Task Force Report 10

December 1975

Psychiatrists' Viewpoints on Religion and Their Services to Religious Institutions and the Ministry

American Psychiatric Association

Task Force Reports

This is the tenth report in a monograph series authorized by the Board of Trustees of the American Psychiatric Association to give wider dissemination to the findings of the Association's many commissions, committees, and task forces that are called upon from time to time to evaluate the state of the art in a problem area of current concern to the profession, to related disciplines, and to the public.

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Judd Marmor, M.D.
President, APA, 1975-1976

December, 1975

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PSYCHIATRISTS' VIEWPOINTS ON RELIGION AND THEIR SERVICES TO RELIGIOUS INSTITUTIONS AND THE MINISTRY

Report of a Survey Conducted by the APA Task Force on Religion and Psychiatry

Abraham N. Franzblau, Ph.D., M.D., Chairperson and Editor
Angelo D'Agostino, S.J., M.D., Vice-Chairperson
Edgar Draper, M.D.
Merritt H. Egan, M.D.
William N. Grosch, M.D., M.Div.
Emanuel M. Honig, M.H.L., Rabbi, M.D.
Ana-Maria Rizzuto, M.D.

Approved for publication by the Council on Professions and Associations (1975-1976)

Ruth I. Barnard, M.D., Chairperson
William R. Sorum, M.D.
Robert S. Garber, M.D.
Warren Williams, M.D.
Loren H. Roth, M.D.
Martin Booth, M.D. (Consultant)
Henry Brackin, Jr., M.D. (Assembly Liaison)
Donald W. Hammersley, M.D. (Staff Liaison)

American Psychiatric Association
1800 Eighteenth Street, N.W.
Washington, D.C. 20009

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THE BACKGROUND OF THE RESEARCH PROJECT

ABRAHAM N. FRANZBLAU, Ph.D., M.D.*

Although there have been a few surveys of services rendered by psychiatrists to religious institutions, the survey herein reported is the only one ever conducted under the auspices of the American Psychiatric Association.

In 1966, the Bureau of Applied Social Research of Columbia University sent out an extensive questionnaire to 1,850 psychiatrists in New York City, under the aegis of Dr. John M. Cotton. The Bureau received 960 responses. Basically, it was a "study of Catholic psychiatrists in comparison with non-Catholic psychiatrists and with other Catholics."

In 1967, one of our own Task Force members, Dr. Emanuel M. Honig, made a postcard survey of the membership of the Southern California Psychiatric Society (897 postcards sent out, with 322 returns) asking about interest in working with clergy or religious organizations in a consultative or teaching capacity, and whether and how such service was actually rendered. About three-quarters were both interested and currently involved in such work.

In the same year, there was considerable discussion in APA components and within what was then the Committee on Religion and Psychiatry of what functions the Committee might usefully serve. At this time, Dr. Bernard H. Hall was Chairman, succeeding Dr. Earl A. Loomis, who served from 1956-1961 and Dr. Bernard L. Pacella from 1962-1965. At a meeting held November 3, 1967, in New York City, the writer, by then a member of the Committee, "outlined four areas wherein the psychiatrist fits into general religious activity: teaching at theological schools; screening applicants to theological schools and seminaries; treating mental health problems of seminarians and faculty; providing feedback to psychiatry from theologians about areas which affect psychiatric practice . . ."

One of the decisions made at this meeting was that "a survey of

*Preceptor in Psychiatry, The Mount Sinai Hospital, New York, Dean and Professor of Pastoral Psychiatry (Emeritus), Hebrew Union College-Jewish Institute of Religion, New York.

psychiatrists be made to determine how many members of the APA are involved in some kind of work with religious groups." This effort turned out to be the major focus of the Committee (later converted into a Task Force) in the years thereafter. This report is the culmination of seven years of work.

In 1968, a questionnaire was drawn up for possible distribution to the entire APA membership, covering all aspects of participation of psychiatrists in work with religious institutions, as well as their personal attitudes and beliefs on many relevant matters. This was reviewed and revised by all members of the Committee, and submitted to the staff of APA for implementation; but the problem of cost, as well as other considerations, prevented the project from being completed. Many outside of the Committee doubted whether a questionnaire on this subject would elicit enough interest among the APA membership to justify the effort and expense.

In the same year, when the present Chairman was appointed by Dr. Lawrence W. Kolb, Dr. John M. Cotton strongly urged that the Committee persist in its effort to elicit the desired information, and obtained the help of Dr. John J. Lally, who had been in charge of the Columbia University research on Catholic psychiatrists in New York City, in 1966. New questionnaires were devised, but these, too, failed to win necessary support. Nevertheless, the Committee did not cease to try.

Finally, the APA Manpower Commission agreed to include one question in its *U.S. Census of Psychiatrists—1970*, a 32 page questionnaire. That question was "Do you provide training, therapy, screening or other psychiatric services for any religious institution? Yes— No—." The questionnaire was sent to all APA members, as well as to all AMA members who had indicated "psychiatry" as their sub-specialty, even though they were not APA members. In all, 25,329 questionnaires were distributed, and almost 18,000 responses were received.

It was our optimistic expectation that perhaps three or four hundred APA members might answer "Yes" to our question about whether they provide any kind of psychiatric services to religious institutions. To our complete amazement, the number of "Yes" responders totalled 2198! This answered the question which we had asked for many years, "Is there a need for a Committee on Religion and Psychiatry?" The fact that 12.5% of APA members rendered some kind of psychiatric services to religious institutions proved that we had uncovered an important and sensitive relationship between psychiatry and religion. The next step was to ask our computers to

report out who and where these psychiatrists were. The results are reported herein as Phase I Results.

To answer the next questions, about what kinds of services psychiatrists render, to what kind of institutions, under what auspices, and in what degree, as well as how they do what they do, a further questionnaire survey of the 2198 "Yes" responders was clearly essential. With the help of Dr. Walter E. Barton, then Medical Director of APA and valued counselor to the project, three major steps were taken:

First, The Committee on Religion and Psychiatry was constituted the "Task Force on Religion and Psychiatry (Psychiatric Involvement in Religious Activities)" to undertake this task.

Second, the formulation of a suitable questionnaire was undertaken, to be sent to the 2198 "Yes" responders (hereafter called "providers") requesting full information as to what they do for the religious institutions which they serve, how they do it, and what teaching, research, bibliographic or other materials they have generated in the process. This constituted Phase II of the research.

A bold innovation was to include in the new questionnaire a page entitled *Confidential Information*, which requested personal data about the responders' religious education, that of their children, their church attendance, and their viewpoint as to theological and ritual matters.

Some provision was made for financing the distribution and analysis of this questionnaire, but without the assistance of Dr. D'Agostino's seminarians and staff members at his Center for Religion and Psychiatry of the Psychiatric Institute Foundation of Washington, D.C., who gave countless hours of dedicated service to the research, the task could never have been completed. The total cost of the research, as a result, was almost negligible, as compared with the cost of the analysis of the rest of the data from the U.S. *Census of Psychiatrists—1970.*

Third, in order to determine how the responses of the 2198 providers of services to religious institutions compared with those of "non-providers" on the matters included in the page on *Confidential Information* dealing with religious attitudes and practices, the Task Force was authorized to circularize about 500 unselected APA members who had answered "NO" to the Phase I question on whether or not they render psychiatric services to religious institutions. These were to serve as "controls" as to whether the "providers" constitute a typical or atypical group within the membership of the APA. (A copy of the letter which was sent out to these 500 "non-providers" is included herein.) The number of responses was 259 (52%).

The first publication of the Task Force on Religion and Psychiatry was the "1972 National Directory of Providers of Psychiatric Services to Religious Institutions," a 50-page listing of all "providers," giving their names, addresses, and geographical area, and this was distributed to all 2198 providers, as well as to all APA District Branches, to many theological institutions, and to inquiring individuals.

This Report contains all of the relevant findings resulting from analysis of the Phase I and Phase II survey. It also includes comparison of "providers" and "non-providers," made possible by the "control study" of 500 unselected APA members not affiliated with religious institutions. Since our data from the *U.S. Census of Psychiatrists—1970* contained information about the religious preference of most of those who responded, it was possible to analyze our data differentiating as to the religion of the "providers" and "non-providers," with intriguing results.

The remaining papers included in this report touch upon various aspects of the research which were felt to have special relevance in the fields of psychiatry and religion. Some of these were presented at the Annual Meetings of the APA, in 1972, 1973, 1974, in a series of evening panels conducted by our Task Force.

It is the hope of the Task Force on Religion and Psychiatry that this Survey will not only prove to be a unique and significant contribution to the field, but will also lead to recognition of the extensive cooperative effort already under way between psychiatry and religion, and to fulfillment of the still greater potentials for the future which clearly exist.

THE PHASE II QUESTIONNAIRES TO PROVIDERS AND NON-PROVIDERS

AMERICAN PSYCHIATRIC ASSOCIATION
TASK FORCE ON RELIGION AND PSYCHIATRY

Abraham N. Franzblau, Ph.D., M.D., Chairperson
Angelo D'Agostino, S.J., M.D., Vice-Chairperson
Edgar Draper, M.D.
Merritt H. Egan, M.D.
Emanuel M. Honig, M.D.
Ana Maria Rizzuto, M.D.

December 1972

Dear Doctor:

You are one of a notable group of 2,198 fellow psychiatrists (13%* out of a total of 17,564 responders in the APA U.S. Census of Psychiatrists—1970) who answered 'Yes' to Question 32, on whether you 'provide training, therapy, screening or other psychiatric services for any religious institutions.'

I currently provide these services: *yes* ☐ *no* ☐

We have been assigned the task of following up your affirmative response with the enclosed questionnaire, which has two objectives:

1. to obtain directly from you, the provider of psychiatric services to religious institutions, a comprehensive picture of the specific kinds and quantities of such services which you render, and
2. to obtain copies of any materials which you use in connection with such services in religious institutions, or which have grown out of it (such as syllabi, bibliographies, research papers, etc.) From those which you send us, our goal is to establish a 'National Clearing House and Library of Resource Materials on Psychiatric Services to Religious Institutions.'

