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SOME SOCIO-CULTURAL DETERMINANTS OF CLERGYMEN'S ROLE CONCEPTS IN THE THERAPEUTIC SETTING

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SOME SOCIO-CULTURAL DETERMINANTS OF CLERGYMEN'S

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PREFACE

Clergymen are in the position to be a valuable member of the therapeutic team dealing with mental illness through the clerical function of counseling parishioners. A large percentage of people with emotional problems consult a clergyman before they consult any other professional person. Thus, it is important that clergymen recognize mental illness, and that clergymen know when a person needs the more specialized help of a psychiatrist or mental hospital.

Historical relations between the fields of psychiatry and religion, however, have been anything but cooperative. It has been only in recent years that a rapprochement between the fields has been taking place, and that the ideal of cooperation between members of these disciplines has seemed possible.

This thesis investigates the relations between religion and psychiatry by examining three important aspects of the clergyman's role in dealing with emotionally disturbed parishioners--recognition of symptoms, professional role concepts, and referral policies. Specifically, the effect of training in pastoral psychology and of the clergymen's religious denomination on their treatment of five hypothetical case histories is examined, and compared with psychiatrists' opinions as to the proper handling of the cases by clergymen.

The data used in the analysis comes from a larger study conducted by Dr. Richard F. Larson (Oklahoma State University Research Foundation, State Project No. 236). Indebtedness is expressed to Dr. Larson for the

opportunity to work with his data, and for his guidance and suggestions in his capacity as chairman of the writer's graduate advisory committee. I also want to thank Dr. Solomon Sutker and Mr. Michael Bohleber, members of the writer's committee, for their patience and valuable suggestions in reading numerous drafts of this thesis, and Dr. John Egermeier for his suggestions on the format of the thesis.

I am also indebted to Dr. Dale Grosvenor, director, and the staff of the Oklahoma State University Computing Center, in particular Mr. Ed Butler who did the programming and the analysis of the data. I also thank Miss Anne Morgan for assistance in typing numerous rough drafts and Mrs. Sandra Grimes for typing the final copy of the thesis.

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CHAPTER I

THE NATURE OF THE PROBLEM

Introduction

This thesis is directed at determining some of the factors influencing clergymen's conceptions of their role in dealing with emotionally disturbed people, and comparing these conceptions with psychiatrists' opinions about the clergyman's role. The importance of this area can be graphically seen in the results of a recent study which found that 42 per cent of the people who consulted a professional person with a personal problem first consulted a clergyman.[1] In the event that a person consulting a clergyman is emotionally disturbed, the importance of agreement between psychiatrists and clergymen as to the nature and extent of the clergyman's role is evident.

A superficial perusal of the literature dealing with the counceling function of clergymen shows that many psychiatrists and other physicians, as well as most clergymen, accord the clergyman a legitimate role in the therapeutic process.[2] There is also much evidence to

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[1] Gerald Gurin, Joseph Veroff, and Shelia Feld, Americans View Their Mental Health (New York, 1960), p. 307.

[2] See for example Sol W. Ginsburg, A Psychiatrist's Views on Social Issues (New York, 1963); Samual R. Laycock, Pastoral Counseling for Mental Health (New York, 1961); Robert A. Preston, "Landmarks in the Relations of Psychiatry and Religion," Bulletin of the Menninger Clinic, 19 (1943), pp. 191-198; Hector J. Ritey, "The Common Grounds Between Psychiatry and Religion," Mental Hygiene, 48 (1964), pp. 351-355.

indicate that clergymen are taking an increasing interest in the psychological and psychiatric aspects and responsibilities of their role.[3]

However, the precise nature and extent of the clergyman's role is the subject of much disagreement between the fields of psychiatry and religion. It is this disagreement, as reflected in the attitudes of clergymen and psychiatrists, that is the subject of this thesis. This study compares clergymen's and psychiatrists' opinions concerning opinions involving the clergyman's role in the therapeutic process and examines the socio-cultural characteristics associated with the extent of agreement between psychiatrists and clergymen. In this way present relations between the fields can be better understood, and perhaps future trends may be indicated.

A Historical View of Religio-Psychiatric Relations

In order to give perspective to the problems involved in finding any source of agreement between psychiatrists and clergymen on the nature and extent of the clergyman's role, it is necessary to briefly review the history of relations between the fields of psychiatry and religion.

While an atmosphere of cooperation between the disciplines of religion and psychiatry seems to be on the horizon, there has been a history of conflict between the two disciplines. These historical factors are still a source of differences between the fields.

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[3] See for example John R. Cavagangh, Fundamental Pastoral Counseling (Milwaukee, 1962); Hans Hofmann, ed., The Ministry and Mental Health (New York, 1960); Wayne E. Oates, An Introduction to Pastoral Counseling (Nashville, 1959).

Originally medicine and religion were one or, at least, were very closely related. Medicine often was a part of religion, since religious leaders were supposed to be physical and mental as well as spiritual healers. But with the rise of materialism and the development of the various sciences, a head-on clash between science and religion was inevitable. Psychiatry as a developing science started moving from "earlier preoccupations with sin and evil and renounced its beliefs in demons, unplacated gods, and other magical causes"[4] for emotional and mental illness.

As this trend continued, a gap appeared between the traditions of religion and the new scientific ideas of psychiatry. With each scientific advance, religion had to surrender part of its domain, and psychiatry, especially in the Freudian tradition of psychoanalysis, seemed to be its deadly enemy. The conflict was heightened by Freud's attitude toward religion and his attacks on it as in The Future of an Illusion.[5] In effect, he declared war upon religion. Religious belief, he argued, is an illusion that man clings to because of emotional immaturity. Once he has achieved emotional maturity, religion has no further use. Hence, it is fated to disappear.[6] It is not surprising that this thesis aroused militant opposition to psychiatry among religious leaders, the effect of which is still felt. Not only was

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[4]Ginsburg, p. 90.

[5]Sigmund Freud, The Future of an Illusion, tr. W. D. Robinscott (New York, 1949).

[6]Louis Linn and Leo W. Schwarz, Psychiatry and Religious Experience (New York, 1958), p. 1.

psychiatry infringing on the traditional religious function of helping people who are troubled, it was attacking religion as well.

In recent years, however, there has been the beginning of a rapprochement between religion and psychiatry. Loomis points out the decline in the differences between religion and psychiatry saying that the "state of warfare, which marked the end of the nineteenth and the beginning of the twentieth century, has largely ceased."[7] There are many indications in the literature that this statement is true, and that religion and psychiatry are becoming more tolerant of each other.

This trend toward accommodation, if not cooperation, can be seen first of all in theological schools. In a survey of theological education in the United States, Neibuhr, Williams, and Gustafson note that the center of interest in the field of pastoral theology today

> ...is in the area of counseling, which includes ministry to people at the point of their anxieties, frustrations, and threats of mental illness....The aim is the fusion of scientific understanding with Christian wisdom and concern.[8]

In a concluding statement these authors write:

> When one considers the revitalization of much in the theological curriculum today through new emphasis in psychology or pastoral counseling, it must be concluded that a significant new turn in the education of the ministry has been taken.[9]

Douglas points out that in the last twenty years, the psychology of religion has been displaced in popularity in theological education

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[7]Earl A. Loomis, "The Religion-Psychiatry Problem at Union Theological Seminary, New York," The Ministry and Mental Health, ed. Hans Hofmann (New York, 1960), p. 185.

[8]H. R. Neibuhr, D. D. Williams, and J. Gustafson, The Purpose of the Church and Its Ministry (New York, 1956), quoted in Richard V. McCann, The Churches and Mental Health (New York, 1962), p. 58.

[9]Ibid.

by pastoral counseling, clinical training, or the broader topic of pastoral psychology.[10] The trend is also evident in counseling clinics conducted under the auspices of religious organizations including theological seminaries.

Pastoral counseling is the single most important activity of the churches in the mental health field. Clinical pastoral education is primarily a Protestant phenomenon.

> Its purpose is to provide the theological student or clergyman with better understanding of human behavior as he meets it in a clinical situation so that he may apply it in his usual relations with his parishioners and to a limited extent in the prevention and treatment of mental illness.[11]

According to the report by the Joint Commission on Mental Illness and Health in 1960, there were 343 programs in clinical pastoral training, counseling or psychology offered by 212 Protestant seminaries.[12] Catholic programs are more oriented to academic instruction, although there are seven Catholic centers for the clinical training of priests and chaplains.[13] It is estimated that between 8,000 and 9,000 clergymen have taken formal courses in clinical pastoral training. Many workshops and refresher courses are available to the 226,000 who have not.[14]

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[10] William Douglas, "Psychology in Theological Education," in Hans Hofmann, ed., p. 86.

[11] Joint Commission on Mental Illness and Health, Action for Mental Health (New York, 1961), p. 134.

[12] Ibid., p. 135.

[13] Ibid.

[14] Ibid.

