak into the most ethically and religiously inarticulate theories of human behavior. A psychiatry that claims it attends *only* to how biological functions of the brain shape our moods and behaviors can easily give the impression of saying that "nothing but" neurons and brain cells influence our thoughts and actions. The belief that psychiatry is morally and metaphysically neutral can give rise to a kind of negative normativity—a type of moral and reli-

gious nihilism that can function to set psychiatry at odds with the great fund of Western cultural and religious resources.

As some interpreters have observed, Freud's early attempt to ground psychoanalysis on physiology, currents, excitations, and metaphors of energy implied its own particular view of the mind, purpose, and the meaning of life (Browning 1987, 32–60). Although Freud soon learned that he could not ground a psychology on a strictly biophysical foundation, he was somewhat blind to how the concepts and metaphors of his early energetics continued to shape his psychology and influence his later cosmological dualism between the forces of life and death. Unless psychiatry explicitly states that neuroscience cannot account for all of individual and social behavior, its silence on the additional factors that shape the psyche can imply that there is nothing more. To remain silent is to contribute to reductionism by default.

Psychiatry and Religion

I want to address one prominent aspect of this larger story about the sources of human behavior. This has to do with the religious dimensions of our psychological natures. To narrow psychiatry to psychopharmacology and the diagnosis of mental illness is likely to end in the disparagement of religion as a cultural resource, a defense against mental disorder, or a contributor to mental health. It also is likely to generate an unfounded personal and professional skepticism about religion among psychiatrists. I think that both attitudes are profoundly problematic for the practice and proper social identity of psychiatry. Both engender a stance toward religion that may contribute to alienating psychiatry from the American public as well as the American people from their religiocultural traditions. Rather than encouraging the critical reappropriation of religion, psychiatry in its new scientific narrowing may function to undermine religion and the institutions that traditionally have been its carriers. Psychiatry need not go so far as to attack religion, as did Freud (1961) and some of his followers; it can simply undercut religion by ignoring it and allowing chemical and mechanical explanations of the mind to function as metaphors representing the ultimate or final context of experience—in short, allowing them to symbolize all that there really is, all that counts.

In what follows, I tell a distinctively American story. There is no clear evidence that psychiatry by itself is functioning to alienate Americans from their cultural and religious traditions. There is, however, empirical evidence that American psychiatry's attitudes toward religion have contributed to alienating this profession from a significant portion of the American public. It may be more perception than reality, but the perception appears to be there. Research by psychiatrist David Larson and his associates shows that whereas around 90 percent of Americans believe in God and consider

themselves religious, only 43 percent of psychiatrists hold these beliefs. Even at that, one should observe that psychiatrists in the U.S. are considerably more likely to identify themselves as religious than psychologists and social workers are (Larson, Pattison, and Blazer 1986, 329–34). These statistics point to a significant cultural divide between the entire mental health establishment and the general American population. Furthermore, Larson's team found in a survey of 2,348 articles in four leading psychiatric journals between 1978 and 1982 that only 59 papers contained a quantitative measure of religion and only three treated religion as a major emphasis. They also found that the few articles that did measure religions used weak or static measures—namely, the measure of denominational affiliation. These authors conclude that on the whole "religion has a minimal place in psychiatric theory of behavior." "As a gross generalization," they write, "religion is viewed as a secondary derivative of structural psychic process" (Larson, Pattison, and Blazer 1986, 329–34).

In summary, Larson and his colleagues contend that although American psychiatry has distanced itself from Freudian theory as a major theoretical resource, it still relies significantly on Freud's theory of religion as basically a form of obsessive-compulsive neurosis. In doing so it has tended to disregard alternative and more complicated models of religion found in the work of social scientists such as Erikson, Kohut, Max Weber, William James, Clifford Geertz, and Anthony Wallace. Larson's point is not to pit Freud's view of religion against these thinkers but rather to expose the cultural lag suggested by American psychiatry's adherence to Freud on matters of religion while rejecting him on most other subjects. Recent changes in the DSM-IV that take a more positive view of possible adaptive potential of religious practices (Turner et al. 1995, 435–44) and subsequent work by Larson and others on the contribution of spirituality to mental health suggest that psychiatry in the U.S. may be changing its attitudes toward religion. But anecdotal information suggests that this shift is still in its early stages. Hence, at the level of practical attitude and at the level of scientific research, American psychiatry may be sowing unnecessary seeds of suspicion between itself and large sectors of the population that it hopes to serve. Larson and his group believe that this may explain the rise of alternative, religiously based systems of mental health delivery such as Christian psychiatry, Christian psychotherapy, spiritually oriented psychological counseling, and specialized pastoral counselors. People may be searching for mental health providers whom they can trust at the spiritual level.