*Note: This figure of 13% is incorrect, and should be 12.5%. It was based on early replies (2160 out of 16,615, or 13%.) When the returns were all in, the total proved to be 2198 out of 17,564, or 12.5%. Unfortunately, the error was not caught in time for this printing.

Your positive responses have made it possible, so far, for us to prepare a 'National Directory of Providers of Psychiatric Services to Religious Institutions,' which is now in press.

If you wish to receive a copy of this Directory, in which your name is listed, CHECK HERE ..

We also hope to present a preliminary report on our findings as to 'who you are' at the next Annual Meeting in Hawaii, in May of 1973. We also plan to have an evening for discussion of the topic 'Psychiatry and Religion' at that meeting, which we hope you will attend.

If you plan to travel to Hawaii and attend this part of the Annual Meeting, CHECK HERE ..

We thank you for your help in this work, and will try to keep you posted as to its results.

We have listed below your name and mailing address as provided to us by the APA records. Please provide any corrections that are necessary.

YOUR SERVICES TO RELIGIOUS INSTITUTIONS, TYPES OF SERVICES RENDERED: CHECK THOSE WHICH APPLY

Please fill in the following, regardless of whether the information is current, or if it applied previously.

1. ☐ TRAINING — List below training courses, seminars, lecturing and other activities which you conduct as a psychiatrist in the religious institutions which you serve. (Omit non-psychiatric activities such as teaching Sunday School, Bible classes, etc.)

TITLES	BRIEF DESCRIPTIONS
1. ______	
2. ______	
3. ______	

2. ☐ THERAPY — Indicate briefly the nature of your activities as a therapist working with religious institutions.

DO YOU DO	Individual therapy?	Yes	☐	No	☐
	Group therapy?	Yes	☐	No	☐
	Special therapy?	Family	☐	Addicts	☐
		Alcoholics	☐	Other	☐
AGE RANGE OF PATIENTS?		Child	☐	Adol.	☐
		20-50	☐	50+	☐

3. ☐ SCREENING — Indicate briefly the nature and extent of any psychiatric screening diagnostic interviews, and the like which you do for religious institutions.

4. ☐ CONSULTATION — Describe briefly the nature and extent of consultation work which you do as a psychiatrist serving religious institutions.

5. ☐ RESEARCH — List below titles and very brief descriptions of research projects on which you have worked in the religious institutions which you serve, and identify the role you have played in each.

Title	Brief Description	Role You Have Played
1.		
2.		
3.		
4.		

6. ☐ OTHER SERVICE (Such as administration, referral source, etc., Please Specify)

IDENTIFICATION OF RELIGIOUS INSTITUTION SERVED

Type of Institution

Theological Seminary or Other Institution training ministers or other religious ☐

Church Supported and/ or Controlled non-theological College or University ☐

Local Church, Parish, Synagog or Other Institution or School under religious supervision ☐

Church Supported and/ or Controlled Hospital, Clinic, Social Agency, Pastoral or Religious Career Counseling Guidance Center ☐

National, Regional or Local Denominational Headquarters, Synod, Diocese, Church Body, etc. ☐

Academic Level

Elementary ☐

High School ☐

College ☐

Graduate School ☐

Professional ☐

None ☐

Other ☐

Other, please specify. ☐ ____________________

Name of Institution ____________________

Street Address ____________________

City ____________________ State ____________ Zip ____________

Religious Denomination ____________________

Your title/status, if pertinent ____________________

Services rendered from (years) ____________ To ____________

Hours per month ____________ Per year ____________

Paid? ____________ Volunteer? ____________

(If additional institutions, please write information below)

CONFIDENTIAL INFORMATION

This information will be held in confidence and, if used, will be presented only in statistical, and anonymous, form.

1. Have you ever had formal theological training?	Yes	☐	No	☐
How many years of training?	One	☐	Two	☐
	Three or more			☐
2. Are you now, or were you ever, a minister of religion?	Yes	☐	No	☐
What is, or was, your status?	Ordained	☐	Lay	☐
	Licensed	☐	Other	☐
3. How frequently do you attend church?	Regularly	☐	Rarely	☐
	Occasionally	☐	Never	☐
Religious Denomination (please specify) ________				
4. Do you have children who attend, or have attended, religious school (i.e. Sunday School, Parochial School)?	Yes	☐	No	☐
Have any of them been confirmed?	Yes	☐	No	☐
5. Are you the child of, or are you related to a clergyman?	Yes	☐	No	☐

6. In each continuum below rate yourself by a check mark

A. Religious Viewpoint:

Theistic	Agnostic	Atheistic

B. Viewpoint on Religious Rituals/Ceremonials:

Generally

Observe	Question	Do Not Observe

The Task Force on Religion and Psychiatry is eager to establish a national clearing house and library of resource materials on psychiatric services to religious institutions.

As a service to colleagues and interested members, please cooperate by sending copies of materials used in connection with your services to religious institutions, such as syllabi, bibliographies, source books, case histories or consultation reports, check lists, research papers and the like.

Carefully label each piece and mail to:

TASK FORCE ON RELIGION AND PSYCHIATRY
1100 TWENTY-SECOND STREET, NW, SUITE 908
WASHINGTON, D.C. 20037

LETTER TO "CONTROL" GROUP WITH REQUEST FOR CONFIDENTIAL INFORMATION

AMERICAN PSYCHIATRIC ASSOCIATION
TASK FORCE ON RELIGION AND PSYCHIATRY

Abraham N. Franzblau, Ph.D., M.D., Chairman	Merritt H. Egan, M.D.
Angelo D'Agostino, S.J., M.D., Vice-Chairman	Emanuel M. Honig, M.D.
Edgar Draper, M.D.	Ana-Maria Rizzuto, M.D.

Dear Colleague:

Please help us.

At the time of the 1970 U.S. Census of Psychiatrists we found over 2,000 of your fellow psychiatrists who said that they do 'provide training, therapy, screening or other psychiatric services for any religious institutions.'

Later we surveyed these same people to determine the type and location of services they were providing. We also asked several questions about their personal religious beliefs.

Now we need a 'control' group of psychiatrists so that we can evaluate the responses of our sample. Would you please help us by completing the following information?

Thank you for your help in this project. This information will be held in confidence and, if used, will be presented only in statistical, and anonymous, form.

1. Have you ever had formal theological training?	Yes	☐	No	☐
1a. How many years of training?	One	☐	Two	☐
	Three or more			☐
2. Are you now, or were you ever, a minister of religion?			Yes	☐
			No	☐
2a. What is, or was, your status?	Ordained	☐	Lay	☐
	Licensed	☐	Other	☐
3. How frequently do you attend chuch?	Regularly	☐	Rarely	☐
	Occasionally	☐	Never	☐

Religious Denomination (please specify)____________________

4. Do you have children who attend, or have attended, religious school (i.e. Sunday School, Parochial School)			Yes	☐
			No	☐
Have any of them been confirmed?	Yes	☐	No	☐
5. Are you the child of, or are you related to a clergyman?	Yes	☐	No	☐

6. In each continuum below rate yourself by a check mark:

   A. Religious Viewpoint:

   ____

   Theistic Agnostic Atheistic

   B. Viewpoint on Religious Rituals/Ceremonials:

   Generally

   ____

   Observe Question Do Not Observe

Please return your completed questionnaire in the enclosed envelope.

REPORT OF FINDINGS

ANGELO D'AGOSTINO, S.J., M.D.*
ABRAHAM N. FRANZBLAU, Ph.D., M.D.

Introduction

In the APA'S *U.S. Census of Psychiatrists—1970*, question 32 asked: "Do you provide training, therapy, screening, or other psychiatric services for any religious institution?"

Out of 25,329 psychiatrists queried (which included all members of the APA, as well as several thousand AMA members who listed psychiatry as one of their fields of medical practice), 17,564 replied. Of this number, 2198 (12.5%) replied affirmatively to question 32, indicating that they are providers of psychiatric services to religious institutions.

This raised a number of questions: Who are these providers? What can we find out about them from the other data accumulated by the *1970 Census*? What do they do for the religious institutions which they serve? (kinds of institutions, types of service, extent, etc.) How do they do it? (methods and materials developed, research findings, papers written, etc.) How do providers differ from non-providers of such services?

To answer these questions, a supplementary questionnaire was sent out to all those who responded affirmatively to question 32. Of the 2198 questionnaires sent out, there were about 1000 usable responses. In addition to questions about the services rendered, questions about the religious beliefs and practices of the responders were included.

In studying the results, comparisons were also made between religious beliefs and practices of the providers and a random selection of members of the APA who do not provide psychiatric services to religious institutions, to whom that part of the questionnaire dealing with religious beliefs and practices was sent out. Four hundred and ninety-seven non-providers were randomly selected from within the area centering around Washington, D.C. to facilitate a prompt

*Clinical Associate Professor, Psychiatry, George Washington University Medical School; Director, Center for Religion and Psychiatry; Adjunct Professor, Washington Theological Coalition.

response and follow up, if necessary, by telephone. Since 259 of the non-providers (56%) responded, a follow up proved unnecessary. The responses of both the non-provider controls and the providers were classified as to the religious identification which they indicated. This made it possible to compare the responses of Catholics, Protestants, Jews, and the "no answer" group on all of the questions dealing with religious belief and practice.

Procedure for Data Processing and Coding

Each of the 2198 questionnaires submitted by the providers was coded onto a 3-card data format by a group of seminarians from the Washington Theological Coalition under the supervision of the Director of the Center for Religion and Psychiatry, Dr. Angelo D'Agostino, and his staff members, who rendered dedicated service to us. Key-punching and tabulation of the cards was done by the Punch Card Data Processing Company of Takoma Park, Md., using their EAM equipment. Except for the key-punching and tabulation done by machine, all other work was done by hand by volunteers to whom the Task Force is greatly indebted.* The tabulation follows.

