

## DIAGNOSING EMANUEL SWEDENBORG

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### TWO PERIODS OF SWEDENBORG'S LIFE

**E**manuel Swedenborg (1688–1772), during the first part of his life, wrote prodigiously in science and philosophy as well as serving as a member of the Swedish House of Nobles and as Assessor of Mines. During that time he drew many amazingly accurate scientific conclusions, not proven until years later.<sup>1, 2</sup> In 1743–1744, beginning at age fifty-five, Swedenborg kept a journal of his dreams, reporting the symbolism of some.<sup>3</sup> At one point he reported he saw Jesus Christ face to face and concluded he was called to religious work.<sup>4</sup> Swedenborg left his study of science and subsequently claimed that God had introduced him into the spiritual world where he communicated with angels and spirits for the rest of his life and learned doctrine directly from God.<sup>5</sup> He wrote thirty volumes on religious doctrine and describing those experiences.

Different groups of people, each with its own prior perspective, have drawn different conclusions about Swedenborg's mental status during the events of 1743 and 1744 and beyond. Those who accept his religious writings as a source of appealing, coherent, spiritual principles find it surprising that they have thus far received so little recognition from

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<sup>1</sup> Cyril O. Sigstedt, *The Swedenborg Epic* (New York: Bookman Associations, 1962; reprinted London: The Swedenborg Society, 1981).

<sup>2</sup> Charles G. Gross, "Emanuel Swedenborg: A Neuroscientist Before His Time." *The Neuroscientist* 3: 2 (1997): 142–147. Gross named as Swedenborg's contributions to neuroscience: sensation, movement and cognition as functions of the cerebral cortex, function of the corpus callosum, somatotropic organization of the motor cortex, description of the neural pathway of each sense organ to the cortex, functions of the frontal lobe and the corpus striatum, circulation of the cerebrospinal fluid, and interaction of the pituitary gland between the brain and the blood.

<sup>3</sup> Emanuel Swedenborg, *Journal of Dreams*. Commentary by Wilson Van Dusen; edited by William R. Woofenden (London: Swedenborg Society, 1989).

<sup>4</sup> Swedenborg, *Journal of Dreams* ns. 54–55.

<sup>5</sup> Emanuel Swedenborg, *The True Christian Religion* (New York: The Swedenborg Foundation, 1949), n. 779, p. 339.

students of religion. In their minds, his religious writings are a Divine revelation that unfolds the previously hidden spiritual sense of the Old and New Testaments, constitute the Second Coming, and validate his claim to have been called by God. Some spiritists who have first heard Swedenborg described as a mystic or spiritist have also accepted his work, but from that perspective. On the other hand, some Christian believers, who accept that spiritual events occurred with the Old Testament prophets, Jesus Christ and John, when he wrote the biblical Book of Revelation, consider Swedenborg's doctrines heresy, propounded by one of the false prophets that Christ warned about.

Of particular interest here, however, is the interpretation of yet others, notably mental professionals, who view the experiences that Swedenborg described as spiritual as due to psychosis<sup>6</sup> or, possibly, epileptic seizures.<sup>7</sup> In this point of view, any theistic framework is seen as narrow, with only non-theistic ones assumed to be objective, as demonstrated by the letter from Johnson cited by Talbot.<sup>8</sup> (Both Johnson's<sup>9</sup> and Talbot's articles are reprinted in this issue.)

The question we propose to address here, then, is that of how valid and objective the diagnostic process used to arrive at this conclusion in fact is. To what extent can psychiatrists, psychologists, neurologists or other physicians gauge Swedenborg's mental status? Their perspective certainly adds another dimension to the possible viewpoints on Swedenborg's claims. However, I think their contribution is less authoritative regarding the specific, final answer on this matter than nonprofession-

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<sup>6</sup> Psychosis is a clinical term for "A mental disorder characterized by gross impairment in reality testing as evidenced by delusions, hallucinations, markedly incoherent speech, or disorganized and agitated behavior..."

Insanity is more recently "...a legal rather than medical term denoting a condition due to which a person lacks criminal responsibility for a crime and therefore cannot be convicted of it." *Dorland's Medical Dictionary*; 27th. edition. Elizabeth J. Taylor, editor (Philadelphia: W. B. Saunders Company, 1988).

