

The Resurrection of Jesus: A Clinical Review of Psychiatric Hypotheses for the Biblical Story of Easter

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Abstract

Jesus' resurrection to bodily life after death by crucifixion is foundational to orthodox Christianity. The disciples had encounters with Jesus after his crucifixion which caused them to believe he had been bodily resurrected to life again. Psychiatric hypotheses have been proposed as naturalistic explanations for his disciples' beliefs, which include hallucinations, conversion disorder, and bereavement experiences. Since they propose hallucinatory symptoms that suggest the presence of underlying medical pathology, clinical appraisal of these hypotheses for the disciples' encounters with the resurrected Jesus is warranted. Psychiatric hypotheses for the disciples' belief in Jesus' resurrection are found to be inconsistent with current medical understanding and do not offer plausible explanations for the biblical story of Easter.

Keywords

Bereavement, conversion disorder, Easter, hallucination, Jesus, resurrection

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Introduction

The death of Jesus by crucifixion and his bodily resurrection are the cornerstones of orthodox Christian faith. Jesus' death is considered a historical fact by a majority of modern scholars.¹ The descriptions of Jesus' crucifixion, recorded in the Gospels by medically uneducated writers, are consistent with modern medical knowledge. Shock, and the complications of progressive blood loss, has become an accepted explanation for the mechanism of Jesus' death among medical writers.²

Jesus' early disciples were convinced that they had seen him again after his brutal death by crucifixion. For them, these experiences served to confirm that Jesus was God's messenger. Such an event and the subsequent meaning were a non-negotiable part of the message they preached, and something for which they were willing to accept torture and death rather than recant.

New Testament historians concur that the disciples experienced *something* that made them believe that Jesus had risen from death to life. The point in question is how to explain the disciples' encounters with the resurrected Jesus.³ The biblical accounts notwithstanding, some scholars seek an alternative explanation for the Easter story of Jesus' resurrection. Among the naturalistic explanations, psychological phenomena have been proposed to account for the disciples' belief in Jesus' resurrection.

Psychiatric hypotheses regarding the disciples' encounters with the resurrected Jesus include a few varieties such as: (1) hallucinations, (2) conversion disorder, and (3) bereavement-related visions. These hypotheses, however, are primarily proposed by non-medical writers and found in debates or theological books by New Testament scholars, rather than being subjected to a more appropriate, specialized medical readership. As a result, the analysis of potential medical causes for these hallucinatory symptoms is generally flawed and often absent. Based on a comprehensive Pubmed search of medical literature regarding Jesus' disciples and related topics from 1918 to 2012, psychiatric hypotheses for the disciples' post-crucifixion experiences of Jesus are not to be found in peer-reviewed medical literature. This is noteworthy since these hypotheses propose hallucinatory symptoms which imply an underlying medical pathology. A clinical appraisal of each psychiatric hypothesis for the Easter story of Jesus' resurrection is therefore warranted.

Hallucination Hypotheses

Hallucinations are perceived experiences of one or more physical senses without external stimulus. Origen provides the earliest known literary record of a hallucination

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- 1 Michael R. Licona, *The Resurrection of Jesus: A New Historiographical Approach* (Downers Grove, IL: IVP, 2010), 318.
 - 2 Joseph W. Bergeron, 'The Crucifixion of Jesus: Review of Hypothesized Mechanisms of Death and Implications of Shock and Trauma-Induced Coagulopathy,' *Journal of Forensic and Legal Medicine* 19 (2012):113–116; Frederick T. Zugibe, *The Crucifixion of Jesus: A Forensic Inquiry* (New York: Evans, 2005), 135.
 - 3 Gary R. Habermas, 'Experiences of the Risen Jesus: The Foundational Historical Issue in the Early Proclamation of the Resurrection,' *Dialog: A Journal of Theology* 45 (2006): 288–97.

hypothesis for Jesus' resurrection, proposed by the second-century philosopher Celsus,⁴ who believed that the resurrection of Jesus was the 'cock and bull story' of a 'hysterical female' who 'through wishful thinking had a hallucination due to some mistaken notion.'⁵

A more detailed statement of the hallucination hypothesis was popularized in the 19th century by theologian David Strauss. He did not believe it was possible for a person to revive after being dead for three days and therefore proposed that the disciples, and later Paul, experienced 'hallucinations' or 'subjective visions.'⁶ Strauss concluded, 'Thus the faith in Jesus as the Messiah, which by his violent death had received a fatal shock, was subjectively restored, by the instrumentality of the mind, the power of imagination, and nervous excitement.'⁷

Hallucination hypotheses for Jesus' resurrection have re-emerged in more recent times. Gerd Lüdemann proposed that Peter experienced a visual hallucination of Jesus due to severe grief and mourning. Peter's vision was later followed by similar hallucinations among the other disciples, including group hallucinatory experiences, by a contagious religious ecstasy. Lüdemann believed the disciples were susceptible to such psychological phenomena due to a lack of cultural and intellectual sophistication. To Lüdemann, the disciples' encounters with a resurrected Jesus were a 'shared hallucinatory fantasy.'⁸