RESULTS AND ANALYSIS OF PHASE I QUESTIONNAIRE

A National Registry of Providers

The names and addresses of the 2198 providers of psychiatric services to religious institutions, classified geographically, were published in a 50 page booklet which was distributed to all 2198 providers, as well as to all District Branches of the APA, and to many other interested parties. It was hoped that this Registry of Providers would serve as a resource for those seeking to locate psychiatrists in their area who are interested in working, in one capacity or another, with religious institutions.

Religious Affiliation

In the replies to the *U.S. Census of Psychiatrists—1970* questionnaire, more than 11,000 responders indicated their religious preference. Table I shows their replies compared with the distribution

*Note: All raw data, punch cards, charts, and other materials which resulted from this study and which were used in deriving the statistics and tables herein presented are on file at APA Headquarters. They may be consulted on request.

of the various religious groups in the U.S., as well as with the religious preference of the providers of psychiatric services to religious institutions.

TABLE I
RELIGIOUS PREFERENCES

	U.S. POPULATION		APA MEMBERS		PROVIDERS	
	Number	%	Number	%	Number	%
Protestant	131,046,000	63.4	4,701	31.7	874	40.0
Catholic	48,391,000	23.4	2,185	14.7	519	24.0
Jewish	5,824,000	2.8	3,627	24.4	359	17.0
Other	4,463,000	2.1	875	5.9	129	6.0
None Stated	16,986,000	8.3	3,455	23.3	317	13.0
Total	206,710,000	100.0	14,843	100.0	2,198	100.0

Note on Figures Stated Above for Religious Groups

Catholic and Jewish statistics obtained from publications of the respective religious bodies include all "souls," as stated above. Protestant statistics are published as "members," not counting wives and children. These are not comparable with Catholic and Jewish figures, and therefore required adjustment. The above estimate was arrived at in consultation with Protestant bodies. The recent Canadian Census which included a question about religious preference proved our estimates to be sound. "Other" refers to religions other than Catholic, Protestant and Jewish. The "None Stated" category includes all those who did not reply to the question on religious preference. The total, 14,843, was the number of completed questionnaires available to us when we made our hand tabulations, which was less than the total number of responders to the *Census—1970* questionnaire (17,564). The results correspond closely to those published in *The Nation's Psychiatrists—1970 Survey* (APA—1973).

Discussion

The ratio between the number of Protestant psychiatrists and the total number of psychiatrists in the U.S. is smaller proportionately than the ratio between the total number of Protestants in the total U.S. population (31.7% compared to 63.4%). The figures for Catholic psychiatrists show the same smaller proportion (14.7% compared to 23.4%). The number of Jewish psychiatrists is greater proportionately than the number of Jews in the U.S. population (24.4% compared to 2.8%).

Expressed in different terms, for every 100,000 Protestants in

the U.S. there are about 3.6 Protestant psychiatrists; for every 100,000 Catholics in the U.S. there are about 4.5 Catholic psychiatrists; for every 100,000 Jews in the U.S. there are about 62.3 Jewish psychiatrists; for every 100,000 of other religions in the U.S. there are about 19.6 psychiatrists; while for every 100,000 who expressed no religious preference, there are about 20.3 psychiatrists.

Among the providers of psychiatric services to religious institutions, the Protestants constitute less than their proportion in the U.S. population (40.0% vs. 63.4%), but more than their proportion of APA members (31.7%). The Catholics constitute about the same as their proportion in the U.S. population (24.0% vs. 23.4%), but more than their proportion of APA members (14.7%). The Jewish psychiatrists who provide services are many times their proportion in the U.S. population (17.0% vs. 2.8%), but less than their proportion of APA members (24.4%). The providers of "Other" religions were about three times their proportion in the U.S. population (6.0% vs. 2.1%), but about the same as their proportion in the APA (5.9%). A larger proportion of the "None Stated" group are members of the APA (23.3%) than are providers (13.0%) or are represented in the U.S. population (8.3%). Generally speaking, the providers constituted a larger percentage than non-providers in each religious group.

Age, Sex, and Marital Status

There were no significant differences between the providers and the non-providers in age, sex, or marital status.

National Origin

Among providers, a larger proportion were native born (85%) than among non-providers (75%), as might have been expected. In the U.S., all States as well as the District of Columbia and Puerto Rico were represented among the providers. Almost all (96%) of the providers were Caucasian, while among the non-providers 85% were Caucasian and 15% were of other races. The vast majority of seminaries and other religious training institutions are under Caucasian auspices, but there is a large religious population among non-Caucasians, and this raises some questions about the disproportion in these figures.

Medical Schools

The providers studied medicine at a wide range of American medical schools (91), Canadian medical schools (10), and foreign

medical schools (121). American medical schools supplied 83% of the providers while 13% came from foreign medical schools. The figures for non-providers were substantially the same.

Board Certification

Of the providers, 51% are Board Certified, while among the non-providers, only 41% are. Among all APA members, the percentage of Board Certified responders was 47.4%. Evidently, there is a tendency to favor Board Certified psychiatrists in selecting personnel to serve religious institutions.

Specialization

There is no difference between providers and non-providers with respect to their work status and primary areas of specialization in psychiatry. The vast majority spend the largest portion of their time in private practice. Likewise, more than half of their time is spent in direct patient contact, whereas smaller portions are spent in consultation, teaching, administration, or research. While the amount of time spent in community mental health center-type environs versus state mental hospital-type environs was relatively small in both cases, providers spend 40% more of their time in the former and 24% less of their time in the latter. Similarly, in the medical school, providers tended to be more teaching-oriented while non-providers tend to be more research-oriented.

RESULTS AND ANALYSIS OF PHASE II QUESTIONNAIRE: SERVICES RENDERED AND TYPES OF INSTITUTIONS SERVED

Among the approximately 1000 providers who supplied information on the type of institution in which they render psychiatric services, over one-half served a theological training institution, a local church, local education institution, or a non-theological college, in all, a total of 53.0% (21.6%, 22.9% and 8.6%, respectively). The remaining providers of psychiatric services (47.0%), served in guidance centers (27.8%), denomination headquarters (14.4%), or "Other" auspices (4.8%).

The academic level of the institutions served varied from the graduate level to the elementary school level, the majority being institutions of higher learning. Graduate schools were served by 28.5%, professional schools by 24.2%, and colleges by 20.7%, a total

of 73.4%. The rest were of high school (10.9%), elementary school (6.5%) or "Other" level (9.0%), constituting 26.4% in all.

Table II shows the denominations of the institutions served, the religious affiliation of the providers, and the religious affiliation of APA members responding to the *1970 Census*—questionnaire.

TABLE II

INSTITUTIONS SERVED BY PROVIDERS

	Institution Served	Providers	APA Members
Protestant	52.1%	40.0%	31.7%
Catholic	37.5%	24.0%	14.7%
Jewish	7.7%	17.0%	24.4%
Other (or None)	2.7%	19.0%	29.2%
Total	100.0%	100.0%	100.0%

More Protestant and Catholic institutions are served than the religious preference of either the providers or the general APA membership would lead us to expect. Among the Jewish and "Other" groups, far fewer are served than we would expect from the religious preference of either providers or APA members. Clearly religious institutions utilize the services of psychiatrists from other than their own denomination, as needed, and when they are available. The Jewish and "Other" groups evidently provide a reservoir of qualified psychiatrists who can be called upon regardless of denominational considerations.

TYPES OF SERVICE RENDERED

The services rendered by psychiatrists to religious institutions cover a wide range. Likewise, the same psychiatrist may serve in more than one capacity in the same institution.

The average provider serves an average of three areas. The largest area of service was consultation (24.5%), followed by therapy (23.0%), training (20.3%), screening (16.7%), while research and "other" were lowest (15.5%).

Of the therapy done, 52.2% was individual, 20.9% was group, and the remainder (26.8%) included family, addict and alcoholic (about one-half), and "Others."

The age range of those served by psychiatrists in religious institutions was very broad, covering all ages from childhood to the

over-fifty group. The largest group were the 20-50 year olds (39.6%), followed by the over-50 group (25.7%), the adolescent group (23.7%), and the child group (11.0%). These figures include those seen in therapy, consultation, and teaching situations.

TIME SPENT SERVING RELIGIOUS INSTITUTIONS

The 762 providers who answered the question of how many years they had spent rendering psychiatric services to religious institutions gave a total of 6600 years of service, or an average of 8.66 years each. About 250 of the providers had spent between 10 and 20 years rendering such services. If these figures are typical of all 2198 providers, then APA members have rendered almost 20,000 years of psychiatric services to the religious institutions of this country.

The providers were also asked to indicate how many hours a month they devoted to this work. The answers ranged from a few hours to full-time, and the average was 11.5 hours per month, which indicates that their involvement is a significant one as far as time is concerned.

Of the services rendered, 43.6% were on a paid basis, 32.9% were on a volunteer basis, and the remaining 23.5% were part paid and part volunteer.

THEOLOGICAL TRAINING OF PROVIDERS

About 11% of the providers who responded to our questionnaire about their background, beliefs, and practice had themselves taken some theological training. Some 51.5% had the three years or more usually required by seminaries to complete training, 10.3% two years, and 38.1% one year. Some 6.8% regarded themselves as "Ministers of Religion" (51.8% of them "Ordained Ministers," 25.7% "Lay Ministers," and 12.5% are "Licensed Ministers"). Among all providers, 16.1% are related to a clergyman.

PERSONAL RELIGIOUS ATTITUDES AND PRACTICES

In the special questionnaire sent out to all 2198 providers, a page entitled "Confidential Information" was included, which asked questions (see Supplement 1) about whether they had had any theological training and how much, whether they were "ministers of religion," what was their status as such, how frequently they attended church, their personal denominational affiliation, whether their children attended religious school and had been confirmed, and whether they were related to a clergyman.

In addition, each responder was asked to place a check mark to indicate his position on a line representing a continuum on *Religious Viewpoint*, ranging from "Theistic," to "Agnostic," to "Atheistic," and on *Viewpoint on Religious Rituals/Ceremonials*, ranging from "Observe," to "Question," to "Do Not Observe."