<sup>7</sup> Elizabeth Foote-Smith and Timothy J. Smith, "Emanuel Swedenborg." *Epilepsia* 37: 2 (1996): 211-218.

<sup>8</sup> Brian M. Talbot, "Swedenborg's Alleged Insanity." *New Church Magazine* (March 1996): 22: 2-28; (May 1996): 23: 2-28; (December 1996): 24: 4-60.

<sup>9</sup> John Johnson, "Henry Maudsley on Swedenborg's Messianic Psychosis." *British Journal of Psychiatry* 165 (November 1994): 690-691.

als may think. As with those other groups, subjective bias enters in, and in fact is a constant concern to professionals in all medical diagnosis and treatment studies. They are well aware that no one is objective and that the best we can do is only to broaden our subjectivity enough that it becomes serviceably close to reality. We will thus review here some of the subjective factors in diagnosis.

## THE DIAGNOSTIC PROCESS

### **Finite limitations and subjective perspective**

A diagnosis is more accurately a diagnostic impression. Diagnosis is open to subjective judgment even in laboratory and pathologic, as well as clinical, examination. We must make judgments, but should recognize that we rarely can say we know all the pertinent facts, particularly about people. We are doomed to prejudgment or prejudice, although, we hope, not viciously or stubbornly. During assessment of a situation an important, additional fact can, and should, change our conclusions, including during medical diagnosis.

Expectation and perspective markedly influence diagnosis. After a previously unknown disease entity is recognized, signs and symptoms that had previously been ignored or attributed to another condition are recognized and seen as representing the new condition. As an example of change in diagnosis, in the United States, at least, manic depressive (bipolar) illness is now diagnosed considerably more for cases that were previously diagnosed as schizophrenia. Before lithium, when the same antipsychotic medications were used to treat both conditions, there was little motivation to distinguish carefully between the two. The discovery of lithium and other medications that treated manic-depressive illness effectively, but not schizophrenia, gave observers motivation to notice the subtleties of mood disturbance, instead of jumping to a diagnosis of schizophrenia every time the more easily noticed paranoid thoughts were seen.

Not being able to examine a patient creates more room for error. Not infrequently a clinician may have one impression after getting a limited or incorrect history from friends or relatives, only to change his or her mind

after examining the patient. Parents can have one assessment after hearing a report from one of their children, until they hear the report from another. Knowing one more fact can have an important effect on a conclusion, perhaps leaving no clear answer. More of that later.

Finite limitations are a universal cause of bias and prejudice. Prejudging is the making of a judgment before all the pertinent facts are known. People must make decisions, but should do so with the recognition we can rarely say that we have all the pertinent facts at the time we make a decision, particularly about human beings. It is our perspective from which we organize what we observe, ignore, and rank as to importance. Subjective perspective and judgment cannot be eradicated from that process.

### **The effect of language**

The English language has many words with implications and connotations of good or bad, whereas another word referring to the same phenomena often has the opposite connotation, such as the words "firm" and "rigid" or "flexible" and "spineless." Using a word such as "hallucination" creates a diagnosis of mental abnormality without going through any diagnostic discipline. The words "experience," "report," or "phenomenon" refer to an event without the secondary implication that mental illness is the cause. The person using judgmental words not only conveys a secondary meaning or judgment, but, worse, may fail to realize the effect such words have on his or her own thinking.

In lectures on psychiatry, psychology or neurology, the speaker will sometimes make the passing comment that mind-body unity has replaced the old idea of mind-body duality. That eliminates the possibility of a spiritual reality as described by Swedenborg. Anyone, psychiatrist, psychologist or not, who accepts that comment, perhaps unthinkingly, can only conclude that Swedenborg's claims were the result of mental illness of some sort. That scientist limits his or her conclusions more narrowly than most religious observers. There are few religious persons who would deny the existence of mental illness in the way that some scientists deny the possibility of spiritual phenomena.

Van Dusen<sup>10</sup> demonstrates an ingenious example of adding a new dimension to the study of mental illness. He carried on conversations with patients' voices as though they were separate individuals as the patient said. The response of the voices came as though they were from separate persons, including conversation that Van Dusen could understand, but the patient could not. He found that about 20% of the patients' voices spoke "in universal ideas and in ways that were richer and more complex than the patient's own mode of thought." It's extremely unlikely that a scientist who dismissed the possibility of spiritual beings would ever think of carrying out such an experiment.