In addition to the increasing interest by theological seminaries in the area of pastoral psychology, the ministers likewise indicate a concern in this area. A recent survey among several thousand ministers, typical of many such studies, discovered such facts as these:

> Eighty per cent of the pastors want additional training in counseling. Counseling is the skill they most want to improve through special training. Counseling provides pastors with the greatest 'personal enjoyment and sense of accomplishment' of any of their pastoral activities. Pastors feel that counseling is their most effective activity. Over one-half of the pastors feel that their seminary education was deficient in counseling, a far greater percentage than feel inadequacies in any other point in their seminary training.[15]

Another indication of the rapprochement between the fields has been the booming market for how to books and journal articles to help the clergyman perform more effectively his pastoral responsibilities, especially his counseling of those involved in a crisis situation. This has led to an increased interest in psychoanalytic psychiatry.

Klausner notes this trend in religion, pointing out that from a psychological point of view, some ministers may be said to identify with psychiatrists.[16] This applies to some nonconformist ministers attempting to escape contradictions in their traditional role and moving toward psychiatry. Sociologically speaking, they are taking psychiatrists, a non-membership group, as their reference group.[17]

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[15] The Presbyterian Pastor's Ministry to Families (Philadelphia, 1958), quoted in James E. Dittes, "Psychology and a Ministry of Faith," ed. Hofmann, p. 143.

[16] Samuel Klausner, Psychiatry and Religion (Glencoe, Ill., 1964), p. 61.

[17] Ibid.

Some of the reasons for this trend are discussed by Linn and Schwarz.[18] One factor lies in the great advances in the social sciences in general which fired the imagination of everyone, including religious leaders. Because of new findings in the behavioral sciences, many religious leaders came to feel that their traditional techniques were inadequate. This conclusion was reached in some cases as the result of some crisis or failure in the faith of the religious leader that he moved himself to substitute psychiatry and social work for religion and religious counseling. In other cases religious leaders whose convictions remained unshaken were so impressed with the psychological revolution that they became interested in its implications, not only as these implications might affect their own work, but also as they bore upon the contribution by religious leaders to the welfare services of the community.

However, for a true rapprochement between the two disciplines to take place, it would be necessary for both psychiatry and religion to shift from their earlier, mutually hostile positions. There are some indications that a shift by psychiatrists is taking place, in addition to the above mentioned religious shift.

McCann, in his study of 22 metropolitan area psychiatrists, found that most of the psychiatrists were not religious in any formal sense and reported that they rarely encountered explicit religious themes in the content of the illness of their patients, although there were more general and less traditional religious overtones to conflicts centering

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[18] Linn and Schwarz, pp. 1-4.

around conscience and guilt.[19] However, a majority of these professional mental health specialists said they utilize or favor the use of the clergy in connection with treatment and believe clergymen can be a useful resource, given proper training and experience.[20] It is also significant to note that none of McCann's 22 psychiatrists said he was against religion or expressed a belief that the religious view of reality may create psychological problems.

The most vital factor in the shift in psychiatry is related to what Linn and Schwarz call the "moral crisis of our time."[21] The faith of Freud and his followers in "science as a panacea appears naive in the light of nuclear warfare and the apparent readiness of unprincipled politicians to risk the extermination of the entire human race."[22]

As a result of this moral crisis, psychiatry is moving from an original preoccupation with the possible harmful effects of an excessively punitive moral code and is now prepared to recognize that "normal psychological development cannot occur except on a firm moral basis."[23] McCann quotes a psychiatrist as saying, "Having gone through an orthodox Freudian analysis, I've ended up with the conclusion that the church is the major bulwark against man's inhumanity to man."[24]

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[19] Joint Commission on Mental Illness and Health, p. 137.

[20] Ibid.

[21] Linn and Schwarz, pp. 1-4.

[22] Ibid.

[23] Ibid.

[24] McCann, p. 198.

While this certainly is not a typical psychiatric attitude, a widening acceptance by psychiatrists of such ideas would move psychiatry and religion closer together, because a psychiatric recognition of the legitimacy of religion would be implied.

Most authorities recognize that the gap between religion and psychiatry is far from closed. Ginsburg says, "Despite all the efforts, published and otherwise, to create a harmonious relation between religion and psychiatry, there persists a deep and widespread hostility, shared by many if not most of the practitioners of both."[25] Ritey, a psychiatrist, says that "cooperation between the two disciplines will require extremely thorough study and investigation."[26] One example of cooperation between the disciplines is the Academy of Religion and Mental Health which sponsors psychologically oriented training in pastoral counseling. About one-tenth of the nation's nearly 12,000 psychiatrists and 1,000 clergymen are members of the Academy.[27]

While the gap is not closed it is narrowing. Many authors from both disciplines point out the benefits of cooperation between the two areas. Linn and Schwarz believe the findings of research indicate unmistakably that the religious leader is an indispensable member of the treatment team. The psychiatrist, the psychologist, the social caseworker, and members of allied disciplines need his help, just as he needs theirs to round out his own contribution to the community. Above all, according to Linn and Schwarz, the various findings encourage

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[25] Ginsburg, p. 88.

[26] Ritey, p. 355.

[27] Joint Commission on Mental Illness and Health, p. 135.

the belief that continuing research and cooperation among all the helping and healing professions will make for the enhancement of life.[28]

Purpose of the Study

The need for inter-disciplinary cooperation in the area of mental health is now widely recognized. McCann estimates that there are 35 clergymen in this country for every one psychiatrist.[29] Cooperation between clergymen and psychiatrists would expand the effectiveness of mental health programs. However, a major problem exists when the question of implementing cooperation is raised. More specifically, just what should the clergyman's role be when he is confronted by an emotionally or mentally disturbed parishioner? Hopefully, this thesis will be a contribution toward answering this question through comparing how clergymen view their role with how psychiatrists view the role of the clergyman.

Two other closely related problems will also be analyzed. First, do clergymen recognize the symptoms of mental illness. Whether the clergyman does or does not define a person as mentally disturbed is important in how he defines his role in the realm of mental health. Second, in the event that the clergyman defines his role as that of referral to some other professional person, who is this professional to be? Whether it is another clergyman, a general physician, or a psychiatrist is important in determining the present relations between clergymen and psychiatrists.

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[28] Linn and Schwarz, p. 21.

[29] Joint Commission on Mental Illness and Health, p. 137.

If there is to be consensus between psychiatrists and clergymen on the clergyman's role in the therapeutic process, it must first be determined where the differences in opinion lie at the present time. Once this is determined, common ground may be found which may allow agreement to be reached.

CHAPTER II

BACKGROUND OF THE PRESENT STUDY

Introduction

In this chapter, findings of related research will be discussed, and the background for the present study will be outlined. Particular attention will be paid to the role of the clergymen, and the factors which have been found to be associated with psychiatrically favorable attitudes in clergymen. More specifically, research dealing with the effect of such factors as age, training in pastoral psychology, and religious denomination will be reviewed. Also, the present status of clergymen as members of the therapeutic team will be discussed.

Review of the Literature

The Importance of the Clergyman

Evidence clearly indicates that the clergyman has an important role in the therapeutic process for emotionally disturbed parishioners. In the Louisville study by Woodward, 26 per cent of the subjects felt that an emotionally disturbed person would seek advice concerning his condition from a clergyman.[1] Gurin, Veroff, and Feld in their national

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[1]Julian L. Woodward, "Changing Ideas on Mental Illness and Its Treatment," ed. Arnold M. Rose, Mental Health and Mental Disorder (New York, 1955), p. 488.

survey of attitudes found that 42 per cent of the people who have sought professional help for a personal problem in the past first consulted, as a help-source, a member of the clergy.[2] In fact, clergymen were the most frequently consulted professional persons, being consulted more frequently than psychiatrists and other physicians combined.[3]

The Role of the Clergyman

The linkages between religion and psychiatry, the increasing interest of ministers in the area of pastoral counseling and pastoral psychology, and the trend toward education in psychotherapy in religious seminaries still leave unanswered questions about what psychiatrists and clergymen feel the role of the clergyman in the therapeutic setting should actually be. The sociologist, Klausner, in his book Psychiatry and Religion,[4] reports extensive research on the problem of relations between pastors and psychiatrists through analysis and comparison of books in the area of pastoral psychology written by members of both disciplines. He approaches the question of jurisdiction by classifying the responsibility for counseling with respect to the counseling task and the counseling role. Klausner classifies an author's conception of the task as simply psychological or simply religious, or it may be conceived as involving both psychological and religious elements. He

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[2]Gerald Gurin, Joseph Veroff, and Shelia Feld, Americans View Their Mental Health (New York, 1960), p. 307.

[3]Ibid.