Lüdemann similarly proposed a subjective visionary hypothesis for Paul's Damascus road encounter with Jesus (Acts 9:3–6), believing it was the product of religious ecstasy resulting in a self-aggrandizing special revelation. Paul could not distinguish his visual perception from an inner (*psychological*) versus an external stimulus (*physiologic sight*).⁹ Paul used the same Greek word for 'seeing,' *ōphthē* (*horaō*), in referring to his own encounter with Jesus, as he did in describing all the persons mentioned in 1 Corinthians 15:5–8. Lüdemann, among others, therefore generalizes that Paul and Jesus' disciples all had similar hallucinatory experiences.¹⁰ As Paul was not one of Jesus' original disciples, Lüdemann proposes that Paul's hallucination of Jesus was driven by subconscious motivations to assume an exalted position in early Christian leadership.¹¹

On the other hand, James Dunn does not question the validity or intent of the disciples' resurrection reports, believing they are credible descriptions of their experiences and not motivated by deceit. But could the disciples have been deluded in some way? Could Jesus' resurrection appearances have been 'hallucinatory projections ... begotten

4 Gerald O'Collins, *Christology: A Biblical, Historical, and Systematic Study of Jesus* (Oxford: Oxford University Press, 2009), 93.

5 Henry Chadwick, *Origen: Contra Celsum* (Cambridge: Cambridge University Press, 2003), 109.

6 David F. Strauss, *A New Life of Jesus*, vol. 1 (London: Green and Sons, 1879), 414–31.

7 *Ibid.*, 440.

8 Gerd Lüdemann, *The Resurrection of Christ: A Historical Inquiry* (Amherst: Prometheus, 2004), 175–76.

9 Gerd Lüdemann, *The Resurrection of Jesus: History, Experience, Theology* (Minneapolis: Fortress, 1994), 53. Parenthetical italicized comments are added by the authors for emphasis.

10 *Ibid.*, 48–54.

11 Lüdemann, *Resurrection of Christ*, 172.

by hysteria'? Dunn objects, because this kind of explanation requires hypotheses of complex psychological occurrences, making speculative and complicated psychopathologic explanations of the disciples' resurrection encounters with Jesus. As a result, these suppositions are fraught with 'greater improbabilities than is often realized.' He then provides several critiques and charges that these alternatives have failed.¹²

Clinical Considerations of Hallucination Hypotheses

Hallucinations are personal perceptions of objects or events by the physical senses without external stimulus or physical referent. A hallucination is a symptom, not a diagnosis. The presence of hallucinatory symptoms, therefore, mandates consideration of their etiology and the kinds of medical pathology that would account for their occurrence.¹³

Hallucinations can be classified in three types of etiology: psychophysiological, arising from alteration of brain structure and function; psychobiochemical, due to neurotransmitter disturbances; and psychodynamic, arising from intrusion of the unconscious into the conscious mind.¹⁴

12 James D.G. Dunn, *The Evidence for Jesus: The Impact of Scholarship on Our Understanding of How Christianity Began* (London: SCM, 1985), 71–72.

13 Some psychologists espouse theoretical viewpoints regarding hallucination that differ from medical perspectives. Noting that persons without physical or mental illness may have visual or auditory experiences without external stimuli (for example, arising from stress, bereavement, sleep deprivation, etc.), some psychologists hypothesize that hallucinatory phenomena occur in a spectral continuum of phenotypic expression within the general population, affecting normal individuals and to a greater degree those with medical or psychiatric illnesses. Aleman and Laroi reviewed population studies of hallucination prevalence in 'non-clinical' groups. They note that studies report a prevalence of hallucinations in the general population from 10% to 39%. This does not imply, however, that individuals in this population cross-section experiencing hallucinations are free of underlying risk factors or medical pathology. It should be noted that these population studies vary in methodology, reporting, and inclusion and exclusion criteria. Underlying comorbid risk factors or causation for hallucinations are often noted in these studies, which are primarily general population surveys intended to measure gross prevalence of hallucinations often without exclusion of individuals affected by physical or mental illness. As is often the case with population and survey studies, they vary in methodology and scientific quality and are often not directly comparable. Taken together, this kind of varied data does not provide convincing evidence that comparable hallucinations are experienced by both normal and pathologically affected individuals in the general population. Aleman and Laroi admit that the idea that hallucinations are continuous with normal experience is a psychological perspective and a departure from the medical point of view which finds hallucinations discontinuous with normal experience. See A. Aleman and F. Laroi, *Hallucinations: The Science of Idiosyncratic Perception* (Washington, DC: American Psychological Association, 2008) 9, 61–68. (Aleman and Laroi make no mention of simultaneous collective group hallucinations. See below, footnote 19.) While some psychological theories of hallucination may differ from medical perspectives as to the etiology, prevalence, and clinical implications of varied hallucinatory phenomena, this does not affect the premise that hallucinations fail to provide satisfactory explanation for the disciples' post-crucifixion encounters with Jesus.

14 Bryan Teeple, Jason Caplan, and Theodore Stern, 'Visual Hallucinations: Differential Diagnosis and Treatment,' *Journal of Clinical Psychiatry* 11 (2009): 26–32.

Psychophysiological causes of hallucinations can be many. Structural injury to the brain, such as tumors, midbrain strokes, or localized dysfunction of brain structures can cause hallucinations. For example, seizure activity causing irritation of visual association regions of the cortex can cause complex visual hallucinations. Lesions causing deafferentation (loss of input) to visual cortices, as well as brainstem lesions, can be associated with visual hallucinations. Some progressive neurologic disease processes, such as dementia with Lewy bodies and Parkinson's disease can be associated with hallucinations.