Over 900 of the providers answered these questions. Also, the same questions were put to the 497 randomly selected non-providers. The first inquiry of its kind, it is remarkable that such full and frank replies have been received.

In addition to the analysis of the responses as a whole to the various questions of belief and practice, it was possible to separate out the responses according to whether the responders were Protestant, Catholic, Jewish, or of other religions.

THEOLOGICAL VIEWPOINT

Most of the responders to the questions on the "Confidential Information" page (86%) placed their checkmarks squarely on the "theistic," "agnostic," and "atheistic" portions of the line. However, a small number (14%) placed their mark between the stated categories, perhaps indicating some ambivalence. Table III shows the percentages of the squarely marked replies of the providers, the adjusted replies for ambivalence (one-half of each in-between-checked group attributed to the category on each side of it), and the replies of the control group of non-responders.

TABLE III

THEOLOGICAL VIEWPOINTS

	Squarely Marked Replies	Adjusted Replies	Control Group Replies
Theistic	70.3%	74.7%	40.4%
Agnostic	17.1%	21.1%	36.6%
Atheistic	8.2%	8.6%	23.0%

It is clear, first, that adjusting the replies in terms of the ambivalence of the responders produces only very slight changes in the percentages of "theistic," "agnostic," and "atheistic" responses.

Second, the providers of psychiatric services to religious institutions differ markedly from the control group of non-providers in respect to these categories. Almost twice as large a percentage of providers check "theistic" as in the control group, whereas only about one-half the percentage are in the "agnostic" category, and only about one third the percentage of providers place themselves in

the "atheistic" category as among the control group of non-providers. Expressed differently, three-quarters of the provider group designate themselves as "theistic," whereas only two-fifths of the control group do. Less than 10% of the providers classify themselves as "atheistic," whereas almost three times as many of the control group of non-providers do. Evidently the providers' cooperation with religious institutions stems from ideological roots, as well as from other possible sources.

The third interesting finding demonstrated in Table III is that in the control group, which may be taken to represent the typical APA membership, only one out of every four list themselves as "atheistic," contrary to the commonly held stereotype, while fully two-fifths list themselves as "theistic," and more than one-third list themselves as "agnostic."

RITUAL/CEREMONIAL OBSERVANCE

A line was also provided for responders to position themselves with regard to Ritual/Ceremonial observance. The three positions on the line were "Observe," "Question," and "Do Not Observe." A certain amount of ambivalence appeared on this question, too, check marks being placed between the various categories. However, when these were treated in the same manner as the theological viewpoint line, the adjusted percentages in each category differed very little from the squarely-marked responses.

Table IV shows the squarely-marked replies of the providers, the adjusted percentages for ambivalent responses (one-half of checks placed in-between the categories being attributed to each category above and below it), and the replies of the control group of non-responders.

TABLE IV

RITUAL VIEWPOINTS

	Squarely Marked Replies	Adjusted Replies	Control Group Replies
Observe	53.4%	56.4%	33.5%
Question	20.7%	26.1%	22.0%
Do Not Observe	20.5%	22.9%	44.5%

Although the differences between the providers and the non-provider controls remain evident insofar as ritual viewpoint is concerned, they are much less marked than in the case of theological viewpoints. Only a little over one-half of the providers check the

"observe" position, whereas three-quarters checked the "theistic" position, indicating that they are less committed on observance than they are on theism. (A position assumed by 75% of a group may be regarded as characteristic of the group.)

To reach the same percentage (75%) among the controls, on *Theological Viewpoint*, one would have to include those who checked both "theistic" and "agnostic," leaving, in the remaining 25%, only those who checked "atheistic." On the *Ritual Viewpoint* scale, the providers would have to include those who checked "Observe" and those who checked "Question" to reach around 75%; while among the control non-providers, combining these two groups brings the total to only a little over one-half (55.5%); and it is necessary to reach half-way into the "Do Not Observe" category to reach the 75% mark. In both groups, providers and non-providers, ritual/ ceremonial viewpoint is not as strongly positive as theological viewpoint.

CHURCH ATTENDANCE

The "Confidential Information" questionnaire also asked, "How frequently do you attend church?," and offered "Regularly," "Occasionally," "Rarely," and "Never" as alternatives. This same set of alternatives was also offered to the non-provider controls. Table V sets forth the findings.

TABLE V

CHURCH ATTENDANCE, PROVIDERS AND NON-PROVIDERS

	Providers	Non-Provider Controls
Regularly	49.9%	17.8%
Occasionally	24.4%	22.1%
Rarely	16.5%	32.2%
Never	9.2%	27.9%

Here the contrast between the providers and the non-providers is marked. If we combine the "Regularly" and "Occasionally" categories, which is probably a fairer measure of church-going than either alone, the providers total 74.1%, while the non-providers total only about one-half as much (39.9%). The "Never" group is only 7.9% among the providers, while among the non-provider control it is 27.9%.

Another possibly significant index of religious attitude is whether the children are sent to religious school, and if so, whether they are

confirmed. (Parents often reserve judgment as to their own religious beliefs and practices but want their children to have a religious background and to make their own decisions as they grow up.)

Among the providers, 79.8% send their children to religious school, and 70.0% of them are confirmed. Among the non-provider controls, 52.9% send their children to religious school, and 47.0% of them are confirmed. In this instance as well, providers appear to be more committed to the beliefs and practices of religion than non-providers, not only for themselves, but for their children as well.

DIFFERENCES AMONG RELIGIOUS GROUPS

About 900 of the providers stated their religious affiliation, and so did the 259 non-providers. It was thus possible to compare the response of providers and the non-providers among Protestants, Catholics, and Jews on the questions of religious belief and practice.

THEOLOGICAL TRAINING

The group of providers was differentiated from the non-providers in a number of ways. While among the providers of all three faiths considerable percentages had undergone some theological training (13.3% for Catholics, 11.9% for Protestants, and 8.9% for Jews), among the non-providers as a whole the percentage was 3.5%, and only among the Catholics had any appreciable percentage undergone such training (15.6%). Those who had any theological training (whether by religious preference or by providers or non-providers) had the same number of years of training, namely 2+ years. Only a small fraction (around 1.0%) identified themselves as "ministers of religion."

RELIGIOUS VIEWPOINT

The most significant differences between the providers and the non-providers appeared when the questions of religious belief and practice were analyzed.

Table VI shows the figures for the religious groups by providers and non-providers on "Religious Viewpoint." The ambivalent check marks (those which were placed between two categories, instead of squarely in any one category) were assigned one-half to each contiguous category, since previous analysis had shown that the numbers of these was small and the effect upon the totals was negligible. (See Tables III and IV.)

Among the providers, the theistic position was held by a larger percentage of each religious group than among the non-providers. (Protestants — theistic providers 69.8%; non-providers 49.4%. Catholics — theistic providers 90.8%; non-providers 73.3%. Jews — theistic providers 40.5%; non-providers 29.3%). Catholics had the highest theistic percentages, Protestants the next, and Jews the smallest, among both providers and non-providers.

TABLE VI

RELIGIOUS VIEWPOINTS

	PROTESTANT		CATHOLIC		JEWISH	
	Providers	Non-Providers	Providers	Non-Providers	Providers	Non-Providers
Theistic	69.8%	49.4%	90.8%	73.3%	40.5%	29.3%
Agnostic	21.0%	41.6%	7.8%	17.8%	39.6%	39.0%
Atheistic	6.6%	9.0%	1.0%	8.9%	16.7%	31.7%
Other or no	2.6%	0.0%	.4%	0.0%	3.2%	0.0%
Agnostic + Atheistic	27.6%	50.6%	8.8%	26.7%	56.3%	70.7%

Viewed from the other end of the spectrum, namely the agnostic and atheistic responders, the same characteristic appears. The Catholics are least represented both among the providers and the non-providers (8.8% providers; 26.7% non-providers); the Protestants are next (27.6% providers; 50.6% non-providers); and the Jews most represented (56.3% providers; 70.7% non-providers). Thus, at both sides of the "Religious Viewpoint" line, providers place themselves more toward the believing side than non-providers, and Catholics more than Protestants, and both more than Jews.

This may be related, on the one side, to the strongly atheistic position taken by Freud, and on the other, to the strong anti-psychoanalytic position taken, until comparatively recently, by the Catholic Church. From another point of view, the differences may be related to the fact that Catholicism involves a strong credal position, while Judaism has no fixed creed. The Protestant denominations have varying positions in this respect. This may account for the fact that, while differences appear between all provider and non-provider groups, they are consonant in all cases with the position of the religion to which they subscribe, i.e., non-providers are less theistic than providers in all three religious groups.

RITUAL/CEREMONIAL VIEWPOINT

Table VII shows the differences between providers and non-providers among all three religious groups on the question of ritual/ceremonial viewpoint.

TABLE VII

RITUAL/CEREMONIAL VIEWPOINTS

	PROTESTANT		CATHOLIC		JEWISH	
	Providers	Non-Providers	Providers	Non-Providers	Providers	Non-Providers
Observe	54.7%	36.4%	69.8%	59.0%	37.8%	31.7%
Question	24.2%	26.0%	23.0%	20.5%	36.2%	25.6%
Do Not Observe	17.5%	37.6%	5.4%	20.5%	21.3%	41.5%
Other or No	3.6%	0%	1.8%	0%	4.7%	1.2%
Question + Do Not Observe	41.7%	63.6%	28.4%	41.0%	57.5%	67.1%

Generally, the providers observe more than the non-providers, and, again, the Catholics among both providers and non-providers are more inclined to observe religious rituals and ceremonials, while the Protestants among both groups are less inclined to observe, and the Jews least of all. Only among Catholics does the degree of observance reach the proportion of 50% among both providers and non-providers. Only among Protestant providers does it reach a majority, while among Protestant non-providers and Jewish providers and non-providers, it falls closer to the one-third mark. Combining the "Question" and "Do Not Observe" figures shows up the same tendencies among the providers and non-providers in all three religious groups.

CHURCH ATTENDANCE

Table VIII shows the differences between the providers and non-providers of the three religious groups with reference to their church attendance.