Just as there is no way to prove that a person doesn't have any cancer or other disease, none of the above discussion proves that Swedenborg wasn't mentally or neurologically ill. But professional knowledge adds little to making that decision. The professional only adds to the physical/mental categories possible. The nonprofessional can make the decision essentially as well as the professional. The implication of the claim to have communication with God or spirits does not require professional education. But if Swedenborg was necessarily deluded and hallucinated, so must have been every other religious figure claiming such contact, including the Old Testament prophets, John, the author of the Book of Revelation, and Jesus Christ. Even those who accept the possibility of religious experience must decide which religious figures they will believe. Those decisions are made based on acceptance of the message and what appears logical.

### Well designed studies

Double blind studies of treatments, in which neither the observer nor the patient knows who is getting the real treatment being studied or who the placebo (nonactive pill or treatment), indicate science's recognition that observer bias can distort evidence gathered and the results in a study. Observer convictions of benefit or uselessness will influence how the

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<sup>10</sup> Wilson Van Dusen, *The Presence of Other Worlds* (New York: Perennial Library, Harper Row, 1974), 117–138.

questions are asked and what the patients report. The number of people studied is as large as possible and compared to a group matched for everything possible, such as age, sex and severity of illness. The intent is to have the treatment be the only difference between the two groups. Following the most well designed of studies, the results are then evaluated for probability, not proof. Only if probability is better than one in twenty that the results could have come about by chance, are they felt to indicate significance. Before publication, studies are screened by reviewers for validity of design. And only after other investigators reproduce significant results, are findings felt to be probably valid. After all this, later evidence may prove the conclusions wrong.

### **Importance of probability**

Everything we do is based on our anticipation of the importance and probability of results from our action. Medical and psychiatric diagnoses are also based on probability. How clearly do certain findings indicate a diagnosis or method of treatment? This idea will be discussed in relation to diagnosing Swedenborg.

## **SWEDENBORG'S DIAGNOSIS**

What caused Swedenborg's experiences in 1743 and for the rest of his life? What are the diagnostic possibilities?

In considering Swedenborg's whole life, he does not demonstrate the blunting and inappropriateness of emotional tone and responsiveness to people, the gross disorganization of thought, and the impairment of function associated with schizophrenia. Neither do descriptions of Swedenborg demonstrate the abnormal, exaggerated mood swings and marked disruption of thought and behavior present in bipolar (manic-depressive) illness.

The closest modern diagnosis in DSM-IV, the Diagnostic and Statistical Manual of the American Psychiatric Association,<sup>11</sup> that could fit

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<sup>11</sup> American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. (Washington: American Psychiatric Association, 1994).

Swedenborg is Delusional Disorder, Grandiose Type, which includes delusions of inflated worth, power, knowledge, identity, or that one has a special relationship to a deity or famous person. (A delusion is a false belief that cannot be corrected by reasonable evidence or logic.) Functioning, other than that pertaining to the delusion, must not be obviously impaired or odd, mood disturbance must have been brief. Swedenborg did not demonstrate the usual findings that one discovers when an individual's single psychotic area is opened up, which include agitation, grandiosity, hyperexcitability, hyperactivity and decompensation into floridly incoherent and suspicious thought. He was composed and coherent in his description of his spiritual experiences in his writings. It should be noted that a diagnosis of delusional disorder in Swedenborg's case would be made on the single decision that his claims were delusional. A psychiatrist or psychologist has no more insight into the truth of that than a layman.

### Temporal lobe epilepsy

Johnson,<sup>12</sup> reports that Henry Maudsley, renowned 19th century English psychiatrist, thought that, in addition to what he called acute and chronic mania, Swedenborg may have had several epileptic "fits." An article by Foote-Smith and Smith<sup>13</sup> (reprinted in this issue) proposes the diagnosis of temporal lobe epilepsy (TLE) as the cause of the episodes in 1743 that Swedenborg attributed to Jesus Christ's appearing to him, and to an interictal (between seizures) psychosis that caused his belief that the world of the afterlife was opened to him in order to write a religious revelation. Their thorough and evenhanded article will be examined in some detail to indicate that observers, in this case they and I, can come to different diagnostic conclusions from the same evidence.