Biochemical derangement can cause hallucinations. Delirium is an acute disturbance of consciousness and attention having many potential causes. These include toxicity, drug effects, withdrawal, metabolic disturbances, and infections among others. Hallucinations in delirium are often unpleasant: for example, seeing snakes crawling in the bed. Hallucinogenic drugs, as signified by their drug category name, are also associated with hallucinations.

Mental illnesses, such as psychotic conditions like schizophrenia, can be associated with visual hallucinations. At times, symptoms of psychosis may even include thoughts and hallucinations with religious content. While auditory hallucinations are more common, visual hallucinations can occur and have a greater association with more severely affected patients.¹⁵

It is noteworthy that hallucinations are private experiences. Hallucination hypotheses, therefore, are unable to explain the disciples' simultaneous group encounters with the resurrected Jesus. While some may consider the disciples' post-crucifixion group encounters with the resurrected Jesus as collective simultaneous hallucinations, such an explanation is far outside mainstream clinical thought. What are the odds that separate individuals in a group could experience simultaneous and identical psychological phenomena mixed with hallucinations? This is a *non sequitur*. Concordantly, the concept of collective-hallucination is not found in peer reviewed medical and psychological literature.¹⁶

Without reference to Jesus, Leonard Zusne and Warren Jones hypothesize that group accounts of visual apparitions may be collective hallucinations. However, they assert that a group sense of 'expectation' and 'emotional excitement' definitely would be required.¹⁷ Jake O'Connell describes six collective group visionary

15 Ibid.

16 This is based on Bergeron's comprehensive data base search of the Pubmed and American Psychological Association websites. In agreement with this conclusion, another author and researcher also attested in March, 2009: 'I have surveyed the professional literature (peer-reviewed journal articles and books) written by psychologists, psychiatrists, and other relevant healthcare professionals during the past two decades and have yet to find a single documented case of a group hallucination, that is, an event for which more than one person purportedly shared in a visual or other sensory perception where there was clearly no external referent.' Gary A. Sibcy, PhD, Licensed Clinical Psychologist, Piedmont Psychiatric Center, Centra Health Hospitals, Virginia, USA.

17 Leonard Zusne and Warren Jones, *Anomalistic Psychology: A Study of Extraordinary Phenomena of Behavior and Experience* (Hillsdale, NJ: Lawrence Erlbaum, 1982), 135. But incredibly, Zusne and Jones then conclude, contrary to their own hypothesis, that these groups may not be seeing hallucinations at all! So the 'final answer to these questions has not been obtained yet' (135–136)!

experiences.¹⁸ O'Connell concludes that collective hallucinations, while rare, do occur. He does not find that collective hallucinations adequately explain the disciples' encounters with the post-crucifixion Jesus, however. Characteristics of these collective hallucinations were inconsistent with the biblical accounts of the post-crucifixion Jesus. In other words, collective hallucinations occur when there is a heightened sense of group expectation, not everyone in the group experiences a hallucination, those that do *see* something have different hallucinations from one to another, and the apparitions do not carry on conversations.¹⁹

Furthermore, O'Connell notes that since collective hallucinations require a significant sense of expectation, at least some of the disciples would probably have had apparitions of Jesus in a glorified state. However, no such glorified apparitions of Jesus are present in the narratives. In sum, O'Connell does not find that group collective hallucinations offer a supportable explanation for the disciples' encounters with Jesus after his crucifixion.

After Jesus was crucified, the disciples did not have expectation of his resurrection according to the biblical accounts and were forlorn (Lk 24:10–11, 17, 21), as a majority of critical scholars concede. Further, this is precisely what would be expected in psychological terms among committed friends after a grisly death. As a group, no experiences consistent with collective hallucinations are described nor were the group psychodynamics present to suggest that this occurred. O'Connell seems to agree too. Again, it is important to note that simultaneous identical collective hallucinations are not found in peer-reviewed medical literature, and there is no mention of such phenomena in the *Diagnostic and Statistical Manual of Mental Disorders*.²⁰ As such, the concept of collective hallucination is not part of current psychiatric understanding or accepted pathognomy. Collective hallucination as an explanation for the disciples' post-crucifixion group experiences of Jesus is indefensible.

The implications ascribed by Lüdemann to Paul's use of the Greek word *ōphthē* (*horaō*) seem exaggerated. The text in 1 Cor 15:3–7 is considered almost unanimously by critical scholars to be a very early kerygmatic creedal formula, most likely from the

18 Jake O'Connell, 'Jesus' Resurrection and Collective Hallucinations,' *Tyndale Bulletin* 60 (2009): 69–105.

19 To use the term 'collective hallucinations' in reference to collective group visionary experience seems imprecise. Individuals within a group simply do not 'collectively' experience identical simultaneous hallucinations. Rather, when collective visionary experiences occur, some individuals in the group may experience similar but not identical personal hallucinations. It should be noted that O'Connell even agrees here and makes the point himself. It is worth noting that there are no current scientific data to substantiate the occurrence of identical simultaneous collective group hallucinations. On this point, Michael Licona communicated by email with Aleman and Laroï as to why there was no mention of collective group hallucinations in their book, *Hallucinations: The Science of Idiosyncratic Perception*, to which Aleman and Laroï replied, there was 'very little (scientific) documentation on this topic.' See, Licona, *The Resurrection of Jesus*, footnote 64, 484–485. Also, see above comments by Gary Sibcy, PhD, footnote 16.