[4]Samuel Klausner, Psychiatry and Religion (Glencoe, Ill., 1964).

also classifies an author's conception of the role as either one role, to be carried out by either psychiatrist or clergyman, or two roles, requiring the cooperation of both types of practioner. Klausner calls these breakdowns the problem of task differentiation and the problem of role differentiation. Klausner diagrams these as follows:[5]

		Role Differentiation	
		One Role	Two Roles
Task Differentiation	One Task	Material Reductionists Spiritual Reductionists	Alternativists
	Two Tasks	Dualists	Specialists

Klausner says that although this does not include all positions, it is very nearly inclusive and is the simplest typology. He explains the various positions:

> Reductionists see no reason for either task or role differentiation. Personal problems may be subsumed under a single rubric, and one type of therapist is sufficient. Material reductionists believe that personality and the problem of counseling are exhaustively analyzable in terms of scientific psychology. Psychiatrists in this ground tend to believe that they alone should do psychotherapy. Ministerial material reductionists tend to accept psychiatric therapy but believe that a psychologically trained minister would be a self-sufficient counselor. Spiritual reductionists grasp personality and counseling solely in religious terms. Ministers in this group tend to believe that they alone should counsel. Psychiatrist spiritual reductionists accept pastoral counselors but believe a religiously oriented psychiatrist alone could counsel as well.
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> Dualists believe that a disturbance of personality has both religious and psychological aspects but do not see the need for two types of practitioners. Ministers and psychiatrists in this

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[5] Ibid., p. 155.

group believe that each alone would be a self-sufficient counselor if he were doubly qualified.

The alternativists are opposite to the dualists in their conception. They support role differentiation but retain an undifferentiated concept of the task area. Minister and psychiatrist roles are considered functional alternatives for meeting the same, usually psychological, problem.

The specialists recognize task differentiation and role differentiation. Religious and psychological problems are placed in different, in this sample usually complementary, categories for which the pastoral and psychiatric roles are respectively competent.[6]

Klausner then analyzes the 553 books included in the sample, showing the percentages of ministers and psychiatrists who hold each position. His breakdown is seen in Table I.

TABLE I

PROPORTION OF MINISTERS AND PSYCHIATRISTS ADVOCATING EACH TYPE OF ROLE AND TASK DIFFERENTIATION

Role and Task Differentiations	Ministers	Psychiatrists
Material Reductionists	13%	9%
Spiritual Reductionists	20	10
Dualists	33	23
Alternativists	1	2
Specialists	33	56

Source: Samuel Klausner, Psychiatry and Religion, (Glencoe, Ill., 1964), p. 158.

As the figures show, over half of the psychiatrists are specialists in their counseling orientation as compared with one third of the ministers. Ministers are more likely to be reductionists or dualists than are psychiatrists. These preferences are generally consistent

[6] Ibid., p. 156.

with their orientation toward their clients within their roles. Ministers tend to be concerned with a broad range of parishioner relations. Psychiatrists tend to be specific, to limit concern to a narrow range of the patients' behavior.

Little research has been done to determine the extent to which psychiatrists and clergymen agree on what the clergyman's role should be in the practical situation. Larson, in a study very similar to the one involved in this thesis, found significant differences between clergymen and psychiatrists in their views as to the expected role behavior of clergymen in handling four hypothetical case histories. These case histories included behavior symptomatic of paranoid schizophrenic, hallucinations, nymphomania, and homosexual panic, respectively.[7]

It was found that, while clergymen tend to accept the jurisdictional claim of psychiatrists, clergymen are more likely to define their role as providing major assistance or some assistance while the psychiatrists are more likely to define the role of the clergyman as one of referral.[8] In a limited number of cases psychiatrists indicated the clergyman could be of some assistance. Also, the referral policy mentioned by clergymen differed from the policy suggested by psychiatrists on the four case histories.[9]

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[7]Richard F. Larson, "Clerical and Psychiatric Conceptions of the Clergyman's Role in the Therapeutic Setting," Social Problems, 11 (1964), p. 422.

[8]Ibid., p. 423.

[9]Ibid.

Another study in this general area was conducted by McCann, who interviewed 22 psychiatrists selected at random in a major city.[10] These psychiatrists were asked when a clergyman should refer a parishioner to a psychiatrist. The most frequent components of the responses could be paraphrased variously as when the parishioner appears sick, when he exhibits danger signals, or when he shows obviously bizarre and/or psychotic behavior.[11]

When asked if they ever utilize the clergy in any way in the treatment process, half of these psychiatrists gave a definite yes answer. Only three gave a definite no. In addition one-fourth of this sample of psychiatrists indicated that they use clergymen occasionally, and they spoke favorably of the idea.[12] Also, "the most frequent response to the question, Do you think these clergymen might be a useful resource in combating mental illness?, was an unqualified yes[13] (about one-half of the respondents). If the response was qualified, the qualification most often added was in terms of proper training and/or experience on the part of the clergyman. Another qualification was that the clergy and psychiatrists should work together. However, only three psychiatrists said no.[14]

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[10] Richard V. McCann, The Churches and Mental Health (New York, 1962), p. 202.

[11] Ibid.

[12] Ibid., p. 203.

[13] Ibid., p. 204.

[14] Ibid.

The conclusions of the above study are also relevant to this discussion:

> On the whole there seems to be an uninhibited recognition of the importance of the clergyman's role in mental health combined with criticism directed at the way this role has been played in the past and a lesser degree of criticism directed at the way it is still being played. None is opposed to religion, none expressed the idea that the religious view of reality as such may create problems for his patients, and all welcome the assistance and support that religious affiliations provide for their patients.[15]

Linn and Schwarz, however, have some reservations about the idea of the clergyman becoming involved in the treatment of emotionally disturbed parishioners.[16] While they feel the best of intentions are behind the trend of thinking of the role of the religious leader in psychotherapeutic terms, the results of this trend would result in lessening the effectiveness of the religious leader and would make his position on the psychological team ambiguous. Their reasoning is that each member of a team should confine himself to the techniques of his profession, if there is to be a team. It would be just as mistaken for the religious leader to assume the role of psychotherapist as for the psychiatrist to assume the role of moralist.

Rado points out another peril in the clergyman's involvement in the therapeutic process.[17] The parishioner's unconscious emotional involvement with the clergyman may elicit in the clergyman an unconscious emotional counter-involvement with the parishioner. The clergyman may

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[15] Ibid., p. 206.

[16] Louis Linn and Leo W. Schwarz, Psychiatry and Religious Experience (New York, 1958), p. 87.

[17] Sandor Rado, "The Border Region Between the Normal and the Abnormal," Ministry and Medicine in Human Relations, ed. Iago Galdston (New York, 1955), p. 335.

wish to do more than he actually can and thus end up by defeating his purpose. This involvement may also be a factor in the clergyman's referral policies.

Factors in the Clergyman's Psychiatric Attitudes

Age

In the previously mentioned study of New England clergymen by Larson, age was one variable that was significantly related to the conceptions which clergymen have about their role involvement in some of the case histories.[18] Younger clergymen were more likely to agree with psychiatrist's recommendations pertaining to the extent of the clergyman's involvement in the therapeutic process.

Myers, in a study of a related profession, polled 405 non-psychiatric physicians and found more favorable attitudes in younger physicians than older physicians in regard to mental illness and psychiatric matters in general.[19] He offered two explanations for this. First, younger physicians are more exposed to formal learning about psychiatry in medical school and during their internship than are older physicians. This learning is translated into more interest in the care and treatment of mental disorders. This explanation could also be applied to clergymen in light of the previously mentioned increasing emphasis on pastoral psychology in theological schools. Second, the older physician probably becomes less interested in newer developments than the younger physician. This might hold true for older clergymen also.

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[18] Larson, p. 425.

[19] Robert C. Myers, "Influence of Age on Physician's View Concerning Mental Health Matters," Public Opinion Quarterly, 19 (1955), p. 258.

Training in Pastoral Psychology

Larson found that training in pastoral psychology was positively related to a clergyman's having a role conception which was viewed as favorable by psychiatrists.[20] Those who had training in pastoral psychology had more favorable attitudes than those who had not had this training. Other studies have indicated that education can influence attitudes.

Newcomb pointed out, years ago, that increased familiarity will change attitudes when existing attitudes are fairly weak.[21] He demonstrated this in his study of attitude change at college. He found that the average senior is less conservative than the average freshman.[22] The common element conservatism was applied to such different issues as prohibition, birth control, organized labor, and American isolationism. The study was done during the late thirties.

Other studies have shown that attitude shifts in the area of mental illness can be expected upon exposure to the facts about mental illness. Altrocche and Ersdorfer demonstrated that positive attitude change occurs where information about mental illness is supplied to persons with relatively low levels of information.[23] "Positive attitude change at higher levels of education may be related to other factors such as more intensive training."[24] They cite a study involving 48 nursing

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[20] Larson, p. 425.

[21] Theodore Newcomb, Social Psychology (New York, 1950), p. 200.

[22] Ibid.

[23] John Altrocche and Carl Ersdorfer, "Changes in Attitudes Toward Mental Illness," Mental Hygiene, 45 (1961), p. 569.

[24] Ibid.

students undergoing training in psychiatric nursing in which attitudes were assessed toward personality sketches of people with emotional problems and a number of significant positive attitude changes were found.[25]

Marston and Levine suggest there are two general clusters of variables which are important in the formation of attitudes toward mental health.[26] The person with "greater exposure to mental health problems and the sophistication of the university environment shows more positive attitudes"[27] toward psychologically oriented help-sources. The second cluster seems to involve personal characteristics and general background rather than specific experience. The student "who is more rigid, authoritarian, and less intellectually oriented"[28] has less favorable attitudes toward psychologically oriented help-sources. This would indicate that education in pastoral psychology would be positively related to favorable attitudes toward psychologically oriented help-sources, and would also partially explain why there would be inter-denominational differences, even at the same education level.