The interictal psychosis described by some to occur in TLE is reportedly characterized by lack of mental deterioration over time and the preservation of good affect (emotional tone). It has also been differentiated

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<sup>12</sup> Johnson, "Maudsley." *Brit. Jour. Psych.*

<sup>13</sup> Foote-Smith, "Swedenborg." *Epilepsia.*

from chronic schizophrenia by an absence of schizoid features in the prepsychotic personality and the maintaining of social efficiency.<sup>14</sup> Such people also show organic mental findings, of which there was no known indication in Swedenborg.

Despite Foote-Smith's and Smith's thorough study and apparent respect for Swedenborg, one can draw different conclusions than their assessment and diagnosis. After quoting Hauser et al that the cause of repeated occurrence of seizures is usually "idiopathic" (unknown pathology) or "cryptogenic" (hidden cause), they state, without establishing that Swedenborg had epilepsy, that "This is the case with Swedenborg," which conveys the impression the diagnosis had been demonstrated.

A key part of their diagnosis of TLE is based on Swedenborg's self-reports of his dreams as recorded by him in a private, unpublished journal, the *Journal of Dreams*. The authors state as follows:

Based on his own testimony, Swedenborg had multiple symptoms of TLE, including a characteristic aura, falling, loss of consciousness, convulsions, visual and auditory hallucinations, and trance.<sup>15</sup>

To begin with, the word "aura" is defined as "a...phenomenon that precedes and marks the onset of a paroxysmal attack, such as an epileptic attack."<sup>16</sup> Their use of this word thus already conveys a diagnosis of epilepsy. The authors then cite a description by Swedenborg in the *Journal* that they conclude indicates Swedenborg experienced a generalized tonic-clonic seizure (GTCS).<sup>17</sup> A summary of the subjective sequence of events was as follows: strong shuddering accompanied by noise of thunder repeated several times, sleep, shuddering and thunder, being prostrated on his face while wide awake, words put in his mouth, a hand squeezing

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<sup>14</sup> M. Rayport, S. M. Ferguson, "Psychiatric Evaluation for Epilepsy Surgery." Chapter in *The Diagnosis of Epilepsy*, edited by Simon Shorvon, Fritz Dreifuss, David Fish, and David Thomas (Oxford: Blackwell Science, Ltd., 1996), 633.

<sup>15</sup> Foote-Smith, "Swedenborg." *Epilepsia*, 212.

<sup>16</sup> Taylor, *Dorland's Dictionary*.

<sup>17</sup> Foote-Smith, "Swedenborg." *Epilepsia*, 212-213.



his praying hands, sitting in Christ's bosom, seeing Him face to face, brief conversation about his having a clear bill of health, and wakening with shuddering. That does not appear to me to be the description of a grand mal seizure or GTCS, which may start with a warning aura, followed by a cry, total body spasm for 30 seconds or more accompanied by loss of consciousness and a fall, generalized gross shaking, usually loss of bladder and bowel control, sleep and a gradual return of consciousness. Other than possibly remembering the strange, characteristic feeling of an aura that sometimes occurs just prior to a seizure, the patient afterward reports only such things as having sore muscles (from the spasms of the convulsions), an injury (from a fall not remembered by the patient), a sore tongue or blood on a pillow (from biting his/her tongue). To the best of my knowledge, remembering the fall or convulsion of a seizure eliminates the diagnosis of a GTCS.

Both simple and complex partial seizures of temporal lobe epilepsy and also generalized tonic-clonic seizures can occur in the same patient. However, while a patient experiencing a TLE seizure typically remembers an aura, if it occurs, and the sensory portion of the actual seizure, such as déjà vu, a pervasive color, micropsia or an odor, he or she usually does not remember the generalized doing of some motor activity, called automatism,<sup>18</sup> such as going into a different room or pointlessly moving something. The patient reports being in one place and next finding himself somewhere else. Manford<sup>19</sup> did describe a series of patients with a diagnosis of TLE which included four patients with simultaneous, bilateral clonic movements, with preservation of awareness, during which they could talk.

The hallucinations associated with TLE are described as fragmentary and not coherently progressive,<sup>20</sup> unlike what Swedenborg reports.

The memory deficits that Foote-Smith and Smith describe related to Swedenborg's dreams appear quite compatible with the normal forgetting

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<sup>18</sup> Fritz E. Dreifuss, "Classification of Epileptic Seizures and the Epilepsies." Chapter in Shovron, *Treatment of Epilepsy*, 62-3.