20 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC, 2013).

church in Jerusalem, adopted only a few years after Jesus' crucifixion.²¹ Even well-known agnostic New Testament scholar Bart Ehrman freely dates it and other early texts to within one to two years of the crucifixion!²² As such, this creedal tradition almost certainly predates Paul's times of personal interaction with the disciples as a group (Gal 1:16–2:10). Paul himself explains that he received the material from others (1 Cor 15:3) and the consensus position seems to be that it was derived from his direct communication from Peter and James the brother of Jesus in Jerusalem.²³

It seems untenable to suggest that Paul's literary record of the 1 Cor 15:3–7 creed carries some implied clinical insight into the visionary experiences of all persons mentioned in the creed. While *ōphthē* (*horaō*) and similar terms can indicate nonphysical sight or understanding, it far more commonly signifies normal physiologic sight.²⁴ Further, even prominent skeptical scholars agree that, for Paul himself, the relevant texts indicate his belief that Jesus had appeared bodily,²⁵ which would be a peculiar life-long belief had Paul experienced hallucinations instead.

It is also counterintuitive to think that Paul's vision of Jesus arose from a subconscious desire to assume a place in early Christian leadership, as Lüdemann proposes. There is no record to suggest Paul sought a leadership position among the other apostles in the church at Jerusalem, the headquarters of first-century Christianity. Paul also described himself the 'least of the apostles' (1 Cor 15:9). Furthermore, Christian leaders of the period would almost certainly meet with ostracism, personal loss, persecution, and the threat of death. This was well understood by Paul, having previously been a

21 For many details why there is such widespread critical agreement here, see N.T. Wright, *The Resurrection of the Son of God* (Minneapolis: Fortress, 2003), 319.

22 Bart Ehrman, *Did Jesus Exist?* (New York: Harper Collins, 2012), 22, 27, 92–93, 97, 111, 141, 144–145, 155–158, 171–173, 260–263, especially 131–132, 157, 164, 170, 251, 254.

23 See Richard Bauckham, *Jesus and the Eyewitnesses* (Grand Rapids, MI: Eerdmans, 2006), Chapter 11 in particular.

24 Michael Licona has provided extensive documentation of various aspects of this issue, including a survey of more than 1,000 occurrences of this and relevant terms in both Paul and other writers from about the same time, plus discussions of the immediate Pauline contexts and other passages. See Licona, *The Resurrection of Jesus*, particularly 329–33 and 400–37. N.T. Wright takes a related though somewhat different angle, spending nearly 200 pages on Paul's usage alone (see *The Resurrection of the Son of God*, 207–398). Wright's primary contribution may be his documenting of the almost unanimous definition in the ancient world among pagans, Jews, and early Christians alike regarding the meaning of terms such as *anastasis*, *egeirō*, and their cognates, plus evidences of the predominant Jewish view of bodily resurrection. For key summaries, see Wright, *The Resurrection of the Son of God*, xix, 31, 82–83, 200–206, 271–74, 314, 321, 414, 476–79.

25 Four examples of such scholars who nevertheless concede this last point include John Dominic Crossan and Jonathan L. Reed, *In Search of Paul: How Jesus' Apostle Opposed Rome's Empire with God's Kingdom* (New York: Harper Collins, 2004), 6–10, 296, 341–4, Gerd Lüdemann, *The Resurrection of Jesus*, 177, plus Lüdemann's final response in *Jesus' Resurrection: Fact or Figment?* ed. Paul Copan and Ronald K. Tacelli (Downers Grove, IL: InterVarsity, 2000), 151–52, and Dale Allison, *Resurrecting Jesus* (New York: T. & T. Clark, 2005), 321–26.

perpetrator of Christian persecution himself (Phil. 3:6; Gal 1:13). Positions in first-century Christian leadership would not be thought of as means to advance one's religious career or social standing.

The proposed hallucination hypotheses are naive in the light of medical and psychiatric pathognomic considerations. Those suffering illnesses characterized by hallucinations are sick. They require medical and psychosocial support, a structured environment, pharmacological support, and behavioral treatment. Persons suffering from psychosis in Jesus' time, not having the benefit of modern medical treatment, might well be considered lunatics or demon possessed (e.g. Matt 4:24). They would be unlikely candidates to organize as a group and implement the rapid and historic widespread expansion of the Christian religion during the first century.

In considering the possible etiologies of hallucination, we have seen that neither the predominant Jewish view of bodily resurrection nor the situations, actions, and characteristics of the New Testament apostles themselves fit typically observed medical and psychological phenomena. This would especially be the case with those who prior to these appearances did not venerate Jesus as other than a misguided common man, such as Paul and probably James the brother of Jesus thought. Further, if Jesus' tomb had been found empty, as a majority of scholars now concur was the case, this would be an additional factor counting against a purely psychiatric hypothesis for the biblical account of Easter.