Costin found a favorable change in attitudes toward parent-child relationships as a result of one course in child psychology in college.[29]

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[25] Ibid.

[26] Albert R. Marston and Edward M. Levine, "Variables Affecting Mental Hygiene Attitudes in a College Sample," Mental Hygiene, 48 (1963), p. 221.

[27] Ibid.

[28] Ibid.

[29] Frank Costin, "The Effect of Child Psychology on Attitude Toward Parent-Child Relationships," Journal of Educational Psychology, 49 (1958), p. 309.

Bruder and Barb, in discussing the results of a pastoral psychology training program, say "it has become almost axiomatic for a supervisor to look for 'changes' in the student as a result of the training experience."[30]

Freeman and Kassebaum studied the psychiatric attitudes of a random sample of adults in the state of Washington.[31] They found a strong correlation between level of formal education and knowledge of technical psychiatric vocabulary.[32] However, only a low correlation between education and recognition of neurotic symptoms was found.[33] They suggest that basic research is required into the question of the frames of reference by which persons integrate factual information and personal opinion. One of the most important frames of reference in this area would be the religious denomination of the clergymen.

Religious Denomination of the Clergyman

Larson found there were denominational differences in clergyman's conceptions of the clerical role in the therapeutic setting.[34] The more fundamental the denomination, the less favorable from a psychiatric point of view was the attitude. Why are these differences found?

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[30]Ernest E. Bruder and Marian L. Barb, "A Survey of 10 Years of Clinical Pastoral Training at Saint Elizabeths Hospital," Journal of Pastoral Care, 10 (1956), p. 87.

[31]Howard E. Freeman and Gene G. Kassebaum, "Relationship of Education and Knowledge to Opinions About Mental Illness," Mental Hygiene, 44 (1960), pp. 43-47.

[32]Ibid., p. 45.

[33]Ibid., pp. 45-46.

[34]Larson, pp. 422-423.

Psychologically, no one is born a Methodist or a Baptist. He becomes one, and his becoming any one means his forming the appropriate attitudes.[35] Returning to Newcomb's idea that increasing familiarity may bring about attitude change when the existing attitude is weak, we can see why there would be religious denominational differences in attitude, even when training in pastoral psychology is fairly comparable. If there are strongly held pre-existing attitudes, then the effect of training upon attitudes would be minimized. This would be especially true in the fundamentalist denominations where anti-psychiatric attitudes are widely and deeply held.

The problem of pre-existing attitudes is discussed by Shirley Star.

> I think, too, the primary reason for the failure (of mental health education) is readily apparent; it is that mental health education has primarily devoted itself to attempting to implant its psychiatrically oriented conclusions into the thinking of people starting from different premises. Now these conclusions I keep referring to are generally called facts; you know, mental health education disseminates the facts about mental illness.[36]

Stouffer and his associates discuss the same problem in noting that the attitude of only a small proportion of individuals is determined by rational analyses of relevant facts.[37] So the pre-existing attitudes of the clergyman which are determined in part by the beliefs and theology of his religious denomination may act as a barrier to

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[35] Muzafer Sherif and Carolyn Sherif, An Outline of Social Psychology (New York, 1956), p. 488.

[36] Shirley Star, paper read at the 1957 AAPOR meetings, quoted in Freeman and Kassebaum, p. 47.

[37] Samuel A. Stouffer, The American Soldier, Vol. 1, (Princeton, 1949), pp. 465-466.

acceptance of psychiatrically sound beliefs. This would minimize the effect of training, and would influence his role conception in the therapeutic setting.

Wise points out that since pastoral counseling is essentially the personal communication of feelings to a pastor who warrants such a relationship, the pastor's general attitude toward people, his view of man as inherently depraved or creative, and his view of his ministry (pivoting on his concept of God) determine his reactions.[38] And these factors are determined in great part by the denomination of the clergyman.

One other study deserves mention in this review. Namache devised a simple scale along a conservative-liberal line for clergymen involved in counseling.[39] The Protestant ministers who were interviewed were divided into three theological categories, based on their responses: conservative, moderate, and liberal. The moderate Protestant group did by far the most counseling; the liberals were second; and the more conservative pastors (including fundamentalists) did the least.[40]

Theoretical Background for the Study

The study by Gurin, Veroff, and Feld, mentioned at the beginning of this chapter, contained some findings which in combination with

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[38] Carroll Wise, Pastoral Counseling, Its Theory and Practice (New York, 1951).

[39] G. F. Namache, "Pastoral Counseling in Protestant Churches. Part I: The Minister as Counselor," Unpublished Manuscript, Quoted in McCann, p. 76.

[40] Ibid.

findings of other studies indicate a definite need for research into the area of role conceptions of the clergyman. The research will be briefly reviewed as an introduction to the theoretical background for the present study.

When analyzing the responses from 345 subjects in the Gurin, Veroff, and Feld study according to various demographic variables, some interesting relationships appeared. Especially revealing were the help-sources mentioned by persons in various socioeconomic categories. Table II shows the relationship of income to the source of help used. This is a partial table from the study, including only mention of clergymen, physicians, and psychiatrists. The percentages in the table were based on all help-sources, and therefore they do not add up to 100 per cent.

TABLE II

RELATION OF SOURCE OF HELP TO INCOME OF HELP-SEEKERS

	Income in Dollars					
Source of Help	Under $2000	2000-3999	4000-4999	5000-6999	7000-9999	10,000 & over
Clergyman	48%	43%	56%	39%	36%	29%
Physician	18	26	28	33	40	24
Psychiatrist	5	15	12	14	24	47

Adapted from Gerald Gurin, Joseph Veroff, and Shelia Feld, Americans View Their Mental Health (New York, 1960), p. 336.

Table III shows the relationship of education and income to the use of psychiatrists. The percentages are based on the total number of help-sources mentioned by those respondents who reported that they had consulted professional help for a personal problem in the past.

TABLE III

RELATIONSHIP OF EDUCATION AND INCOME
TO THE USE OF PSYCHIATRISTS

	Below Median Income (Under $5,000)			Above Median Income ($5,000 and Above)		
	Grade School	High School	College	Grade School	High School	College
Percentage Using Psychiatrist	4%	11%	23%	16%	20%	32%
Number	(47)	(89)	(35)	(12)	(94)	(63)

From Gurin, Veroff, and Feld, ibid., p. 338.

From these tables it can be seen that those in the lower income and lower education groups are more likely to use a clergyman for help than are those in the upper income and upper education groups. Conversely, those in the upper groups are more likely to use a psychiatrist than are those in lower income and education groups. These findings become even more significant when viewed in the light of research on incidence of mental illness. Other studies indicate that mental illness, especially schizophrenia, is inversely related to social class.[41] Research supports the notion that members of the lower socioeconomic classes are more likely to become mentally ill. And it is the members of this socioeconomic group that are most likely to consult a clergyman for help with a personal problem, as Table I and Table II indicate.

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[41] Arnold M. Rose and Holger R. Stub, "Summary of Studies on the Incidence of Mental Disorders," ed. Arnold M. Rose, pp. 102-103.

Now obviously not all of the people who consult a clergyman have severe mental disturbances. It seems reasonable to conclude, however, that a number of them would need some type of therapy over and above that which a clergyman, even well-trained, could provide. Gurin, Veroff, and Feld discuss the importance of the clergy as diagnostic agents.[42] Clergymen should know which of the cases that come to them should be referred to psychiatric specialists. This includes cases that are not perceived by the people in difficulty as psychological and personal. The clergyman should be able to handle the resistances of those they wish to refer since many of the people who come with problems do not see the difficulty as psychological or personal and, even when they do, they do not see the cause of the problem in themselves. This hope might be a little optimistic, however, at the present time. But, the importance of the clergyman's recognizing his own limitations and the needs of his parishioners is obvious. But does he? Gurin, Veroff, and Feld provide a partial answer.

They note that "the path to the doctor or clergyman is a direct one, almost always unmediated by any formal or even informal referral source. Psychiatrists, clinics and social agencies, being less well known to the public are usually reached through some referral agent."[43] Because clergymen are the most frequently consulted source of help for a personal problem we would expect them to be high on the list of referral agents to psychiatric therapeutic resources. Gurin, Veroff,

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[42] Gurin, Veroff, and Feld, p. 307.