Among the providers, Catholics are the most regular churchgoers, 76.7% attending regularly and an additional 15.1% occasionally. Among Protestant providers, the regular attenders are 57.5%

and the occasional 25.7%. Jewish providers are not nearly as regular in church attendance (10.9%), but adding their occasional attendance brings their total over the 50% line (10.9% + 48.4% = 59.3%).

TABLE VIII

CHURCH ATTENDANCE, BY RELIGIONS

	PROTESTANT		CATHOLIC		JEWISH	
	Providers	Non-Providers	Providers	Non-Providers	Providers	Non-Providers
Regularly	57.5%	18.2%	76.7%	55.6%	10.9%	8.5%
Occasionally	25.7%	31.2%	15.1%	15.5%	48.4%	30.5%
Rarely	14.0%	40.2%	6.8%	15.5%	27.3%	41.5%
Never	2.4%	10.4%	1.4%	8.9%	13.3%	19.5%
Other or No	.4%	0%	0%	4.5%	.1%	0%
Regularly + Occasionally	83.2%	49.4%	91.8%	71.1%	59.3%	39.0%
Rarely + Never	16.4%	50.6%	8.2%	24.4%	40.6%	61.0%

The non-providers of all three religious groups are far less inclined to attend church than the providers. Even among Catholics, where regular church attendance among providers is 91.8%, among non-providers it is 55.6%. Adding the occasional church goers raises the total percentage to only 71.1%. Among Protestants, 18.2% attend regularly and 31.2% occasionally, bringing their total of both to 49.4%, just short of a majority. Among Jewish non-providers, the regular attenders are only 8.5%, the occasional attenders 30.5%, and the total of regular and occasional attenders is 39.0%.

These differences can probably not be attributed entirely to the attitudes of the responders since the base of religious practice from which they start differs so greatly from religion to religion. Regular attendance at church is obligatory among Catholics for Mass, Communion, and Confession, hence deviation is more significant than it is among Jews, where regularity of church attendance, however desirable, is not obligatory. The "Once-a-Year" attender, who comes only on the High Holy Days, is welcomed gladly. Among Protestants the requirements as to attendance vary greatly from denomination to denomination, which may explain our findings with regard to Protestants.

CHILDREN'S ATTENDANCE AT RELIGIOUS SCHOOL

Children's attendance at religious school (Table IX) was remarkably similar among the provider groups of all three religions. The Protestants send 86.6% of their children to religious school; the Catholics, 80.3%; and the Jews, 78.9%. Even among the non-providers, though the figures were somewhat lower, there was a similar tendency, the Catholics falling below the Jews (64.4% vs. 68.3%), while the Protestants send only 57.1% of their children to religious school.

Evidently, the providers have stronger theological convictions, greater inclination to observe rituals and ceremonials, and a greater tendency to give their children a religious education.

CHILDREN'S CONFIRMATION

The differences between the religious groups and between providers and non-providers are less marked when the figures on confirmation of children are compared (Table IX). While among providers the figures are higher than among non-providers, as they were in all other characteristics studied (Catholic providers, 82.7%; Protestant, 68.1%; Jewish, 63.5% vs. Catholic non-providers 53.9%, Protestant 47.6%, Jewish 44.6%), the same relative position is maintained among all three groups, namely, having their children's religious education go forward at least to confirmation.

TABLE IX

CHILDREN'S ATTENDANCE AT RELIGIOUS SCHOOL AND CHILDREN'S CONFIRMATION

	PROTESTANT		CATHOLIC		JEWISH	
	Providers	Non-Providers	Providers	Non-Providers	Providers	Non-Providers
Children attend	86.6%	57.1%	80.3%	64.4%	78.9%	68.3%
Children confirmed	68.1%	47.6%	82.7%	53.9%	63.5%	44.6%

COMMENTS ON THE DATA FROM PROTESTANT RESPONDERS

WILLIAM N. GROSCH, M.D., M.DIV.*

The Protestant responders in our Survey represent a wide variety of denominations (10), which made it impossible to handle them individually, as was possible for the Catholic and the Jewish responders. We, therefore, grouped all who listed themselves either as "Protestant," or as belonging to any recognizable Protestant denomination (Methodist, Baptist, Presbyterian, etc.) together, for statistical purposes.

The Protestant responses, therefore, represent a grouping of a wide variety of theological viewpoints and positions on ritual and ceremonial religious observance. Thus, broad denominational differences may have been obscured or eliminated. As a matter of fact, however, this, in itself, is characteristic of what goes under the rubric of "Protestant" in this country, a very wide variety of viewpoints and positions being included, from the Episcopalian group, which calls itself Anglo-Catholic, to denominations which are far removed from this kind of theological and ritual orientation.

Understandably, most of the Protestant figures fall between those of the Catholic and Jewish responders. This is in line with the general experience that Protestants fall between Catholics and Jews with regard to both theological viewpoint and religious observance requirements.

It is hardly remarkable, furthermore, that the figures for the Protestant responders closely approximate those for the general Protestant population, since this group is the largest in both the APA and the general population.

In other respects, the figures on Protestant responders appear to be self-explanatory, requiring no comment.

*Associate in Psychiatry, Duke University Medical Center; Ordained Minister, United Church of Christ.

COMMENTS ON THE DATA FROM CATHOLIC RESPONDERS

ANGELO D'AGOSTINO, S.J., M.D.

Introduction

The following remarks must be read simply as one man's interpretation of the raw data presented by the Survey. It is an attempt to be as little biased as possible and yet to fill out a sketch which bare figures can hardly achieve. The bias is that of a practicing, psychoanalytically trained psychiatrist who is also an ordained Jesuit priest. The image of the Catholic provider to emerge from the Survey is that of a psychiatrist who indeed has some religious conviction of varying viability. I will compare his profile with that of the Jewish and Protestant psychiatrist where this seems useful and feasible.

Formal Theological Training. As to the formal religious training of the subject and its extent, the proportionate figure of 13.3% of the total sample received stands higher than either of the other two denominations (8.49% and 11.9%). To reconstruct the history of an individual who has had formal theological training and yet practices psychiatry, one must determine the extent of that training in terms of years (see data on "Years of Formal Training") and also whether or not that training has been completed and ordination has been achieved (see data on "Status of Ministers"). In making these comparisons then, we see that the Roman Catholic subject falls to only 3.1% of the sample when ordination is considered, and this is almost a quarter of the Protestant sample, which is 11.3%.

This brings out a rather important difference between the attitude of the various religions concerning the role of the minister. Prior to Vatican Council II, a rather rigid pattern of behavior was expected of the priest, especially the diocesan priests (termed secular priests) who generally staff the local parishes. The priests who were associated with religious orders such as the Dominican, Jesuit, Franciscan, etc. (termed religious priests), enjoyed a somewhat broader identity (witness the Alaskan explorer of the '30's, Fr. Hubbard, S.J.; the minister to the lepers on the Hawaiian Island of Molokai, Fr. Damien; the Nobel Peace Prize winner, Fr. Pire, a Dominican; and countless others). Since Vatican II (1965), the role of even the diocesan priest has begun to become somewhat blurred, and while the

priest is still primarily a minister to the "people of God," his manner of ministry has taken on a wider scope in response to their needs. So, for example, in the past two years (since the completion of the Survey) some five more priests known to the author have entered the ranks of psychiatry. Several other priests are currently pursuing medical studies, even among the ranks of diocesan priests.

This underlines the fact that unlike the Protestant context, a Roman Catholic seminarian, prior to Vatican II, could not envision himself as encompassing both a clerical and psychiatric role. If he did have such a desire, it became conflictual, and he had to choose one or the other.

Our figures seem to show that while the Roman Catholic subjects did have formal religious training in a relatively high percentage of cases, very few of them completed their training. Their vocational ambivalence was resolved in favor of medicine. It would be interesting to know how many were resolved otherwise. This ambivalence is not as keenly felt within the Protestant context, and for that reason a relatively higher percentage do become ministers of religion (11.3%).

Years of Formal Training. As to "Years of Formal Training," the relatively high number with three or more years of formal training is perhaps a function of the delayed maturing in seminary, consequent to rather early age of admission—sometimes before high school (junior seminary). These figures will undoubtedly be quite different (increased) with the changes in the Church and in priestly training pursuant to the promulgation of the documents of Vatican II and subsequent episcopal pronouncements.

Medical School Training. The Survey states that figures on the medical schools attended by the providers and the non-providers were substantially the same. It is interesting to note, however, that among the first ten schools* in order of the number of providers who are their graduates, three are religiously sponsored and are or were Jesuit schools (viz. St. Louis, Loyola, and Marquette). It is interesting to speculate whether any inferences can be drawn as to the relationship between this fact and its possible etiology.

Psychological Assessment of Candidates for Seminary Admission. Since the Vatican II, there has been a notable rise in acceptance of psychological testing for seminary admission. In fact, over the past

*Harvard Medical School, Columbia College of Physicians and Surgeons, St. Louis University Medical School, University of Illinois Medical School, University of Pennsylvania Medical School, Loyola University School of Medicine, University of Minnesota Medical School, University of Texas, Galveston, University of Michigan Medical School, Marquette University Medical School.

decade or so, the American Council of Catholic Bishops has also strongly advocated psychological and psychiatric assessment of candidates. This has caused a growing demand for psychiatrists to provide this screening service.

Minister of Religion and *Status of Ministers.* The section of the Survey dealing with ministerial status has little bearing on the Roman Catholic situation in contrast to the Protestant, in which there is significant differentiation. In the Roman Catholic tradition, a person either is a priest or he isn't. The one subject is a psychiatrist who was at the time of the Survey in seminary training. But the clarity of this situation will also probably not persist, again as an outgrowth of Vatican II, because the institution of the Deacon has been revived and larger numbers are being ordained yearly. It is not inconceivable that psychiatrists might be included in the ranks of deacon ordinandee. Finally, it would be of no small interest to know to what extent *bona fide* pastoral duties are taken on by the subjects of the survey.