Conversion Disorder Hypotheses

Conversion disorders are characterized by genuinely experienced disturbances of bodily function but with symptoms inconsistent with current understanding of neurophysiology and anatomy. Jack Kent proposes that Paul's Damascus road experience of Jesus (Acts 9:3–6) was a conversion disorder. He suggests that Paul's consent to the execution of Stephen, the first Christian martyr (Acts 7:57–59), created inner conflict for Paul. According to Kent, Paul's conflict was further fuelled by his mentor Gamaliel, who recommended that Jesus' followers not be persecuted (Acts 5:34–39, Acts 22:3).²⁶ Kent concludes that Paul's acceptance of Christian faith was a complex psychological occurrence which culminated in Paul seeing and hearing Jesus speaking to him. From this psychologically mediated experience, according to Kent, Paul concluded that Jesus had resurrected from death to bodily life and was the Messiah.²⁷

Michael Goulder cites Carl Jung and concurs with Jung that Paul's Damascus road encounter with Jesus was hallucinatory and accompanied by psychogenic blindness. Goulder cites Jung's statement, 'psychogenic blindness is, according to my experience, always due to the unwillingness to see, that is, to understand and realize something that is incompatible with the conscious attitude.'²⁸ Jung believed that Paul could not conceive

26 Jack A. Kent, *The Psychological Origins of the Resurrection Myth* (London: Open Gate, 1999), 54.

27 *Ibid.*, 61.

28 Michael Goulder, 'The Explanatory Power of Conversion-Visions,' in Copan and Tacelli, eds, *Jesus' Resurrection: Fact or Figment?* 94.

of himself as a Christian and, therefore, became blind until his internal conflict resolved, thus leading Paul to Christian beliefs and advocacy.²⁹

To explain the disciples' and Paul's encounters with Jesus as visionary experiences, Goulder coined the term 'conversion visions.' He believes 'conversion visions' arise from events creating emotional forces acting on the psyche, causing an individual to see something subconsciously desired. He cites the religious experiences of others, for example Manson Family member Susan Atkins and the Old Testament prophet Ezekiel, as having experienced similar 'conversion visions.' Goulder admits that what he terms as 'conversion visions' are generally referred to as 'hallucinations' by mental healthcare professionals, but he feels the term 'hallucination' is pejorative and that 'conversion visions' should be distinguished from hallucinations in general.³⁰

Clinical Features of Conversion Disorder

The term 'conversion disorder' is attributed to Sigmund Freud and his understanding of physical or neurological symptoms arising from subconscious conflicts.³¹ In Freudian Psychoanalytic Theory, subconscious conflicts in some cases can be 'converted' to neurological or physical symptoms.³² The term 'conversion' in psychiatric parlance is conceptually unrelated to religious 'conversion.'

29 Carl Jung believed that religious experience and seeing 'spirits' arose from an 'autonomous complex.' Jung theorized that the human psyche was comprised of *complexes*, a complex being a similarly emotionally toned set of connected psychic elements which are often repressed. Paul had unconsciously been a Christian for 'a long time' according to Jung but subconsciously repressed this until it broke into conscious experience (ego-consciousness). This resulted in Paul's visual perception of Jesus and concomitant psychogenic blindness. Paul's physical sight could only return by submission to Christianity. Jung further believed that recurrent repression of this *complex* was the source of Paul's recurrent illnesses referred to in the epistles without diagnostic specification. Jung referred to Paul's bouts of illness as 'psychogenic fits' of repression. See Carl G. Jung, *Contributions to Analytical Psychology* (New York: Harcourt, Brace, 1928), 9, 258–60. However, a more current understanding of psychogenic blindness groups it within the diagnostic category of conversion disorder. Conversion disorder is characterized by suspension or alteration of normal neurological function without identifiable organic cause, and includes psychogenic blindness. Conversion disorder, however, is not associated with hallucinatory phenomena. See Matthew Allin, Anna Streeruwitz, and Vivienne Curtis, 'Progress in Understanding Conversion Disorder,' *Neuropsychiatric Disease and Treatment*, 1 (2005): 205–9. If hallucinations are present in conjunction with conversion disorder, it would suggest an additional pathological process (dual diagnosis).

30 *Ibid.*, 87–96.

31 Josef Breuer and Sigmund Freud, *Studies in Hysteria*, trans. James Strachey (New York: Basic Books, 1957), 206.

32 Freudian psychoanalytic theory considers conversion disorder to arise from involuntary 'conversion' or substitution of physical symptoms to communicate or resolve unbearable psychological conflict or psychic trauma. Earlier monikers of 'conversion reaction' and 'hysterical neurosis' have been replaced by conversion disorder in recent editions of the *Diagnostic and Statistical Manual of Mental Disorders*. While other schools of psychological thought differ in concepts of etiology, the historical descriptions of medical writers leading to current

Conversion disorders are characterized by one or more neurologic symptom, without identifiable medical explanation, and are associated with inciting psychological stress factors. A conversion disorder is twice as likely to affect women than men and is often associated with comorbid mood and personality disorders.³³

Conversion disorders are associated with some kind of psychologically traumatic event. A characteristic example would be that of a mother who finds her child dead from drowning in a creek, causing the mother to become blind without physiologic cause. The clinical course of conversion disorder and prognosis are positive. While symptoms may persist in rare cases, complete spontaneous resolution would be expected within a few days and nearly all cases resolve within 30 days.³⁴

Since Paul's encounter with Jesus was reportedly accompanied by a brief period of blindness, it is understandable that some might think of this as a possible conversion disorder. Paul does not fit the diagnostic profile for conversion disorder, however. Paul clearly states that he had been motivated by religious zeal with no misgivings in his efforts to persecute Christians (Gal 1:13–14). During the time period when Paul was persecuting Christians, he considered himself 'blameless' with respect to Jewish law and tradition (Phil 3:4–6). To suggest, therefore, that watching Stephen being stoned to death (the first Christian martyr, Acts 7:59–60) caused Paul psychological trauma leading to a conversion disorder is unsupported. There is also no suggestion in biblical record that Paul suffered psychological comorbidities that might make him susceptible to experiencing a conversion disorder. Rather, he appears to have been an ambitious intellectual and rising star in the Hebrew religious community of his day. The notion that Paul struggled with severe subconscious conflict cannot be shown through any positive evidence.