[43] Ibid., p. 316.

and Feld's figures indicate that in their sample of those who were referred to psychiatrists from some referral agent, 29 per cent were referred by physicians, 29 per cent were referred by family and friends, 10 per cent by schools, courts, and other civic agencies; only three per cent were referred by clergymen. The remainder were referred by mass media or some other referral agent.[44]

These data suggest a rather unfortunate and unhappy picture. Clergymen are most likely to be consulted for help, especially by those groups in which a large amount of mental illness is found. But they are unlikely and possibly unwilling to refer these people to further, more specialized help. As Gurin, Veroff, and Feld conclude, "Ministers apparently see themselves as the final therapeutic agent much more often than physicians do since clergymen do not so often refer the people that come to them to more specialized therapeutic resources.[45] Their conclusions may be questionable only because a small number, 96 cases, was used in securing the results. The number was necessarily small because only a small number of people go to psychiatric resources, and only a small number, less than one-third, of these mention some referral agent as leading them to the psychiatric agent.

Their findings, however, received some substantiation from a study by Wolfrom, Pang, and Courtney who interviewed the wives of mental patients in a state mental hospital in Washington state.[46] The average

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[44]Ibid., p. 315. It should be noted that the percentages mentioned include only those respondents who spontaneously mentioned referral from an outside source.

[45]Ibid., pp. 314-315.

[46]Essey Wolfrom, Lila Pang, and Barbara Courtney, "Roads to the Mental Hospital," Mental Hygiene, 47 (1963), pp. 398-407.

number of contacts made by the patients before commitment to the mental hospital was three. These contacts were as follows: physicians 70 per cent, clergymen 42 per cent, psychiatrists 39 per cent, hospitals 39 per cent, social agencies 36 per cent, mental illness court and prosecuting attorneys 25 per cent, attorneys 18 per cent, uncertified psychologists 18 per cent, others 14 per cent.[47] Once again the clergyman was in the position to be an important referral agent in counseling people who actually required hospitalization. Yet, "of the 12 wives who made contact with the clergy, seven said marriage counseling was recommended, and six said they received 'comfort.' In only one case did the clergyman recommend the possibility of the need for psychiatric care for the husband."[48] In comparison, of the 22 families seeing a physician, there were 12 recommendations for the state hospital and five referrals to psychiatrists.[49]

This thesis will examine various socio-cultural factors which might determine or shape a clergyman's professional role concept in the therapeutic process. Particular attention will be focused both on variables which seem to create within the clergyman a negative attitude about psychiatry, and on those which seem to be associated with producing within a clergyman a professional role concept in line with those recommended by psychiatrists. The hypotheses to be tested should provide information as to the impact that (1) training in pastoral counseling and/or pastoral

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[47] Ibid., p. 403.

[48] Ibid.

[49] Ibid.

psychology has on professional role concepts, and (2) certain aspects of denominational ideology has on professional role concepts.

Little research has been done on this problem. Atwood[50] and Bruder and Barb[51] have reported data supporting the hypothesis that increased training in pastoral psychology and counseling brings about both a more favorable psychiatric orientation and a more favorable professional concept from a psychiatric standpoint. A study by Gynther and Kempson,[52] however, cast some doubt on these findings. The previously mentioned study by Larson once again indicated that training in pastoral psychology was associated with what psychiatrists indicate to be a favorable professional role concept of clergymen.[53] In addition it was found that the clergymen of more liberal religious denominations showed closer agreement with psychiatric standards than did clergymen of fundamentalist denominations.

This study will examine the relationship between professional role concepts of clergymen and training in pastoral psychology, as well as test hypotheses regarding the relationship between professional role concepts and religious ideologies. In addition, the analysis will include examination of clergymen's recognition of symptoms of mental illness.

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[50] B. M. Atwood, "Personal Change in Clinical Pastoral Training," Unpublished Doctoral Dissertation, Columbia University, 1958. Quoted in Malcomb D. Gynther and J. Orbert Kempson, "Seminarians and Clinical Pastoral Training: A Follow-Up Study," Journal of Social Psychology, 56 (1962), p. 9.

[51] Bruder and Barb, p. 90.

[52] Malcomb D. Gynther and J. Orbert Kempson, "Personal and Interpersonal Changes in Clinical Pastoral Training," Journal of Pastoral Care, 12 (1958), p. 218.

[53] Larson, p. 425.

and attempt to determine to whom clergymen would refer a mentally ill parishioner in the event that they feel they could not handle the case alone.

In testing the above mentioned relationships, this study is very similar to the above mentioned study by Larson. However, there are several important differences between the two studies. The Larson study used four hypothetical case histories. These same four case histories are used in the present study. In addition, a fifth case history is used in this study. The Larson study was conducted in a New England state with predominantly Roman Catholic clergymen. The present study is conducted in a Southwestern state with a predominantly Protestant population. The sample used in the present study is also much larger than the earlier Larson study. The final important difference is the statistical procedure used. While the Larson study used chi-square, the present study uses the more powerful Mann-Whitney U statistic.

CHAPTER III

HYPOTHESES AND METHODOLOGY OF STUDY

The preceding chapter outlines the theoretical background for the present study. The hypotheses tested in the research as well as operational definitions of the terms used are listed in this chapter. In addition, the methodology of the study and the statistical procedures used in the testing of the hypotheses are discussed.

Hypotheses

This thesis is centered around the testing of six hypotheses. These deal with clergymen's recognition of symptoms of mental illness, the professional role concepts of clergymen, and clergymen's willingness to refer emotionally disturbed persons to a psychiatrist. College training in pastoral psychology or counseling and religious denomination of clergymen are treated as independent variables. The hypotheses are stated here in research, rather than null, form.

Hypothesis 1: Clergymen with college training in pastoral psychology are more likely to recognize selected symptoms as being associated with mental illness than are clergymen without this training.

Hypothesis 2: Roman Catholic and Conventional Protestant clergymen are more likely to recognize selected symptoms as being associated with mental illness than are Fundamentalist and Conservative Protestant clergymen.

Hypothesis 3: The professional role concepts of clergymen with college training in pastoral psychology are more likely to conform to psychiatric standards than are the professional role concepts of clergymen without this training.

Hypothesis 4: The professional role concepts of Roman Catholic and Conventional Protestant clergymen are more likely to conform to psychiatric standards than are the professional role concepts of Fundamentalist and Conservative Protestant clergymen.

Hypothesis 5: The referral policies of clergymen with college training in pastoral psychology are likely to conform more closely to psychiatric standards than are the referral policies of clergymen without this training.

Hypothesis 6: The referral policies of Roman Catholic and Conventional Protestant clergymen are likely to conform more closely to psychiatric standards than are the referral policies of Fundamentalist and Conservative Protestant clergymen.

Definition of Terms

The terms used in the hypotheses are operationalized in the following way for this study:

Clergyman refers to any person recognized by the central office of his religious denomination as a clergyman or any person who claims to be a clergyman. Clergymen are divided into four religious categories for purposes of analysis.

Roman Catholic refers to any person defined by the Roman Catholic Church as a priest in the state of Oklahoma.

Fundamentalist Protestant is one of three categories into which Protestant denominations are divided.[1] Fundamentalist Protestant includes clergymen identified with Assembly of God, Pentecostal, Pentecostal Holiness, Church of the Nazarine, or the Churches of God.

Conservative Protestant includes clergymen identified with Church of Christ, Southern Baptist, or other Baptist churches.

Conventional Protestant includes clergymen identified with Presbyterian, Lutheran, Episcopalian, Methodist, or Disciples of Christ churches.

Psychiatrist refers to a M.D. listed in the 1963 American Medical Association Directory as a psychiatrist in the state of Oklahoma.

Selected symptoms refers to behavioral symptoms described in five hypothetical case histories which clergymen and psychiatrists are asked to evaluate. The case histories are presented in the next section of this chapter.

Emotionally disturbed person refers to the individual described in each hypothetical case history who exhibits selected symptoms of emotional disturbance.

Professional role concept refers to the expressed opinion of a clergyman as to the extent he can help the emotionally disturbed person

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[1] Religious denominations are divided into categories following the lines of Dynes' Church-Sect Typology on the basis of (a) acceptance or rejection of secular value systems, (b) literal Biblical interpretation, (c) amount of professionalization of officials, and (d) emphasis on evangelism. See Russell Dynes, "Church-Sect Typology and Socio-Economic Status," American Sociological Review, 20 (1955), pp. 555-560. Sociology students in a graduate level methodology class and two staff members are used as judges in the present study and fit the various Protestant denominations into three categories.

described in a hypothetical case history, i.e., handle alone, provide major assistance, etc.

Psychiatric standard refers to the distribution of expressed opinions of 54 Oklahoma psychiatrists as to how a clergyman ideally should respond to the items concerning the five hypothetical case histories.

Training in pastoral psychology refers to formal course work done in pastoral psychology or counseling as measured by the number of completed college semester hours in these subjects reported by each clergyman.

Referral policy refers to clergyman's responses to a question concerning to whom he would make a referral in the five hypothetical case histories.

Data

Clergymen. A 12 page questionnaire was mailed to 5,542 clergymen in the state of Oklahoma. The master list of clergymen was compiled from data furnished by the central offices of numerous denominations, from Go To Church columns in local newspapers, from the yellow pages in telephone directories, and from individual clergymen of small denominations known to the investigator. The master list was fairly complete as indicated by the fact that it contained approximately 1,200 clergymen more than reported in the 1960 U. S. Census of Population for the state.