Larson's study, doubtless well known to the general psychiatry community, has now joined with those of other researchers dedicated to assessing the health benefits of religion. These investigations, still in their infancy but increasingly more sophisticated, should not be ignored by psychiatry in particular and the public in general. If empirical research continues to

show that persons who understand themselves to be religious and who participate in religious institutions also have less depression, enjoy better life satisfaction in their work, have better interpersonal relations, are more generous with their philanthropy, volunteer more of their time, live longer, smoke and drink less or live longer even if they have these habits, psychiatry in the name of promoting health would not want to do anything that would alienate people from religion (Fagan 1996; Larson and Larson 1995; Matthews and Larson 1995). It might instead want to seek practical alliances with religion, especially in the mental health ministries of religious institutions. Of course, as the American Psychiatric Association's Committee on Religion and Psychiatry has shown, the amount of practical service that psychiatrists provide religious institutions in the U.S. is not insignificant in spite of the cultural gulf that may be increasing between psychiatry and the general religious public (American Psychiatric Association 1975). There are reasons to believe that these practical alliances should grow.

A Public Philosophy for Psychiatry

The confusion about psychiatry's relation to religion gives rise to an important question: Does psychiatry need a public philosophy to address this and other issues? The purpose of this public philosophy would be to clarify and communicate psychiatry's self-definition and its relation to various aspects of life, especially to the religious aspects of life. Whether psychiatry is defined narrowly, as primarily concerned with overcoming mental disorder, or broadly, as interested in health and human fulfillment, it must take on the task of locating its specialization in relation to the whole of life and to other spheres of society such as law, ethics, and religion.

The idea of a public philosophy for psychiatry is not a concept I claim to have originated. During the mid-1980s I had the privilege of chairing a task force brought together by the Park Ridge Center in Chicago, Illinois, a research center dedicated to studying the relations of health, faith, and ethics. A group of about twelve psychiatrists, theologians, and historians met together regularly for several years and produced a book titled *Religious and Ethical Factors in Psychiatric Practice* (Browning, Jobe, and Evison 1990). The meetings were concluded by a major conference that issued in another book, *Does Psychiatry Need a Public Philosophy?* (Browning and Evison 1991), containing contributions from such distinguished psychiatrists and scholars as Robert Michels, Thomas Jobe, Thomas Szaz, Edwin Wallace, and James Drane. The idea of a public philosophy for psychiatry included but went beyond a code of professional ethics. Professional ethics governs the specific conduct of psychiatrists in relation to patients, but a public philosophy attempts to define the special focus and limits of psychiatry with reference to other spheres and activities of life. Not everyone at our final conference agreed that psychiatry needed a public philosophy.

Among those who did, however, the image of philosophy became more that of a conversation or ongoing dialogue about a public philosophy than about any one agreed-upon philosophical stance. And most of us concurred that psychiatry's relation to religion should be one of the central concerns of a public philosophy for psychiatry. Religion should be of central concern for a public philosophy for psychiatry for one simple reason: Religion's concern with healing and psychiatry's concern with healing inevitably overlap, and these two great practices will be seen as either competitors or partners, enemies or friends. A public philosophy for psychiatry should articulate, among other things, why psychiatry and religion should be partners and the possible limits of that friendship.

Resources for a Public Philosophy for Psychiatry

What are some resources for a public philosophy for psychiatry? I want to nominate American philosophical pragmatism, enriched by certain insights from European hermeneutic phenomenology, as a possible resource. I nominate this tradition of philosophy not to win the day and stop the philosophical conversation but to illustrate that resources do indeed exist and that their possible contributions can be identified.

I believe that all American psychiatrists are philosophical pragmatists in their hearts, just by virtue of being Americans. For this reason, the views of Charles Peirce, William James, and John Dewey should be easily accessible resources for their work. As was the case with these thinkers, American psychiatrists are interested in how theory impacts experience—specifically how their theories affect patients and the actual practices of psychiatry. Pragmatists tend to view cognitive and moral knowledge as emerging out of the challenges of practice and returning to, and finally being tested by, the realities and constraints of practice.

For the purposes of my argument, I am interested not in philosophical pragmatism in its entirety but specifically in its views of religion, especially the views advanced by James, whose philosophical approach to religion has much to offer psychiatry. James teaches us that it is philosophically more sound to be interested in the consequences of religion than it is to be preoccupied with religion's origins. In "Religion and Neurology," the first chapter of *The Varieties of Religious Experience* (1978), he readily admits that many forms of religious experience seem to be associated with pathological psychological states, developmental disorders, and sexual conflicts. In the days of neuroscience, we have learned that religious experience is associated with measurable changes in the brain. But James claims that the causal factors, which may in part shape the origins of any human experience including religious experience, do not constitute the philosophical grounds upon which the value and truth of that experience can be judged (1978, 31). He calls the view that a religious experience is "nothing but" its lowly origins in developmental conflicts, neurological malfunctioning,

or observable changes in the brain "medical materialism." He found this kind of reductionism quite prevalent in the psychiatric practice of his day (1978, 33); we see both hard and soft forms of it even in our own time.