Frequency of Church Attendance. As to church attendance, we see a notable difference in percentages between the three groups studied. The fact that the highest proportion (76.7%) is Roman Catholic is not surprising since observance of Sunday Mass has always been a matter of serious obligation. The figure given compares favorably with the figures of national church attendance by Roman Catholics in 1972-73 in general. The attendance of this particular sample of psychiatrists is higher than U.S. Census Bureau statistics on church affiliation nationally.

Religious School Attendance by Children. The findings indicate that a significant number of children do attend religious schools of one type or another. That Protestant subjects lead by 86.6% is not surprising since the traditional "Sunday School" has been an integral part of religious development for Protestant congregations. It is somewhat surprising that the Catholic figure is as high as it is (80.3%).

In the interim since the Survey was made (about two years), there have been powerful forces at work to reduce the number of Catholic schools. That these forces continue is almost inevitable so that substantially fewer children of Catholic subjects will probably be attending Catholic schools. But this will be in line with the general decline and not peculiar to the profession.

Religious training is being rapidly provided by professional religious educators who may or may not operate out of a structured school setting. Parents, likewise, are being given more responsibility in the religious teaching of their children.

Confirmation of Children. Doctrinally, confirmation is one of the seven sacraments of the Roman Catholic church. The grace conferred by this sacrament is particularly meant for the mature person who is ready to accept the Holy Spirit and achieve the fullness of being a Christian. It is administered in most cases by a bishop and is a significant event in the religious life of the adolescent. Therefore, it is not lightly avoided.

Most children raised in any parochial setting whatever will almost inevitably be confirmed sometime during their early teen years. As a result it is not surprising to have such a high figure (82.7%). (I would suspect most of the children not confirmed are still too young.)

Relationship to the Clergy. In attempting to determine the influence of clergy relationship to the subject, the survey, unfortunately, does not clarify whether or not these relationships are parent-child, sibling or whatever. Needless to say, since Roman Catholic clergy are unmarried, none of the relationships will be of the parent-child variety.

With regard to Roman Catholics, a brother or an uncle being a priest could serve as another ego ideal for the embryonic medical student, thus explaining possible dual identities.

Religious Viewpoint. This section presents little difficulty when compared with the Jewish and Protestant data. By definition, a Roman Catholic believes in God. While one can readily admit to an atheistic or agnostic stand as such, it is difficult to understand how a person, allegedly a Roman Catholic, can also be agnostic or atheistic. There may be "crises of faith" or serious doubts about religion, but to classify oneself as atheistic and still purport to be a Roman Catholic is a contradiction in terms. It is no wonder then that 86.2% of the Roman Catholic subjects are theistic. The wonder is how the other 13.3% are able to resolve the contradiction.

Ritual Viewpoint. The rather vigorous discipline of the Roman Catholic church—requiring Sunday Mass attendance, performing one's "Easter Duty," i.e., receiving communion at least during the Easter season, having weddings, baptisms and funerals all in church—contributes to the high proportion of members who observe these various rituals. The sanctions are serious and call into jeopardy not only one's relationship to the Church but to God Who has founded that Church.

Since Vatican Council II, however, with the profound changes in liturgy, there is a new look at morality derived from love rather than fear. Also, with the increased emphasis on freedom of con-

science, there has been a notable decrease in traditional observance. The figure 62.6% is down considerably from that which might have been predicted several years ago by perhaps ten or fifteen points. Where the leveling off will take place is difficult to say, but the trend is still downward. The ritual of aural confession has dropped markedly over the last 10 years, while the receiving of communion has risen notably. The Sacrament of the Sick (known as Extreme Unction before Vatican II) is being administered much more freely. (A future survey would do well to inquire as to the reason for the non-observance.)

In conclusion, the response from the target group appears to have been far greater than predicted. This is especially so on the last section which contains confidential material concerning one's religious beliefs and practices. All in all, it is the writer's opinion that the Roman Catholic provider of services to religious institutions is at least as faithful to his religious convictions as the average and, if more data were available, he might even prove to be more so. He has at least had a college degree and therefore has survived a questioning of his religion. Furthermore, his psychiatric experience has forced him to examine his own personal beliefs vis-a-vis neurosis, superstitions, etc., and again they have survived. The figures show a rather high degree of conformity with Church teaching and practice. As generations grow through the after-effect of Vatican II, there will probably be a change in the type of observance and yet a deepening of personal religious belief and influence on behavior.

COMMENTS ON THE DATA FROM JEWISH RESPONDERS

EMANUEL M. HONIG, M.H.L., RABBI, M.D.*

It has been alleged that psychoanalysis is a Jewish science. Its origin probably stems from the fact that the father of dynamic psychiatry was a Jew.

The survey does not shed any light on this question, of whether there is any affinity between Jewish thinking and psychiatry. However, it does show that there is an unusually large percentage of Jewish psychiatrists, as compared to their proportion in the United States population. Jews represent merely 2.8% of the general population of the United States, yet 24.4%, almost a quarter of the membership of the A.P.A., indicate a Jewish religious preference.

Is there a special emotional or psychic predilection which draws Jews to the field of psychiatry?

Sigmund Freud himself repeatedly called attention to the relationship between his work and his Jewishness, "—Only to my Jewish nature did I owe the two qualities which have become indispensable to me on my hard road. Because I was a Jew I found myself free from many prejudices which limited others in the use of their intellect, and being a Jew I was prepared to enter the opposition and renounce agreement with the compact majority."

Karl Menninger sees the separatism of the Jew, which has been fostered by prejudice, as a factor in his predilection for psychiatry. "The result of separatism, however one explains its origin, is that many Jewish children grow up with an extraordinary interest in and curiosity about people, reinforced no doubt by the background of religion and philosophy which is their heritage. Their own detachment, when successfully achieved, enables them to be more objective, more analytical and at the same time more discerning in their judgement of others, partly because they understand and partly because they have been able to rise above suffering and even feel able to relieve it in others."

The concept of the collective unconscious might lead one to

*Assistant Clinical Professor, Psychiatry, UCLA Medical School; Faculty, So. Calif. Psychoanalytic Institute; Ordained Rabbi, Jewish Institute of Religion, N.Y.; Visiting Professor, University of Judaism, and Hebrew Union College, California School.

conjecture that the bigotry and suffering that the Jewish people have experienced in their wanderings over the centuries have stamped an indelible psychic mark on the character of this people, which has made them forever sensitive and responsive to similar experiences in others.

Another reason that those raised in the Jewish tradition may have some unique predisposition for psychiatry is the high value placed on verbal expression of feeling. In Judaism, there is a marked awareness of the emotional need of the human being for a confidant to whom he might express his thoughts and feelings. This is exemplified in the poetry of the Psalms and in other Jewish religious literature.

In Psalm 32, God is seen in the role of a non-directive therapist, so to speak, "Happy is the man unto whom the Lord counteth not iniquity, and in whose spirit there is no guile. When I kept silence, my bones wore away through my groaning all the day long. For day and night, Thy hand was heavy upon me. . . . I acknowledged my sin unto Thee, and Thou forgavest the iniquity of my sin." (vss. 2-5).

The Chasidim, a Jewish sect of the eighteenth century, perceived their Zaddik, a Holy sage, as a therapist. Simcha Bunim said, "It is highly necessary for every human being to have at least one sincere friend, one true companion so close to us that we are able to tell him that of which we are ashamed."

In view of the large proportion of Jews in the field of psychiatry and serving as providers of psychiatric service to religious institutions, it is paradoxical that 56.3% declared themselves to fall into the agnostic and atheistic categories.

When one considers the basic concepts of Jewish theology, this seeming contradiction can be clarified. The emphasis in Judaism is more on deed than on creed. Jewish Theology insists that man's duty and obligations to God can be fulfilled only through his relationship to his fellow man. The rabbis in the Talmud pictured God as stating, "Would that they forsake me, but keep my commandments; because if they keep my commandments, they will eventually find me."

The emphasis in Judaism is not so much on a God-centered philosophy, but on the religious ethic that man's finest way of serving God is through fulfilling his obligation to human society.

On Yom Kippur, the Day of Atonement, a person may seek godly forgiveness only after seeking forgiveness from those of his fellow men whom he has wronged. Solomon Schechter, one of the founders of Conservative Judaism, summarized the Jewish concept of God: "The rabbis cared more about what God requires us to be, than about knowing what He is."

In Judaism, the true worship of God aims not at achieving mystic ecstasy, but at achieving the good life. The accent in Judaism is not on abstract speculation, but on its ethical message and its program of moral action.

The survey findings appear to exemplify this philosophy, in that many Jewish psychiatrists who do not classify themselves as theistic, nevertheless "work in the vineyard of the Lord," supplying psychiatric services to both Jewish and non-Jewish theological and religious institutions.

This same phenomenon is evident in the area of attendance at religious services. Despite the large percentage who declare themselves to be agnostic-atheistic, 59.3% of the Jewish psychiatrists attend worship services and an even larger percentage (78.9%) encourage their children to attend religious school, 63.5% of them continuing on to confirmation.

Jews place great importance on identification with the group and fellowship within Judaism, hence they tend to be tied together by other than religious creed alone. Jews have a strong belief in Peoplehood, and a strong sense of the importance of philanthropic endeavors within the community.

The synagogue is the meeting place which ties all the facets of Jewish life together. It is referred to as Beth HaMidrash (A House of Learning). The education of both adult and child is given major stress. The large number of Jewish children who pursue higher education, both in secular and Jewish studies, attests to this. The essence of Judaism is Torah, which means teaching, leading to the well-being of both the individual and society.

This survey indicates convincingly that whether or not the Jewish psychiatrist believes in God, attends synagogue, or observes the rituals, in his service as a professional, he still identifies with the Jewish tradition, and encourages his children to follow this way of life.

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PROVIDERS VIS-A-VIS NON-PROVIDERS

WILLIAM N. GROSCH, M.D., M.DIV.

The Survey results prompt speculation about the nature of the relationship between the providers and the religious institutions which they serve. About 25% provide 6-10 hours per month, and about 10% provide these services in concentrated segments or blocks of time. In addition, the years of service rendered by the psychiatrists tend to be lengthy, almost half of them serving from 6-10 years and almost two-thirds more than five years.