It is also noteworthy that conversion disorder is generally associated with a marked lack of distress regarding the patient's symptoms, an emotional demeanor that has been termed '*la belle indifférence*.'³⁵ It is, therefore, inconsistent with the usual clinical presentation of conversion disorder that Paul's radical life-style change from vigorous persecutor of Christians to a prolific writer and advocate of Christianity would result from conversion disorder symptoms. It should also be noted that hallucinations are not part of the diagnostic criteria or clinical features of conversion disorder.³⁶ For Paul to have experienced a conversion disorder and a hallucination simultaneously would be doubly atypical and inconsistent with current psychiatric understanding of conversion disorder.

theories of conversion disorder have been efforts to codify and treat a relatively uniform clinical presentation. Namely, conversion disorder is characterized by involuntary symptoms of deficits or distortion of neurological function or symptoms that suggest a medical condition that is not referable to an organic cause. See Colm Owens and Simon Dein, 'Conversion Disorder: The Modern Hysteria,' *Advances in Psychiatric Treatment*, 12 (2006): 152–57, and Allin, Streeruwitz, and Curtis, 'Progress in Understanding Conversion Disorder,' 205–209.

33 Benjamin J. Saddock and Virginia A. Saddock, *Kaplan and Saddock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry* (Philadelphia, PA: Lipincott, 2003), 647.

34 *Ibid.*, 649–50.

35 Allin, Streeruwitz, and Curtis, 'Progress in Understanding Conversion Disorder,' 205–9.

36 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., 319.

Goulder's proposition that Paul had a 'conversion vision' of Jesus simultaneous with psychogenic conversion disorder-blindness is conceptually divergent from current understanding of conversion disorder. Conversion disorders do not occur *in reverse*. The intense desire to see something either consciously or subconsciously, giving rise to a hallucination, is very different from clinical features of conversion disorder which is characterized by alteration or suspension of neurophysiologic function arising from a psychologically traumatic event causing subconscious turmoil. In Goulder's concept of 'Conversion Vision,' his use of the word 'conversion' seems misplaced since Conversion Vision is not remotely analogous to current understanding of Conversion Disorder. It is noteworthy that the term 'conversion-vision' is not listed in *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.³⁷ Goulder's concept of 'conversion-vision' is not recognized in psychiatric nomenclature or pathognomy.

Bereavement Hypothesis

Grief and bereavement have been proposed as the etiology for the disciples' resurrection encounters with Jesus. In normal grieving, persons emotionally attached to the deceased, most typically a spouse, sometimes even experience visual appearances of the deceased. Such experiences of bereavement are generally not considered pathologic. The term 'hallucination' has been used for visual experiences of the deceased, but visual experiences of this kind are best described otherwise. Since the term 'hallucination' carries the inherent implication of underlying pathological processes, bereavement experiences of this kind are perhaps better termed 'bereavement visions.'

As mentioned earlier, Lüdemann cites Peter's denial of Jesus, his subsequent weeping and deep sense of remorse as signs of bereavement. Peter was unable to successfully mourn according to Lüdemann. Experiencing a vision of Jesus, therefore, helped Peter resolve his mourning as well as formulate his theological beliefs about Jesus.³⁸ Lüdemann concludes that Peter's bereavement vision of Jesus arose from delusional 'wishful thinking' and 'unsuccessful mourning.' Peter's vision enabled him to enter 'the world of his wishes.'³⁹

Kent similarly believes that Jesus' disciples 'experienced grief-related hallucinations or illusions following the traumatic death of their leader.' He notes that various sensory experiences during grief are not abnormal, but they do 'not exist outside the mind.'⁴⁰ Kent considers Mary Magdalene seeing Jesus outside the tomb as 'evidence for grief and not for the physical resurrection of Jesus of Nazareth.'⁴¹ He argues that the biblical accounts of the disciples' resurrection encounters of Jesus were similar to currently recognized bereavement experiences but were exaggerated by the Gospel writers.⁴²

37 Ibid.

38 Lüdemann, *Resurrection of Jesus*, 100.

39 Lüdemann, *Resurrection of Christ*, 165–66.

40 Kent, *Psychological Origins of the Resurrection*, 21.

41 Ibid., 33.

42 Ibid., 48.

Dewi Rees's 1971 survey study reported spouses' subjective experiences of their deceased partner, and provided valuable insight into bereavement in widowhood.⁴³ In his later book, *Pointers to Eternity*, Rees expands the implications of his study, purporting that bereavement experiences can have emotional and even religious significance. Rather than being contradictory to religious beliefs, Rees feels that some bereavement experiences provide spiritual benefit, namely consolation and assurance of Christian faith.⁴⁴ Rees reports that such bereavement experiences can affirm the reality of life after death in general and, to some, even belief in Jesus' resurrection.⁴⁵

Rees acknowledges that there are differences between bereavement experiences and the disciples' resurrection encounters with Jesus but stops short of saying they are distinctly separate. Instead, he proposes that the disciples' encounters with the resurrected Jesus should not be excluded from the genre of bereavement experiences, stating they are comparable in nature. To Rees's thinking, the religious implications of belief in Jesus' resurrection are not diminished, whether or not Jesus experienced a literal bodily resurrection.⁴⁶ Rees admits that bereavement experiences cannot account for the disciples' simultaneous group encounters with the resurrected Jesus.⁴⁷