Clergymen were asked to respond to three structured questions concerning each of five hypothetical case histories contained in the questionnaire. These case histories dealt with parishioners who could be classified as abnormal or possibly psychotic. After reading each

case history the clergymen were asked, "To what extent is the person emotionally disturbed?" (no evidence of emotional disturbance, mild emotional disturbance, moderate emotional disturbance, severe emotional disturbance). Responses from this question are used in testing hypotheses one and two--clergyman's recognition of symptoms of mental illness. Next the clergymen were asked, "To what extent could you help this person?" (handle alone, provide major assistance, provide some assistance, referral to professional person only). These responses are used to test hypotheses three and four which deal with the professional role concepts of clergymen. Finally they were asked, "Is there anyone to whom you would recommend that this person go?" (no, another clergyman, family physician, psychiatrist, other). Responses from this question are used in testing hypotheses five and six dealing with the referral policies of clergymen.

The hypothetical case histories to which the clergymen were asked to respond are as follows:

> CASE ONE: Mrs. Smith is a pleasant woman in her forties. She has been very active in church or synagogue affairs and is considered a good woman. She states that she conversed with God shortly after seeing a strange star a few weeks ago. Later, in a vision she saw and heard God talking with His angels. She also got a glimpse of the devil and thefires of Hell. She repeatedly hears a strange voice telling her what to do and how to behave. Mrs. Smith wants to know whether she should obey the voice.

> CASE TWO: Mr. Brown is a young man in his twenties. During the last two years he has become very suspicious. He comes to you because his wife insists that he seek help. Mr. Brown does not trust anybody, and he is sure that everybody is against him. Sometimes he thinks that the people he sees on the street are talking about him or following him around. He began to curse his wife terribly, then he hit her and threatened to kill her because, he said, she was working against him too, just like everyone else.

CASE THREE: Mrs. Thompson has been widowed for five years. She is a respectable person whose husband died when she was just 20. They had no children, and she went home to her parents. She has not had a job in five years and does not seem to want to go out and look for one. She is very quiet; she does not talk much to anyone--including her parents. She acts as if she is afraid of people, especially young men her own age. She won't go out with anyone and whenever someone comes to visit her parents, she stays in her own room until the person leaves. She just stays by herself and daydreams about her husband.

CASE FOUR: Mrs. Green is a young woman who is physically incapable of having children. She comes to you because she is experiencing serious marital difficulties. Mrs. Green has been unfaithful to her husband although she does engage occasionally in marital relations with him. She feels that her husband cannot sexually satisfy her, and, consequently, she actively seeks out other men on numerous occasions. She has become so preoccupied seeking "adequate" sexual satisfaction that she can no longer carry out her normal household duties.

CASE FIVE: Mr. Jones is a young man in his thirties and unmarried. He comes to you for counsel. He complains of regular headaches and that he is working too hard. Then--without any preliminaries--he starts talking about sexual problems. He is afraid that he is perverted and has been bothered with homosexual thoughts. He claims to have had no heterosexual contact, but masturbates a great deal. He wants advice and help to make him normal. He tends to go off on a long monologue about his sex life and is difficult to interrupt.

A total of 5,542 questionnaires were mailed to clergymen. One-half of these questionnaires contained the hypothetical case histories used in the analysis of the hypotheses in this thesis. The remaining half of the questionnaires contained the same symptoms in the case histories, but the sex of the persons described in the case histories is reversed in order to test the impact of sex of the described person on the judgments of clergymen. Since this problem is outside the scope of this thesis, only the previously described half of the questionnaires are used. The total sample of clergymen was divided at random in sending out the two forms of the questionnaire so that the responses from each half of the clergymen would be representative. A total of

994 clergymen returned questionnaires of the form used in this analysis, representing slightly more than 36 per cent of those mailed out.[2]

Psychiatrists. All of the 104 Oklahoma physicians listed in the 1963 American Medical Association Directory as psychiatrists were mailed a questionnaire which contained the same case histories that were included in the clergymen's questionnaire. The structured questions and response categories were modified slightly, as can be seen in Appendix A, because the psychiatrists were asked how clergymen should respond rather than how they themselves would respond.

Each psychiatrist was asked to specify how, from his viewpoint as a psychiatrist, members of the clergy should ideally respond when confronted by the five hypothetical case histories. They were not asked to take the role of the clergymen and give the response that the clergyman should give. Fifty-four questionnaires were returned by psychiatrists, a return rate of 52 per cent.

The distribution of responses from the psychiatrists is used as a psychiatric norm to which clergymen's responses are compared. The hypotheses posit that there will be differences between trained and untrained clergymen and between clergymen in various religious categories. The hypotheses furthermore posit that responses from trained clergymen and clergymen from the Roman Catholic and Conventional Protestant categories would be closer to the psychiatric norm than

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[2]The literature indicates that bias of non-response can be, in some degree, measured by comparison of early returns with late returns. This is done in the present study, and very few significant differences are found between the early and late returns. This indicates that the respondents were similar to the non-respondents.

responses from untrained clergymen and clergymen from Fundamentalist and Conservative Protestant categories, respectively. The responses from the psychiatrists are used as a standard for determining which group is closer to psychiatric expectations where there is a difference noted among groups of clergymen. The psychiatric norm is not posited as absolutely correct, rather it is used as a basis of comparison only, as a standard for evaluating the responses of clergymen. Since psychiatrists are the recognized authorities in the area of mental illness, the use of their responses as a standard for comparison seems legitimate.

Coding

The responses of both clergymen and psychiatrists are coded in a similar manner. On the first two questions for each case history--the extent of illness and the extent the clergymen could help--the responses are coded 1,2,3, and 4 in order of the response categories listed in the questionnaire. The response categories for the third question which deals with referral policy--no referral, other clergyman, family physician, psychiatrist, and other--are modified for coding purposes. Three categories are used. Responses of no referral, other clergymen, and others listed which are non-professional are combined into one category called non-professional and coded <u>one</u>. Family physician is coded <u>two</u>. Psychiatrists and others mentioned which were of a psychological nature--such as clinical psychologist, psychiatric social worker--were combined into a category called psychiatrically oriented professional person and coded <u>three</u>.[3]

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[3]The data were put on IBM cards and were programmed for and analyzed by the IBM 7040 computer at the Oklahoma State University Computer Center.

Statistical Procedures

Two statistics are used in the testing of the six hypotheses. The first is the Mann-Whitney U;[4] the second is a measure of probability called the Bernoulli model.[5]

Mann-Whitney U z-scores are used to test if responses from any two groups are significantly different. Initially, this statistic is applied to psychiatrists' and clergymen's responses on each question concerning each case history. It is necessary to know these differences between clergymen and psychiatrists in order to determine which group is closer to the psychiatric norm when sub-groups of clergymen are compared. These sub-groups are, of course, trained, untrained clergymen, and the clergymen in the four religious categories. It is these groups with which the hypotheses deal.

After differences between clergymen and psychiatrists are determined, the analysis proceeds to the differences between the sub-groups of clergymen. Mann-Whitney U z-scores are also used in testing these differences. Because differences between clergymen and psychiatrists were determined in the first step, it can be determined in this second step which sub-group is closer to the psychiatric norm when significant differences are present among the sub-groups.

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[4] See Sidney Siegel, Non-Parametric Statistics for the Behavioral Sciences (New York, 1956), pp. 116-127. Mann-Whitney is used to determine if the responses from two groups on an ordinal scale are independent of one another. It should also be noted that statistical independence is being tested rather than goodness of fit to the psychiatric norm.

[5] For a discussion of the Bernoulli model see Jacob Marchak, "Probability in the Social Sciences," Mathematical Analysis in the Social Sciences, ed. Paul F. Lazarsfeld (Glencoe, Ill., 1954), pp. 166-187.

Once again these differences were computed for each question on each case history. It is recalled that for each of the five case histories there are three questions; one concerning the recognition of symptoms, one concerning the professional role concept of clergymen, and the final one concerning the referral policies of clergymen. The six hypotheses deal with these three questions.

Since there are five case histories and comparisons among several groups of clergymen involved on each hypothesis, it is necessary to use some measure of probability in order to determine if the null hypotheses should be accepted or rejected. The Bernoulli model of probability is used to test the hypotheses. As can be seen in the next chapter, there are 15 separate comparisons on hypotheses involving training in pastoral psychology and there are 20 separate comparisons on hypotheses involving religious category of the clergymen. The Bernoulli model is used in determining how many of these possible significant differences are required in order for the null hypotheses to be accepted or rejected. It found that on hypotheses (training) on which there are 15 comparisons, three significant differences (out of the 15 possible between trained and untrained clergymen) are required to reject each of the null hypotheses. On the hypotheses (religion) in which there are 20 comparisons, four significant differences (out of the 20 possible) between Fundamentalist-Conservative and Catholic-Conventional are required to reject each of the null hypotheses.

On each of the six hypotheses, the same procedures involving both Mann-Whitney U and the Bernoulli model are used. The results of this analysis are reported in the following chapter.