Furthermore, about 40% are paid only, about 30% volunteer only, while about 25% are both paid and volunteer. Does such a proportion of volunteers suggest a religious interest? Ordinarily, not many consultants consult "for free." Such a substantial percentage of volunteers suggests some identification with the role of minister and the aims and goals of the institution or people served.

The length of the association between the providers and the religious institutions suggests service that goes beyond mere technical use of skills. This is supported by the fact that about 10% report having had some theological training. Of these, more than half have had three or more years, while about 40% have had one year. (Most accredited seminaries require three years for a degree.) Over 7% state that they are ministers, about half, ordained. Thus it appears that providers do have a special religious and ritual interest.

The percentage of providers and non-providers attending church is especially interesting when compared with findings on this subject among the general population. Gordon Allport, in his studies of religion and prejudice in the 1960's, found that 63% of the population claimed formal religious affiliation. In 1961, Lenski found among Protestants in Detroit, in his study *The Religious Factor*, that 30% attended every Sunday, 20%, 1-3 times a month, 30% occasionally, and only 14%, never. According to a Gallup Poll in 1966, church attendance during an average week was 44% for the nation as a whole, and for Catholics, 68%. In 1974 *Newsweek* reported the figures for Catholics as 48%, for Protestants, 38%, and for Jews, 22%.

Although the questionnaire did not include a specific inquiry into what the responders mean by the terms "theistic" and "religious," the literature in the field may shed some light on this subject, which many workers in the area of the scientific study of religion

have sought to clarify. Allport, for example, suggests that a distinction exists between extrinsic religion and intrinsic religion. He said, "There are churchgoers and churchgoers." Those with extrinsic religion go only three times in a lifetime: when hatched, matched and dispatched. They tend to be communally oriented, gregarious and other-directed, self-centered, opportunistic, and utilitarian. They attempt to use religion. He found these people also to be highly prejudiced. Church-goers with intrinsic religion (faith), Allport maintains, are characterized by a basic trust, compassion, an understanding of others, "dogma tempered with humility," "no longer limited to single segments of self-interest." He found these people to be low on prejudice.

Other investigations have shown that regular and frequent church attenders harbor less ethnic and racial hostility than do members who are casual about their attendance. Streuning found that among 900 faculty members in a large midwestern university, almost a third never attended church at all, and they had a low prejudice score (14.7). Many attended once a month and for these the average prejudice score nearly doubled (25.0). Non-churchgoers were found to be less prejudiced than casual churchgoers. The prejudice scores of those attending once, twice, or three times a month were all high. For weekly attenders the prejudice score fell, and it continued to fall rapidly for those whose attendance was 5-11 or more times a month. For the group attending 11 or more times a month, the average prejudice score of 11.7 was significantly lower even than for the non-attenders. This data appears to demonstrate a curvilinear relation — non-attenders and frequent attenders have low prejudice scores; intermediate attenders high prejudice scores. This conclusion is supported by a recent review and interpretation of all the research done so far on Christian faith and ethnic prejudice (Gorsuch and Aleshire, 1974).

Dr. Elizabeth Kubler-Ross, in her observations of religion as a human resource in the dying, noted that the people who had a little religion (a token religion) had the most difficulty. The ones that were a-religious or non-attenders and those with an intrinsic faith had the least difficulty.

Milton Rokeach investigated whether religious sentiments foster humanitarian attitudes (social compassion). He found little correlation or a slightly negative correlation. In other words, people with religious feelings scored slightly less humanitarian than those without religious feelings. The so-called religious person he was measuring (Allport's extrinsic religious person) had punitive (authoritarian, dogmatic) attitudes toward criminals, delinquents, prostitutes, homo-

sexuals, and those who might seem in need of psychological counseling or psychiatric treatment. They were more intolerant of racial and ethnic groups than were non-believers. Recent findings of Rokeach, however, do correlate health and intrinsic religious motivation, which is also associated with humanitarian attitudes.

Certain questions remain: Is there a positive relationship between religion and emotional disturbances? Are the people that are the most intolerant and anxious the ones that seek religious affiliation — for the sake of "peace of mind" and mental balance? This is what Freud described in his "Obsessive Actions and Religious Practices" (1907). Perhaps, after Allport, it can be said that to the extent that religion is extrinsic, we are immature, unhealthy, or at least anxious. Moreover, to the extent that the providers are *extrinsically* religious, the service they may be providing to religious institutions would not be of the best possible kind.

Finally, theism probably means different things to different people. We did not ask the theists and the atheists what they really believe. If we had, we might have found as much variance within the groups, as between theists and atheists.

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IMPLICATIONS OF DATA FOR PSYCHIATRIC CONSULTATION AND THERAPY

EDGAR DRAPER, M.D.*

The Survey's findings are interesting, surprising, albeit not shocking. Especially noteworthy are the facts that so many APA members render this service, that religious institutions utilize psychiatrists without prejudice as to their belief or denomination, that the relationships often last over many years, that a sizeable number of psychiatrist-providers are trained in the ministry, that theism is prominent, while atheism is rare among both providers *and* non-providers, and that a majority of even non-providers give their children religious training.

A recent study has shown that knowing the details of a person's belief system or personal philosophy can help to assess his personality, defenses, conflicts, developmental attainment and symptoms. From that study we learn, "In order to determine the diagnostic utility of patients' religious interests, the authors saw 50 randomly selected psychiatric patients in a semistructured 'religious interview,' concurrent with but separate from their diagnostic evaluation. Religious history and answers to a series of religious projective questions were used as the data for diagnostic assessment. Symptomatic, characterological, and psychodynamic diagnostic conclusions could be correctly drawn from the religious history and ideation, without the benefit of clinical data. Regardless of religious preference, including the 'a-religious,' patients presented past or present conflicts expressed in individualized religious values. Patients were found to utilize religious beliefs and practices in the service of pregenital as well as oedipal expressions developmentally, and of id and ego as well as superego functions structurally."[1]

The responders in this survey felt relatively "safe" from diagnostic assessment in affirming or denying belief in God, without further elaboration. No details or projective material were sought. This may help explain their unexpected readiness to answer the

*Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Mississippi, Jackson, Mississippi.

"personal" questions asked. The Survey's findings do not support biases like psychiatrists are "religious" or "not religious." Although the opportunity to indicate belief or disbelief was afforded in the Survey, the question of what is believed was not.

Large numbers of hours are offered by psychiatrists for pay or free in working with religious institutions as (1) Consultants, (2) Therapists. We may examine some of the implications:

(1) Does the role of a psychiatrist as a *consultant* to religious institutions differ from that of psychiatric consultants to other institutions?[2] The earliest consultative relationship in recorded history is that of Joseph to Pharaoh (*Genesis 41:40*). Pharaoh stated that the consultant is not the king, "only Pharaoh is king." Religious institutions do not expect administrative or theological leadership from psychiatric consultants, but only certain well-defined services. Neither do institutions expect conformity to their belief system, but they expect only that they be non-destructive to the institutions' goal — which is hardly different from what is expected of consultants to any institution.

Within this framework the consultant needs to believe sufficiently in the efficacy of the institution and his own work, to respect the belief systems of the persons he serves and understand their acceptance of its value, to have enough appreciation of the psychological potency of religious factors to use the institution's strengths for the benefit of its constituents regardless of his own personal beliefs, and not to be his own "hidden preacher" (Kubie).

This framework is in line with community psychiatry's principles of non-intrusiveness, identification of the community's psychological strengths, its anatomy, physiology, and chemistry, its power structure, economy, leadership, racial and cultural issues; in other words, one major consultative task is learning the language of the community of the religious and using it effectively.

(2) As to the psychiatrist as *therapist,* the survey challenges Freud's assumption that religion is a "universal obsessional neurosis," but supports his other view, expressed in the Pfister correspondence (September 20, 1909), that "in itself, psychoanalysis is neither religious nor non-religious, but an important tool which both priest and layman can use in the service of the sufferer." The survey indicates clearly that religious belief is not "out there" with "disturbed patients," and that even psychiatrists who are non-providers and "non-theists" have some kind of belief system which they wish to transmit to their children.

Sometimes the psychiatrists' "belief system" is not rooted in theological dogmas, but is one that rests on psychoanalytic, behav-

ioral, community psychiatric, organic, existential or pragmatic theories. It is in these schools of psychiatric belief and practice that Kubie found his "hidden preachers." Among them, as among religious orthodoxies, perpetuation of belief is more appealing than inquiry into it, and doubt is labeled as heresy.

It has been documented that the philosophical beliefs of an individual can be used in psychiatric diagnostics as effectively as any other data, including psychological testing.[1] But beyond diagnosis, the religious convictions of patients can be used effectively in brief therapy and supportive psychotherapy. Short term psychotherapy or crisis intervention requires rapid appreciation of patients' psychological strengths, and utilization of them in conjunction with environmental support systems. Religion can be such a usable support system for a patient, even when the therapist believes the patient's religious system to be of little or no objective value. For example, panic in a patient convinced she is under a voo-doo curse can be handled more effectively by a therapist who understands and is willing to use her belief system psychodynamically, than by one who regards it as arrant nonsense. An informed and skilled therapist can utilize the power of religion and its meaningfulness in the transference, much as his speaking a foreign language helps him to treat a troubled patient for whom that language is his native tongue.

In long-term therapy, patients who have strong religious identifications may respond better to therapists whose personal belief system is unconflicted, since belief systems sometimes serve as "stalking horses" for psychological conflict. If the therapist's own belief system is sufficiently clear of counter-transference consequences, he may more successfully interpret such conflicts than otherwise.

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IMPLICATIONS OF DATA FOR PSYCHIATRIC EDUCATION

ANA-MARIA RIZZUTO, M.D.*

Our figures on religious beliefs and practices indicate that both the general population and psychiatrists have an emotional investment in some form of religious belief. This may be what makes the providers define themselves as religiously affiliated in such large proportions, motivating them to believe, to practice, and to send their children to religious school. These figures raise several questions:

First, and most urgent, do we as psychiatrists know enough about the religious needs of the people we deal with?