Clinical Features of Grief and Bereavement

Bereavement may be defined as the state of mourning following the death of a beloved individual. Grief refers to subjective feelings precipitated by the death.⁴⁸

Mourning occurs in stages; the initial stage of shock may last 1–2 months, with resolution of mourning expected in 6–12 months. Visual apparitions may occur, but in the absence of underlying psychotic illness, are recognized as not real. Abnormal or complicated grief can be associated with more intense and persistent mourning. Suicidal ideation and psychotic features can also develop.⁴⁹

Prospective studies of grief reactions are rare. Gurmeet Singh recorded parental interviews immediately after the unexpected traumatic deaths of children in a boating accident, along with interval follow up interviews. Common first-week reactions including sadness, weeping, sleep disturbances, psychomotor slowing were pervasive in the study participants. Denial of the incident, guilt, and blaming were also common. Somatic complaints included achiness, loss of appetite, abdominal discomfort, restlessness, chest tightness, and choking. A *sense of presence* of the deceased was reported by 11% the first week, was

43 W. Dewi Rees, 'The Hallucinations of Widowhood,' *British Medical Journal* 4 (1971): 37–41.

44 Dewi Rees, *Pointers to Eternity* (Talybont: Y Lolfa, 2010), 198.

45 *Ibid.*, 205.

46 *Ibid.*, 193–95.

47 *Ibid.*, 205. After a lengthy analysis, including parallels between apparitions or visions of the dead and the resurrection appearances of Jesus, New Testament scholar Allison still argues that there are also major differences, that both phenomena are real occurrences, and that the former are not some natural hypothesis that explains Jesus' appearances. See his *Resurrecting Jesus*, especially 295 and 333.

48 Saddock, *Synopsis of Psychiatry*, 61.

49 *Ibid.*, 63.

highest at one month at 21%, but had subsided to 4% by six and 12 months. Bereavement visions were not described, merely the sense of presence of the deceased.⁵⁰

Rees's 1971 survey study provided an important contribution to the awareness of bereavement experiences of widowhood. Various experiences of deceased loved ones are now well recognized as non-pathologic occurrences of bereavement. Rees surveyed 293 subjects in Wales; 46% reported bereavement experiences, often occurring for years, but most commonly in the immediate 10 years following the loss of their spouses. The most common description, reported by 46%, was 'feeling the presence' of the deceased spouse. Visual experiences were reported by 14%, speaking with the spouse 11.6%, and tactile experiences being the least common at 2.7%.⁵¹ Tactile experiences were the rarest among bereavement reactions and were often considered disturbing by those experiencing them.⁵²

The proportion who felt they were helped by their bereavement experiences was 68.6%; 25.5% felt they were neither helpful nor unpleasant, while 5.9% found them unpleasant. Most (72.3%) did not disclose their bereavement experiences to others until participation in the study.⁵³

Visual experiences of the deceased were more common in those older than age 40. Speaking with the apparition of the deceased spouse was more common among those beyond the age of 60.⁵⁴ If the grieving spouse attempted to speak with the apparition, the vision would dissipate.⁵⁵

The duration of marriage had a positive linear correlation to the percentage of persons describing bereavement experiences. Thus, the longer the marriage, the more likely it was for the living spouse to have bereavement experiences.⁵⁶ Those having no bereavement experiences and no 'sense of presence' of their deceased spouse often had no desire of such experiences and reported negative life experiences with the spouse.⁵⁷

Naomi Simon surveyed a larger group of 782 individuals whose spouse had died within the preceding six months. Study participants were recruited by advertisement. Participants were considered to have complicated grief experiences if the Inventory of Complicated Grief scores were 30 or more. By this, along with further selection criteria, 288 individuals were identified as having experienced complicated grief reactions. Visual appearances of the deceased in the entire group (782) had a prevalence of 4%, versus 10.8% in the 288 individuals meeting the complicated grief criteria.⁵⁸

50 Gurmeet Singh et al., 'Acute Grief: The First Year of Bereavement,' *Indian Journal of Psychiatry* 31 (1989): 187–95.

51 Rees, 'The Hallucinations of Widowhood,' 37–41.

52 Rees, *Pointers to Eternity*, 177.

53 Rees, 'The Hallucinations of Widowhood,' 37–41.

54 Ibid.

55 Rees, *Pointers to Eternity*, 176.

56 Rees, 'The Hallucinations of Widowhood,' 37–41.

57 Rees, *Pointers to Eternity*, 179.

58 Naomi M. Simon et al., 'Informing the Symptom Profile of Complicated Grief,' *Depression and Anxiety* 28 (2011): 118–26.

Jesus' disciples, having just witnessed the brutal torture and death of their beloved mentor, from current understanding of grief and bereavement, may have initially experienced early phase grief reactions which would include anger, protest, denial, numbness, sobbing, and perhaps abdominal complaints among other emotional or physical symptoms.⁵⁹ Bereavement experiences could have included visions of Jesus, but it definitely would be unexpected that all the disciples would have such visions. Bereavement visions would not have been considered actual or real encounters with a physically living Jesus. Tactile bereavement experiences of the deceased Jesus would have been unlikely and, if experienced, would likely have been considered unpleasant. It is also unlikely that the disciples would have disclosed their bereavement experiences to others, let alone have launched a campaign of widespread public proclamation of Jesus' resurrection based on such illusions of bereavement.