In contrast to a preoccupation with what Erikson would later call "originology," James approached religion with his own brand of phenomenology. In fact, historical research has now demonstrated that James was a major source for the phenomenological philosophy of Edmund Husserl and the entire European existential-phenomenological movement that Husserl inspired (Stevens 1974; Linschoten 1968). Frequently it has been overlooked that James's pragmatic approach to religion was built on a nonreductive phenomenological beginning point; he simply began his analysis of religion by describing as thoroughly as possible the thick sense of "reality" and "objective presence" that accompanies religious experience (James 1978, 730). He did not overlook the psychological and even neurological conditionedness of religious experience, but he never treated them as exhaustive causal accounts of religious phenomena. Although the full scope of psychodynamic interpretations of religion was not available to James, we can be certain that his pragmatism could have made use of them. But he would not have used psychodynamic perspectives in such a way as to completely reduce religion to them or unseat his first concern to describe religion phenomenologically.

James's first step of generous description did not exhaust his treatment of religion. He was just as interested in assessing the consequences of religious experience as he was in describing it. This is where we see his pragmatism in full force. He located the descriptive or phenomenological moment of handling religion under the rubric of what he came to call *radical empiricism* (1976). James took experience seriously. Experience was not just sense impressions of objects, as Locke defined it; nor was it external reinforcements, as B. F. Skinner viewed it. Experience for James in the radical sense was first of all a complex web of felt meanings.

James's philosophical pragmatism is distinguishable from his radical empiricism. His pragmatism assumed his radical empiricism but was itself actually more concerned with the consequences of our propositions about experiences (1975, 6). In accord with this point of view, James was particularly interested in the consequences of claims, propositions, and interpretations of religious experiences. His radical empiricism allowed him to describe religion nonreductively; his pragmatism made him interested in the practical truth of religion (that is, its web of consequences in enhancing a range of other goods).

James had a threefold test for the value or practical truth of religious experience—"immediate luminousness," "philosophical reasonableness," and "moral fruitfulness" (1978, 37). The immediate luminousness of the experience counts for something in the evaluation of religion; if people claim that their religion enlightens them, this testimony should be taken

seriously as one important aspect of the assessment. The general philosophical reasonableness of the religious claim (its consistency with other commonly accepted states of knowledge) should also be taken into consideration. But moral fruitfulness, his third criterion, is the most important. Here we are asked to weigh "not its origin, but the way in which it works on the whole" (1978, 39). In James, phenomenology and functionalism are joined. The concern to describe experience nonreductively (the phenomenological move) and the concern to access how the experience functions in individual and communal life (the functional move) are held together in his thinking. This happens because of his insistence that a religious experience not be reduced completely to its associated conflicts, pathologies, human needs, human wants, or correlated brain states.

What, more specifically, does moral fruitfulness mean? In making the moral a partial judge of the religious, James took a step in the direction of Immanuel Kant and most of modern liberal thought about religion. But because he held moral fruitfulness in tension with immediate luminousness and philosophical reasonableness he did not reduce all evaluation of religion to the moral point of view, as Kant probably did. In addition, James had a much richer concept of the moral than did Kant. James saw ethics as guiding the actualization of fundamental psychobiological needs. But because humans have more needs, both high and low, than can be easily organized with one another, a society's ethical systems order them so that the more enduring ones are held supreme and our individual needs are expressed in ways that are compatible with the needs of others.

This last concern made justice central to morality for James just as it was for Kant. James, however, advocated a justice that guided the satisfaction of individual needs. In this sense, justice in James helps actualize individual health. By the same token, health for James is never completely disconnected from justice or allowed to trump it. The religious experience of individuals should be evaluated not by its origins but by its consequences, and these consequences should be judged by the degree to which they shape the whole moral pattern of a person's life as he lives with others and actively helps self and other justly to fulfill their respective needs.