CHAPTER IV

RESULTS

The findings of the present study are presented in this chapter. The hypotheses that training in pastoral psychology and religious category of clergymen are associated with recognition of mental illness symptoms, professional role concepts and referral policies of clergymen are examined.

It is recognized that the variables--training in pastoral counseling and religion--are not independent of one another. Furthermore, such variables as age and family background could also have an effect on clerical responses. Therefore, several tests are made of each hypothesis, some involving controls, others not. The basic tests are presented first; those involving controls are summarized at the end of this chapter.

Mann-Whitney U z-scores pertaining to the six hypotheses are seen in Tables I through VI. Unless otherwise designated in the table, all significant differences ($p < .05$) are in the direction hypothesized.

As is shown in these tables, there are many significant differences between groups of clergymen. These differences are used in testing the six hypotheses. Fifteen comparisons appear on each of the first three tables, three comparisons on each of the five case histories. On each of the final three tables there are 20 comparisons, four comparisons on each of the five case histories.

The hypotheses are tested by applying the Bernoulli model of probability to the significant differences on each table. In other words, how many significant differences (out of 15 on training hypotheses, out of 20 on religious category hypotheses) are necessary in order for the hypothesis that there are no differences to be rejected? Using the Bernoulli model, it is determined that three significant differences out of a possible 15 is significant at the .05 level. Four out of 20 possible significant differences is significant at the .05 level.

Summary of Results

In this investigation, six hypotheses are statistically tested using data for 994 Oklahoma clergymen. In this section, results of the study are shown in tabular form and are summarized separately for each hypothesis that is tested. The types of statistical tests utilized in the testing are also given. These results are reported in the order of analysis, not in the order in which the hypotheses are listed in the previous chapter.

I. Hypothesis

Clergymen with college training in pastoral psychology are more likely to recognize selected symptoms as being associated with mental illness than are clergymen without this training.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (see Table IV)

Four of the 15 comparisons of trained and untrained clergymen show a significant difference ($p. < .05$) in the direction hypothesized.

According to the Bernoulli model, four out of 15 is significant at the .01 level.

TABLE IV

RECOGNITION OF MENTAL ILLNESS SYMPTOMS ON FIVE CASE HISTORIES COMPARED BY COLLEGE TRAINING OF CLERGYMEN (Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Hours of Training Comparison	Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	None against 1-3	1.840	
	None " 4-6	3.947	.001*
	None " 7+	2.890	.01
Paranoid Schiz.	None against 1-3	0.339	
	None " 4-6	0.459	
	None " 7+	0.745	
Simple Schiz.	None against 1-3	1.576	
	None " 4-6	2.191	.05
	None " 7+	2.195	.05
Nymphomaniac	None against 1-3	0.428	
	None " 4-6	1.206	
	None " 7+	1.402	
Homo. Panic	None against 1-3	0.390	
	None " 4-6	0.760	
	None " 7+	1.327	

*Significant difference in direction hypothesized unless otherwise designated.

Disposition of Hypotheses

Null: Rejected

Research: Confirmed

Discussion

There are differences between trained and untrained clergymen only

on the case histories previously labeled Hallucinator and Simple Schizophrenic. Differences are present on these cases only between the clergymen with no training and those with 4 to 6 and 7 or more college hours of training. No differences are found between those with no training and those with 1 to 3 hours. In all cases where a significant difference is present, psychiatrists view the symptoms as more serious than do the clergymen as a whole.

II. Hypothesis

The professional role concepts of clergymen with college training in pastoral psychology are more likely to conform to psychiatric standards than are the professional role concepts of clergymen without this training.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (See Table V)

Six of the 15 comparisons between trained and untrained clergymen show a significant difference ($p < .05$). All of these differences are opposite to the direction hypothesized. According to the Bernoulli model, six out of 15 is significant at the .001 level.

Disposition of Hypotheses

Null: Rejected

Research: Rejected

Discussion

Contrary to the research hypothesis, clergymen with training in pastoral psychology are farther from the psychiatric standard of the clergyman's professional role than are untrained clergymen. Four of the six differences are between those with no training and

TABLE V

PROFESSIONAL ROLE CONCEPT ON FIVE CASE HISTORIES
COMPARED BY COLLEGE TRAINING OF CLERGYMEN
(Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Hours of Training Comparison	Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	None against 1-3	0.317	
	None " 4-6	0.420	
	None " 7+	1.635	
Paranoid Schiz.	None against 1-3	0.033	
	None " 4-6	1.835	
	None " 7+	2.687	.01*
Simple Schiz.	None against 1-3	0.698	
	None " 4-6	1.733	
	None " 7+	2.608	.01*
Nymphomaniac	None against 1-3	0.801	
	None " 4-6	2.125	.05*
	None " 7+	3.561	.001*
Homo. Panic	None against 1-3	1.058	
	None " 4-6	2.781	.01*
	None " 7+	3.959	.001*

*Item discriminated in direction opposite than that hypothesized.

those with 7 or more hours training, the remaining two differences are between those with no training and those with 4 to 6 hours training, while there are no significant differences between the untrained clergymen and those with 1 to 3 hours training. This indicates that the more training a clergyman has had, the more competent he feels in dealing with an emotionally disturbed parishioner, a competence which psychiatrists are not willing to concede to him. It should also be noted that four of the six significant differences occur on the case histories involving sexual problems.

III. Hypothesis

The referral policies of clergymen with college training in pastoral psychology are more likely to conform more closely to psychiatric standards than are the referral policies of clergymen without this training.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (see Table VI)

Thirteen of the 15 comparisons between trained and untrained clergymen show a significant difference ($p < .05$) in the direction hypothesized. According to the Bernoulli model 13 out of 15 is significant at the .001 level.

Disposition of Hypotheses

Null: Rejected

Research: Confirmed

Discussion

Significant differences are present on all but two of the comparisons between trained and untrained clergymen. These two are the comparisons of no training and 1 to 3 hours training on the cases labeled Simple Schizophrenic and Nymphomaniac. The differences present simply indicate a greater willingness on the part of clergymen with training in pastoral psychology to make a referral to a psychiatrist. Those with no training are more likely to recommend referral to a family physician, to some non-psychiatrically oriented person, or to recommend no referral.

IV. Hypothesis

Roman Catholic and Conventional Protestant clergymen are more

likely to recognize selected symptoms as being associated with mental illness than are Fundamentalist and Conservative Protestant clergymen.

TABLE VI

REFERRAL POLICIES ON FIVE CASE HISTORIES COMPARED BY COLLEGE TRAINING OF CLERGYMEN (Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Hours of Training Comparison	Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	None against 1-3	2.109	.05*
	None " 4-6	4.535	.001
	None " 7+	5.919	.001
Paranoid Schiz.	None against 1-3	3.200	.01
	None " 4-6	2.075	.05
	None " 7+	5.145	.001
Simple Schiz.	None against 1-3	1.629	
	None " 4-6	2.897	.01
	None " 7+	2.836	.01
Nymphomaniac	None against 1-3	1.500	
	None " 4-6	2.897	.01
	None " 7+	4.232	.001
Homo. Panic	None against 1-3	2.774	.01
	None " 4-6	2.473	.05
	None " 7+	3.475	.001

*Significant difference in direction hypothesized unless otherwise designated.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (See Table VII)

Ten of the 20 comparisons between these groups of clergymen show a significant difference ($p < .05$). Eight of these differences are

TABLE VII

RECOGNITION OF MENTAL ILLNESS SYMPTOMS COMPARED BY RELIGIOUS CATEGORY OF CLERGYMEN
(Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Compared by Religious Category	Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	Fund. against Cath.	3.898	.001*
	Fund. " Conv.	5.281	.001
	Cons. " Cath.	1.738	
	Cons. " Conv.	1.176	
Paranoid Schiz.	Fund. against Cath.	0.414	
	Fund. " Conv.	1.684	
	Cons. " Cath.	0.579	
	Cons. " Conv.	2.243	.05
Simple Schiz.	Fund. against Cath.	0.304	
	Fund. " Conv.	2.097	.05
	Cons. " Cath.	0.297	
	Cons. " Conv.	1.429	
Nymphomaniac	Fund. against Cath.	5.162	.001
	Fund. " Conv.	2.810	.01
	Cons. " Cath.	3.888	.001
	Cons. " Conv.	0.476	
Homo Panic	Fund. against Cath.	4.938	.001**
	Fund. " Conv.	3.257	.01
	Cons. " Cath.	3.746	.001**
	Cons. " Conv.	1.249	

*Significant differences in direction hypothesized unless otherwise designated.
**Significantly different, but on opposite sides of psychiatric norm. Not clear which group closer to psychiatric norm.

in the direction hypothesized. The remaining two are inconclusive as to which group is closest to the psychiatric standard. Ignoring these two inconclusive differences, the remaining eight out of 20 differences is significant at the .001 level, according to the Bernoulli model.