Second, is not understanding and exploring this facet of their lives a requisite to provide insight into their intrapsychic and interpersonal world?

Third, is this not a crucial element in the individual's mechanisms of self-appraisal and support, so important in diagnosis and therapy?

Fourth, since a majority of Americans (including psychiatrists) find religious living sufficiently attractive to practice it regularly (e.g., weekly church-going), are we prepared to understand and evaluate this factor in our diagnosis and treatment?

Fifth, would not teaching psychiatric residents how to take a religious history add a valuable skill to their total competence?

I should like to focus on two of these issues:

The Values of Taking a Religious History in Psychiatric Practice

Most people have attended religious school as children, learned to pray and may still pray. Part of their early and later emotional involvements have to do with religion regardless of whether they now accept or reject its precepts and practices. However, this is rarely brought out in taking a clinical history.

Even Karl Menninger in his book, *Psychiatric Case Study,* does not talk about the patient's religious *feelings* but rather about

*Associate Clinical Professor, Psychiatry, Tufts Medical School; Graduate, Boston Psychoanalytic Institute; formerly Professor, Pastoral Anthropology, Pontifical Seminary of Our Lady of Loretto, Cordoba, Argentina; faculty of the Psychoanalytic Institute of New England, East.

his concepts, and places religion in the category of "relations to things and ideas." For the patient, religion is loaded with feelings, particularly of interpersonal nature.

In taking careful family, social, student, work, and sexual histories, should we not ask about whether the patient believes there is a God to resort to (or to fear), whether he feels that the universe is a friendly, orderly place, or an incomprehensible world in which he feels lost, whether or not he ordinarily resorts to prayer, how his beliefs affect his understanding of his present emotional illness (an accident, punishment, trial, or tribulation), and his concept of his own guilt or righteousness?

Since we are concerned about the patient's relation to the relevant people in his life, should we not ask about the extent to which their ministers of religion serve them as objects of personal identification and emulation? Might not patients' beliefs about God, whether they see God as an imminent or a transcendental deity, an ever-present friend, or an indefinable force, have a bearing on how they face life, their problems, or their illnesses? Taking a careful religious history might provide important clinical information about the patient's religious background, aspects of his social and family integration, his relation to the community and its institutions, whether his family was average or aberrant.

It might also provide guidelines about the quality of early object-relations between parent and child, the development of trust, dependence and separation from parental figures, what the parental situation offered to be integrated into the superego, and the subsequent intellectual and emotional integration of the growing individual. By examining manifestations of religious doubt and rebellion in adolescence and the quality of religious rumination at the end of adolescence, we might determine whether or not a personal system of beliefs and values was ultimately formed as well as the presence or absence of a mature self-image and morality.

Psychiatric Training and Religious Issues

The psychiatric resident himself, dealing with the emotional life of his patients, has the opportunity to review his own inner world. Ignoring the subject of religion (in many training programs the subject is taboo) leaves his own religious world as untouched as that of his patients. In consequence, the opportunity for integration of religious beliefs or attitudes, at the personal level, into the emotional growth pattern provided by psychiatric training is lost to their future professional competence. This may engender insecurity or defen-

siveness in dealing with religious issues which may arise in working with patients.

The problem is more acute for those who provide psychiatric services to religious institutions. Though thoroughly qualified as psychiatrists, they may be lacking in knowledge about the institution they are serving, or the human needs which bring such institutions into existence.

Another unfortunate consequence is that the lack of training in this area tends to perpetuate itself. Generally, psychiatrists are not inclined to deal with issues isolated from the traditional base of psychiatry. Yet psychiatrists should know about the intrapsychic meaning of religious beliefs, if they are to serve adequately the needs of patient populations in religious institutions. To overcome this, we need teachers and supervisors of psychiatric training who know something about religion and religious feelings.

If this Survey could spur the training of young psychiatrists to deal with their own religious feelings as well as those of their patients, it will have fulfilled a most important objective.

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IMPLICATIONS OF DATA FOR CHILD DEVELOPMENT AND RELIGIOUS EDUCATION

MERRITT H. EGAN, M.D.*

The involvement of the providers with children and adolescents in the religious institutions in which they work is unexpectedly great. Adolescents comprised 23.7%, and children, 11.0% of those served, and the academic level of the institutions served was 10.9% on the high school level and 6.5% on the elementary school level. Providers attend church regularly or occasionally (74.3%) and 79.8% of them send their children to religious school. Also, since the types of service rendered included 24.5% consultation and 20.3% training, the assumption that providers play a focal rather than a peripheral role in the institutions they serve may not be too wide of the mark.

The question may justifiably be raised as to whether the psychiatrist has an appropriate role to play in the religious institution apart from the specific psychiatric services which he renders as a professional in the field. It would appear that there are several areas in which he can be of help. For one thing, if he were to impart to church workers his understanding of the psychological development of children, they might benefit greatly from this information, and be more effective in their work. Furthermore, his knowledge of the dynamics of religion and its practices might help to guide religious leaders so that they may avoid certain shoals, especially in working with some age groups. Finally, he can alert religious school and church personnel to warning signals of potential emotional difficulty so that the individuals who may need it can be brought into treatment sooner.

While there were some among the providers (25.3%) who listed themselves as Agnostic or Atheistic, and even more among the non-providers (59.6%), the fact that more than half of the non-providers send their children to religious school (52.9%) and almost half of these (47.0%) are confirmed, attests to the relevance of this Survey to the common concerns of psychiatry and religion.

Turning first to the contributions which knowledge of the psychological development of the child can make to church workers, the following seem worthy of mention:

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*Associate Professor of Psychiatry and Director, Division of Child and Adolescent Psychiatry, College of Medicine, University of Utah, Salt Lake City, Utah.

1. The child's early ideas of God tend to parallel the portrait of the parents which he gains in his home life. His normal impulses and needs often conflict with the do's and don'ts decreed by the parents. An overly-strict or overly-permissive parental pattern may greatly influence future God ideas, as well as character structure. Fears and phobias may relate to earthly and celestial beings alike, and so may regressive tendencies and rebellious behavior. This may prove a fruitful area for preventive psychiatry.

2. During the elementary school years, there is a birth of curiosity about the physical universe and its mechanisms, the beginnings of acceptance of the need to abide by rules and laws, the budding of physical strength and prowess and the recognition of the need to control and direct it wisely, and the first realistic sallies into personal friendships and socialization into peer groups. The church and its institutions and personnel can render invaluable service to the child in this respect because of the permanence of its relationships and ministrations, the inclusion of the entire family within the scope of its interests and offerings, the warmth of ritual which it can add to the intellectual appeal of its dogma, and the belief in a higher power than any earthly authority, God, which is its spiritual point of reference. Thus, living experiences in the home, the Church, the Vestry and the religious school classroom can afford the concrete learnings which abstract teachings alone cannot achieve in this age range.

3. During adolescence, the process of separation from dependency upon the parents begins, and the struggle for independence, with all of its turmoil and trauma, must be undergone by everyone. The parents are not at all immune from the painful accompaniments of the process. The youngsters undergo crises of values and crises of faith, learning that parental love is conditional, and that contradictions and inconsistencies are more realistic findings upon closer examination of adult behavior and attitudes, than the all-loving, all-knowing, all-giving characteristics with which they had formerly endowed them. They also find crass imperfections in their fellow men which are disappointing to them, and the riddles of the cosmic plan of the universe no longer seem as simply solved as they had appeared in their innocent childhood dream-world. Besides, cataclysmic forces and impulses from within (attending the birth of sexuality, whose imperious demands are all but insatiable, but to whose gratification all but intolerable penalties are attached by parents, church, and society), join the multitude of contenders with whom the adolescent novice must do battle.

Here the forces of religion can become powerful allies, if they

but will to do so. The Church can afford support and that unconditional love which can no longer be attributed to parents. It can offer open social companionship when the outside peer group closes its doors; it can inspire active participation in concrete works benefiting the less fortunate, or advancing social causes which appeal to the young person; and it can supply a bedrock of faith when all other values seem rooted in shifting sands. It can replace the imperfection so blatantly demonstrated constantly in the earthly parent-figures, with a sublime perfection in a heavenly Father whose mercy and love are endless and who offers meaning in a meaningless milieu.

Having a strong faith and a dependable moral code can avert disaster during the crises of faith and values in adolescence, if wise counseling is available to tide the youngster over and hold his hand until he is ready to move forward on his own. Rigid requirements of authoritarianism and unbending rules and regulations of church membership may not facilitate the emergence of this type of individual from his painful crises. Living experience proves the best teacher, and like-minded peers joining in the constructive activities of the church enterprise, the best companions. The result is a gradual but permanent shift to adult values and moral codes, as the individual takes his place, with his life-partner at his side, in his home, his church, and his community.

Finally, some cautions derived from psychiatric experience may be of value to the religious fraternity. Scrupulosity has long been recognized as a minus, rather than a plus, by religious leaders. It should be recognized as a warning signal. Conversion can be received with joyous acclaim in most cases, but sometimes it is a cover for underlying psychopathology. It may be a defense against decompensation or suicide, and it may be quite effective if the cause does not lie too deep. Regular, unfailing church attendance by adolescents may partake of the nature of scrupulosity and be a cover-up. A sudden shift to the right from the extreme left, may be evanescent and forecast an even stronger shift back to the left, later on. This is all in addition to the common warning signals with which all religious leaders ought to be familiar, like school-based symptoms of deterioration of interest and grades, absenteeism, withdrawal from accustomed peer-groups and taking up with lower-level companions, deterioration in family relations, violation of tolerable curfews, money irresponsibilities or delinquencies, sexual acting-out, drug involvement, and others.

The team of provider-psychiatrist and aware church-worker can be an effective adjunct to the resources of the community, if the evidence of the survey is to be credited.

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*Dr. Lally's work with our Committee on Religion and Psychiatry was as Consultant in the early stages of formulation of our research. His study is referred to in "The Background of the Research Project," page 1.

**Former member, Committee on Religion and Psychiatry, APA