James's perspective on religion makes sense philosophically, and it can contribute to a public philosophy for psychiatry in its need to articulate its attitude toward religion. It helps answer the charge that one psychiatrist recently made to the senior psychoanalyst in his community who was also a professor in the religion department of a distinguished university. The first psychiatrist said to the second: "You know, of course, that this religion stuff is all garbage." The analyst-professor did not agree, although he was fully aware that on occasion religion can become distorted and demonic. It is one thing for psychiatry to judge the health and moral fruitfulness of particular expressions of religion; it goes far beyond the epistemological competence of psychiatry as a profession, however, to make the metaphysical

judgment that it is all fantasy and the moral judgment that it is all pernicious. James never took that second step.

James's respectful attitude toward religion also makes sense clinically. How so? Both James and Kant could agree that respecting persons gets to the core of moral behavior. Without invoking Kant or James, many modern psychotherapists are aware that respect for persons gets to the heart of psychological cure. Whether one thinks of Freud's description of the therapeutic relation as "evenly hovering attention" (1963b, 118), or Rogers's characterization of the therapeutic relation as mediating "unconditional positive regard" (1959, 208), or Kohut's view of the therapeutic efficacy of empathy (1978), many modern therapists have unknowingly turned Kant's imperative to treat persons as ends and never as means only into a strategy of cure (Kant 1958). But respect must be administered psychodynamically if it is to be more than a vague attitude and become genuinely restorative. For this to happen, respect, unconditional positive regard, or empathy must be shown not just to the abstract person but, as Paul Ricoeur (1992) has argued, concretely with reference to the person's narrative self (the person's identity, or the story that she tells about herself). And, frequently, a crucial aspect of a person's narrative identity is his or her religious experience. Hence, respecting the self of a patient should entail respecting her conscious or unconscious religious identity, even if one later also assesses its consequences in her life.

Narrative Identity and Religion

The idea of narrative identity is a relatively new concept in philosophy. It also can be found in psychoanalytic thinking and in moral psychology. It suggests that a person is defined not only by the abstract qualities of freedom and self-transcendence, as Kant contended, but also by the stories or narratives that he tells about himself. This is why one of the most effective ways to show respect for another is to allow him to talk about himself, to tell his story. For vast numbers of Americans, as well as people throughout the world, religion is a conscious part of that story, even if they are not participants in religious institutions. Robert Fuller's book *Spiritual but Not Religious* (2001) shows how the deinstitutionalization of religion does not necessarily lead to its disappearance. People often are spiritual even though they may not be involved in institutional religion. Psychiatry must know when it should listen to that religious story of its patients, describe it phenomenologically as James suggested, but also trace its consequences, which sometimes are productive but sometimes not.

If we take the work of Ana-Maria Rizzuto seriously, religion is unconsciously part of everyone's narrative identity. Rizzuto in her *The Birth of the Living God* has argued that all people construct images of the divine during childhood that are complex syntheses of parental and sibling internalized images (1979, 200). Some individuals repress these images and

disconnect them from culturally mediated images of the divine. This may be especially prevalent in more secular societies. These persons think that they are atheists or agnostics when at the unconscious level they still carry images of their childhood God. Others later in their lives bring these primitive images into interaction with the classic images of the divine mediated by a society's enduring religious institutions (1979, 208). In many instances, these are the persons whose religious identities mature and function to guide them to both healthy and morally responsible living.

Rizzuto's insights into how our unconscious images of the divine can interact with culturally mediated images are consistent with the views of James. Both treat these cultural images phenomenologically, just as Ricoeur treats phenomenologically what he calls cultural "figures of the spirit" that most of us carry in our psyches (Ricoeur 1970, 468). In fact, Rizzuto and Ricoeur both surpass James in their capacity to hold together in dialectical tension psychodynamic interpretations and phenomenological descriptions of religious experience. In doing this, they make a further contribution to a public philosophy for psychiatry in its relation to religion. Rizzuto and Ricoeur do not reduce all religion to our unconscious projections, but they help us see how our culturally mediated religious ideas and practices often embellish and redirect childhood religious ideation.

In this connection, we also should note the work of James Jones in his *Contemporary Psychoanalysis and Religion* (1991). Building on the work of Winnicott and Kohut as well as Rizzuto, Jones argues for a relational, or what I would call a dialectical, view of religious experience in which the projected needs of the individual and culturally mediated images of the divine are both allowed to have a voice in the psychiatrist's interpretation. Although Jones in this book makes little use of either James or Ricoeur, there is in his treatment of religion a place for both phenomenological respect and psychodynamic insight.

Psychiatry needs a public philosophy, or at least an ongoing conversation about such a philosophy, and this should, among other tasks, provide frameworks for psychiatry's relation to religion. This may sound like an obligation that an overburdened profession might prefer to let pass. But if such a conversation would give psychiatry a more positive relation to its culture and help smooth access to its services, the effort to create such a conversation and develop such a philosophy would be well worth the effort.

NOTE

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