<sup>19</sup> M. Manford, "Clinical localization: Conceptual Problems and Pitfalls." Chapter in *The Treatment of Epilepsy*, 535.

<sup>20</sup> *Ibid.*, 536.

of dreams that occur with most people most of the time. People commonly forget dreams if they don't make a strong effort to remember them immediately on waking.

Regarding the diagnostic importance of the term "double thoughts," more definition is needed. Van Dusen<sup>21</sup> described his own double thoughts, which indicated only to him a struggle to think only of acceptable thoughts. Not uncommonly, people struggling against unwanted thoughts find those thoughts seeming to intrude into thoughts of the opposite. To focus on not thinking of something is to think of it. In support of this possibility, Swedenborg states in his *Journal of Dreams* when struggling against the worst possible thoughts, "The next day I was from time to time in combat and in double thoughts and strife."<sup>22</sup> At another place, paragraph 158, in the *Journal*, Swedenborg states, "When I thought on Jesus Christ, there came in at once godless thoughts."

Foote-Smith and Smith acknowledge that the association of characteristic interictal (between seizures) or post-ictal behavioral clinical findings in patients with TLE, is controversial. However, as noted by Rayport and Ferguson,<sup>23</sup> and Trimble,<sup>24</sup> many investigators of TLE have reported apparent association of various psychiatric conditions, including psychosis. It seems highly unlikely that the few episodes considered by Foote-Smith and Smith to be seizures would cause delusions and hallucinations for the remaining twenty-seven years of Swedenborg's life.

### **"Behavioral correlates" of TLE**

The authors report Bear and Fedio's description of eighteen behavioral correlates found in some patients with TLE and conclude that Swedenborg clearly manifested eight: emotionality, elation, humorlessness, hypersexuality, aggression, sadness, religiosity and hypergraphia.

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<sup>21</sup> Wilson Dusen, Commentary in Swedenborg, *Dreams*.

<sup>22</sup> Swedenborg, *Dreams*, n.168.

<sup>23</sup> Rayport, "Psychiatric Evaluation." *Epilepsy*, 632.

<sup>24</sup> M. R. Trimble, "Psychiatric Disorders in Epilepsy." Chapter in *The Treatment of Epilepsy*, 337-344.

If one assumes that Swedenborg's conclusion that he was communicating with God is correct, the emotionality, elation, and even sadness over his unworthiness would be appropriate. Neither emotionality nor humorlessness seem equivalent to a description of Swedenborg cited by the authors as "always contented, never fretful or morose" and generally considered pious, sober, dignified, tranquil and measured. Those emotions were associated only with his episodes, and not ongoing, interictal characteristics.

Evidence of hypersexuality appears weak. A review of Swedenborg's *Journal of Dreams* reveals that all of his reports of sexual events in those dreams were brief, matter-of-fact and without any indication of hypersexual preoccupation. When he did elaborate, he commented only that the particular occurrence probably represented changes in his spiritual state and growth or symbolized his relationship to his studies and writing.

Swedenborg's occasionally blunt criticisms of other religious ideas, were directed at what he described as false doctrines and beliefs. They appear to fall quite short of the characteristics described by Bear and Fedio as aggression—overt hostility, rage attacks, violent crimes and murder.

The authors state that Swedenborg showed hyper-religiosity and hypergraphia as behavior characteristic of TLE. Swedenborg stated he had strong preoccupation with God and religion from childhood. His unusual amount of writing began years before 1743, the year of his first suspected seizure. Therefore neither hyper-religiosity nor hypergraphia began interictally. One would have to postulate the unlikely possibility that Swedenborg had TLE from childhood sufficient to affect his psyche without interfering with his education and life, or of being observed. As stated above, it is also unlikely that a few supposed seizures between 1743 and 1744 would permanently produce a psychosis in Swedenborg for the remainder of his life.

All this is not to attack Foote-Smith and Smith in their endeavor to elaborate what, to them, seems to be an appropriate diagnosis. However, in diagnoses subjective judgment often differs among observers. To this observer, the diagnosis of TLE or other neurologically-induced seizures does not seem substantiated.