It should not be overlooked that bereavement visions are most common during widowhood after a prolonged congenial marriage, which is not directly analogous to the mentor–student relationship of Jesus and his disciples. It could reasonably be expected, therefore, that bereavement visions among Jesus' disciples would be less prevalent than reports in bereavement literature which is largely based on experiences of widowhood. Specifically in reference to Rees's studies, Gerald O'Collins made the noteworthy observation that bereavement experiences may persist for years, something inconsistent with the disciples' post-crucifixion encounters with Jesus, which were only for a brief period. Additionally, O'Collins noted that the participants in Rees's study made no particular changes in their lifestyles because of their bereavement experiences nor did they publicly proclaim them.⁶⁰ It can be reasonably inferred that bereavement visions are unlike the disciples' post-crucifixion encounters with Jesus.

Another matter concerns the first-century Hebrew culture, where many Jews had a concept of resurrection at the end of time, but it was unheard of to imagine a near-term resurrection from death to physical life.⁶¹ The disciples, therefore, would not have naturally interpreted bereavement experiences as physical encounters with a resurrected Jesus. The premise that bereavement experiences formed the basis for the disciples' belief in Jesus' resurrection is indefensible.

If established historically, there are several other weighty differences which could also distinguish Jesus' resurrection appearances quite significantly from bereavement visions. These distinctions are sufficient to indicate that they are not to be equated. To summarize briefly just a few of these, the empty tomb would show that something quite different had happened to Jesus' body at his death.⁶² Further, if Jesus predicted his resurrection appearances prior to their occurrence,⁶³ which is now considered likely even

59 Saddock, *Synopsis of Psychiatry*, 62.

60 O'Collins, *Christology*, 99.

61 Wright, *The Resurrection of the Son of God*, 205.

62 For a briefer list of some of the stronger historical considerations favouring the empty tomb, see Gary R. Habermas, *The Risen Jesus and Future Hope* (Lanham, MD: Rowman and Littlefield, 2003), 23–24. For the relation between the empty tomb and the appearances of Jesus, see Wright, *The Resurrection of the Son of God*, 706–10.

63 See especially the excellent discussion by Licona, *The Resurrection of Jesus*, 284–302.

among critical scholars, this would point to Jesus' resurrection being an ordered event fitting into a larger, specific theistic context.⁶⁴ Additionally, the earliest list of resurrection appearances in 1 Cor. 15:3ff. alone presents an amazing array of visits to both individuals and especially groups, which is simply unparalleled in the bereavement literature. Lastly, by simple observation, the bereavement experiences actually convince those grieving that the individual is dead; they don't go looking elsewhere for their loved ones! But Jesus' appearances unanimously convinced all who saw him that he was very much still alive and active in the world.⁶⁵

For these and other reasons,⁶⁶ even though some still consider that the bereavement hypothesis points to items such as the belief in the afterlife and that some think that they saw brief glimpses of their departed loved ones, there are so many widely varied differences with Jesus' appearances that to argue that they are analogous events is simply unwarranted. While, even apart from the data, the logical form of this hypothesis itself may indicate some similarities, similarities fail to prove sameness.⁶⁷

Conclusion

The disciples were certain that Jesus rose to bodily life after his death by crucifixion. Their post-crucifixion experiences of Jesus were personal, veridical, and had a clear effect on the psyche of each. These experiences of the resurrected Jesus cannot be reduced to purely psychological phenomena, however. Hallucination hypotheses for the biblical account of Jesus' resurrection are naïve with regard to the complex and varied psychiatric and neurophysiologic pathologies required to produce symptoms of hallucination. Furthermore, hallucinations are personal experiences and the notion that separate individuals within a group could simultaneously experience identical hallucinations is inconsistent with current psychiatric understanding. Conversion disorder hypotheses for Paul's experience, or those of Jesus' disciples, are also quite unlikely and clearly at odds with current medical understanding. Similarly, grief and bereavement experiences do not satisfactorily explain the different quality of the disciples' meetings with the resurrected Jesus. In sum, psychiatric hypotheses offer no acceptable explanations for the individual or simultaneous group encounters of the disciples with the resurrected Jesus.

64 For the world view component here, see Habermas, *The Risen Jesus and Future Hope*, especially Chap. 3.

65 For many other details on these and additional differences, see Gary R. Habermas, 'Resurrection Appearances of Jesus as After-Death Communication: Response to Ken Vincent,' *Journal of Near-Death Studies* 30 (2012): 149–58.

66 After noting four areas of similarity between the bereavement experiences and those of Jesus' followers, prominent theologian Gerald O'Collins also provides a list of seven dissimilarities between the two, including the groups of people who saw Jesus together (228–35). O'Collins declares in conclusion that the latter list 'reveals too many points of difference to be close and illuminating' (228; cf. also 224, 235). See also Gerald O'Collins, 'The Resurrection and Bereavement Experiences,' *Irish Theological Quarterly* 76 (2011): 224–37.

67 Habermas, 'Resurrection Appearances of Jesus as After-Death Communications,' especially 153.

We must conclude, then, that attempts to explain the disciples' reports of Jesus' resurrection by subjective, psychiatric hypotheses are fraught with many difficulties. Ultimately, they prove to be clinically implausible and historically unconvincing. The available data point elsewhere and confirm the earliest reports that the disciples' experiences were not merely psychological but transformative experiences of faith.

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