### Johnson on Maudsley's diagnosis

Johnson in his article,<sup>25</sup> states that Henry Maudsley, a renowned British psychiatrist (1835-1918), based his pathography and diagnosis of Emanuel Swedenborg on the biography of White.<sup>26</sup> Talbot (this issue) raises significant questions from other reports about some of the supposed incidents reported by White.

### Talbot's work

Talbot's article demonstrates the most useful method of study for anyone interested in assessing Swedenborg's life and mental status. His exhaustive search gathers reports on Swedenborg's behavior, some of which appear to refute other damaging vignettes, such as that reported by Johnson. He shows evenhanded consideration and skepticism of all material available to him. He acknowledges his Swedenborgian perspective and that he has not been able to find all the pieces of the puzzle. Such an approach in evaluating all his facts and their implications is more important in coming to correct conclusions about Swedenborg's condition than the conclusion of the most accomplished psychiatrist, psychologist or physician that is based on limited or incorrect knowledge or prejudgment. Johnson in his letter to Talbot, as reported by Talbot, dismisses the view of someone as biased because he is a Swedenborgian. There are few believers in religion who would deny that mental illness exists. Who is more biased in an inquiry such as this, the person with a religious perspective who acknowledges the possibility of mental illness, or a scientist who has previously concluded that there is no spiritual realm or God?

## CONCLUSION

If a diagnosis were to be assigned to what we know of Emanuel Swedenborg, it would appear closest to delusional disorder. (Monoma-

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<sup>25</sup> Johnson, "Maudsley." *Brit. Jour. Psych.*

<sup>26</sup> *Ibid.* referring to W. White, *Emanuel Swedenborg, His Life and Writings*. (London: Simpkin, 1867).

nia<sup>27</sup> is no longer used, but similar.) Making that diagnosis does not require professional training. It merely means someone has decided that Swedenborg's ideas were crazy and that he experienced visual and auditory hallucinations. It should be noted that his continued functioning and reported equanimity even while discussing his supposed florid delusions and hallucinations, is unusual even for delusional disorder. The perspective of a psychiatrist is to look for signs of mental illness and organize them according to the current system of classification. DSM-IV has no diagnosis for "rare, but normal" or "religious revelator."

Looked at only from the scientific perspective, which eliminates what is not physically observable from its scope of inquiry, one can only conclude that Swedenborg had a mental illness. This materialist point of view is presently pervasive. Reportedly even most academic departments of philosophy, which supposedly study "the processes governing thought and conduct" and the "theory or investigation of the principles or laws that regulate the universe and underlie all knowledge and reality"<sup>28</sup> eliminate God and religion as one foundation from which to consider reality.<sup>29</sup> As science has postponed death, we have decreasing emotional need to believe in God and a spiritual realm. From an intellectual standpoint, the fantastically dynamic complexities and order of nature, found increasingly with each new discovery, would appear to suggest a probability that an intelligent God created it. If God created nature and man, it is quite reasonable that He would establish religious revelation. Yet the above scientific and philosophic assumptions require a diagnosis of mental illness in revelators such as the Biblical prophets or Swedenborg.

Talbot's implied need for a psychiatrist familiar and/or trained in transpersonal psychology and altered states of consciousness occurring outside the boundaries of mental illness to give input about Swedenborg is valid. My lack of such knowledge is a deficit in this inquiry.

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<sup>27</sup> Defined as "a mental disorder characterized by irrationality on one subject." *Webster's New Twentieth Century Dictionary*, Unabridged. Second edition; editor Jean L. McKechnie (USA: William Collins + World Publishing Company, 1977).

<sup>28</sup> *Ibid.*

<sup>29</sup> Barry Stroud, "The Charm of Naturalism." *Proceedings and Addresses of the American Philosophical Association* 70: 2 (November 1996): 43–55.

Even if the cause of the events in 1743, 1744 and afterward in Swedenborg's life was spiritual, one would expect that a physical mechanism would have to have been present in the brain to carry out the spiritual process. In the future, science will likely find physical changes in the brain accompanying the type of experience Swedenborg had. However, the key question is likely to remain unprovable: does a spiritual cause create the effect in the brain, or a physical cause create the mental effect?

At this time, the best answer regarding Emanuel Swedenborg's mental state must come from a careful assessment of his writing, further gathering of as many valid facts as possible about his life, recognizing perspectives and assumptions, and using logic and judgment. For the New Churchman, evaluating the message takes precedence and sets the perspective for considering the messenger. □