Disposition of Hypotheses

Null: Rejected

Research: Confirmed

Discussion

This discussion is confined to the eight differences on which distance from the psychiatric standard could be determined. Five of the differences involved Conventional Protestant differing from the Fundamentalist-Conservative groups; only three of the differences show Catholics differing. The differences are most pronounced on the cases labeled Hallucinator and Nymphomaniac. It should also be noted that on the Hallucinator, Paranoid Schizophrenic, and Simple Schizophrenic cases, psychiatrists view the symptoms as more severe than do clergymen. So clergymen who view the symptoms as being most serious are closer to the psychiatric standard than are clergymen who take a less serious view of the symptoms on these three cases. However, on the two cases involving a sexual problem, the Nymphomaniac and the Homosexual Panic, clergymen judge the symptoms as being more severe than the psychiatrists view them. In these cases the clergymen who see the symptoms as least severe are closer to the psychiatric standard than are those clergymen who see evidence of severe emotional disturbance in the symptoms.

V. Hypothesis

The professional role concepts of Roman Catholic and Conventional Protestant clergymen are more likely to conform to psychiatric standards than are the professional role concepts of Fundamentalist and Conservative Protestant clergymen.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (see Table VIII)

Significant differences ($p < .05$) are present on ten out of the 20 possible significant differences. However, three of these are in the opposite direction to that hypothesized. These are all on the Homosexual Panic case history. The seven out of 20 significant differences is significant at the .001 level according to the Bernoulli model, while three out of 20 could have occured by chance. However, since there are no differences in the direction hypothesized on the two cases with sexual problems, this is probably not due to chance.

Disposition of hypotheses

Null: Rejected.

Research: Partially confirmed.

Discussion

The hypothesis is confirmed for the three case histories which do not involve a problem related to sex. Results on these two cases, while inconclusive, indicate that the Conventionalist and especially the Roman Catholic clergymen define their professional role as being larger or broader than do the Fundamentalist and Conservative Protestant clergymen. Hence, former groups deviate more

TABLE VIII

PROFESSIONAL ROLE CONCEPT ON FIVE CASE HISTORIES
COMPARED BY RELIGIOUS CATEGORY OF CLERGYMEN
(Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Compared by Religious Category	Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	Fund. against Cath.	4.862	.001*
	Fund. " Conv.	7.054	.001
	Cons. " Cath.	1.282	
	Cons. " Conv.	0.272	
Paranoid Schiz.	Fund. against Cath.	4.262	.001
	Fund. " Conv.	6.727	.001
	Cons. " Cath.	2.716	.01
	Cons. " Conv.	3.734	.001
Simple Schiz.	Fund. against Cath.	0.304	.001
	Fund. " Conv.	2.097	.05
	Cons. " Cath.	0.297	
	Cons. " Conv.	1.429	
Nymphomaniac	Fund. against Cath.	1.273	
	Fund. " Conv.	1.315	
	Cons. " Cath.	1.701	
	Cons. " Conv.	1.440	
Homo Panic	Fund. against Cath.	2.184	.05**
	Fund. " Conv.	0.776	
	Cons. " Cath.	3.702	.001**
	Cons. " Conv.	2.956	.01**

*Significant differences in direction hypothesized unless otherwise designated.
**Item discriminated in direction opposite to that hypothesized.

from the psychiatric standard. The case history which most strongly supports the hypothesis is the Paranoid Schizophrenic where four significant differences are found.

VI. Hypothesis

The referral policies of Roman Catholic and Conventional Protestant clergymen are likely to conform more closely to psychiatric standards than are the referral policies of Fundamentalist and Conservative Protestant clergymen.

Statistical Tests

Mann-Whitney U two-tailed test, Bernoulli probability model.

Results (See Table IX)

Sixteen of the 20 comparisons between these groups of clergymen show a significant difference ($p < .05$) in the direction hypothesized. According to the Bernoulli model, 16 out of 20 differences is significant at the .001 level.

Disposition of Hypotheses

Null: Rejected

Research: Confirmed

Discussion

It is in referral policies that the strongest differences between Catholic-Conventional and Fundamentalist-Conservative clergymen are found. However, three of the four non-significant differences occur in comparisons involving Roman Catholics on the case histories containing sexual problems. This reflects, to some extent, less Catholic willingness to refer sexual problems to psychiatrists than to refer other types of problems. On all of the significant

TABLE IX

REFERRAL POLICIES ON FIVE CASE HISTORIES COMPARED
BY RELIGIOUS CATEGORY OF CLERGYMEN
(Mann-Whitney U z-Scores and Significant Probabilities)

Case History	Compared by Religious Category		Mann-Whitney U z-Scores	Probability (Two-Tailed)
Hallucinator	Fund. against	Cath.	5.563	.001*
	Fund. "	Conv.	8.824	.001
	Cons. "	Cath.	2.771	.01
	Cons. "	Conv.	3.641	.001
Paranoid Schiz.	Fund. against	Cath.	4.262	.001
	Fund. "	Conv.	6.727	.001
	Cons. "	Cath.	2.716	.01
	Cons. "	Conv.	3.734	.001
Simple Schiz.	Fund. against	Cath.	3.537	.001
	Fund. "	Conv.	3.783	.001
	Cons. "	Cath.	2.065	.05
	Cons. "	Conv.	1.169	
Nymphomaniac	Fund. against	Cath.	2.199	.05
	Fund. "	Conv.	5.801	.001
	Cons. "	Cath.	1.396	
	Cons. "	Conv.	4.953	.001
Homo Panic	Fund. against	Cath.	0.895	
	Fund. "	Conv.	2.600	.01
	Cons. "	Cath.	0.579	
	Cons. "	Conv.	2.402	.05

*Significant differences in direction hypothesized unless otherwise designated.

differences, the fact that Catholic and Conventional clergymen are closer to the psychiatric standard indicates that these groups are more willing to make a referral to psychiatrists and psychiatrically-oriented help-sources than are Fundamentalist and Conservative clergymen.

Controls of Other Relevant Variables

In the course of the analysis of the relationship of training and religion to clergymen's recognition of symptoms, clergymen's professional role concept, and clergymen's referral policy, several other relevant variables were controlled. Specifically, these variables were age of clergymen and father's education and occupation. In addition, religion was controlled on the training hypotheses, and training was controlled on the religion hypotheses. In this section, the results of this analysis will be summarized.

Training-Extent Controlling Religion

The association between training in pastoral psychology and recognition of mental illness symptoms practically disappears when religion is controlled. The same 15 comparisons which were used in the original test of the hypothesis are made for each religious category separately. The results are: Fundamentalist--none out of 15 significantly different, Conservative--two out of 15, Catholic--one out of 15, and Conventional--two out of 15. None of these results are significant at the .05 level. There is, however, a slight indication that training in pastoral psychology has more effect on the Conservative and Conventional groups.

Training-Role Controlling Religion

Training in pastoral psychology has differing effects on the professional role concepts of the various religious categories of clergymen. The number of significant differences out of 15 comparisons within each religious category are: Fundamentalist--none out of 15, Conservative--eight out of 15, Catholic--one out of 15, and Conventional--nine out of 15. Of these 18 significant differences only one, the Catholic, is in the direction originally hypothesized. It is concluded that training in pastoral psychology has only minimal effect on the professional role concepts of Fundamental and Catholic clergymen, while this training has much effect on Conservative and Conventional Protestant clergymen. And this training is associated with the Conservative and Conventional groups claiming a larger role in the therapeutic process than is accorded them by psychiatrists.

Training-Referral Controlling Religion

The strong relationship found earlier between training and referral policy is weakened somewhat when religion is controlled. However, the significant difference between trained and untrained clergymen disappears only for the Conservative Protestants. The numbers of significant differences out of 15 are: Fundamental--five out of 15, Conservative--two out of 15, Catholic--three out of 15, and Conventional--three out of 15. Interestingly, there are no significant differences between Catholics with no training and Catholics with seven or more hours of training. The differences for Fundamental, Catholic, and Conventional clergymen are all significant at the .05 level.

Religion-Extent Controlling Training

The same 20 comparisons which were used in the original test of the hypothesis are made for each of the four categories of training--none, 1 to 3 hours, 4 to 6 hours, and 7 or more hours. The numbers of significant differences between religious categories out of the possible 20 are: No training--six out of 20, 1 to 3 hours--none out of 20, 4 to 6 hours--four out of 20, and 7 or more hours--five out of 20. The numbers of significant differences for no training, 4 to 6 hours, and 7 or more hours are all significant at the .05 level. This indicates that, no matter how much training in pastoral psychology clergymen have, religion is still associated with recognition of mental illness symptoms.

Religion-Role Controlling Training

Controlling training, an association remains between religious category and professional role concept of clergymen. The numbers of significant differences out of 20 comparisons within each training category are: No training--seven out of 20, 1 to 3 hours--two out of 20, 4 to 6 hours--five out of 20, and 7 or more hours--four out of 20. Only the differences for the 1 to 3 hours category are not significant at the .05 level. Of the 18 total differences found between religious categories, only four are not in the direction hypothesized. So, even when training is controlled, the hypothesis is confirmed.

Religion-Referral Controlling Training

In testing this hypothesis without controls, a strong association (16 out of a possible 20 comparisons) is found between religious category and referral policy. This relationship holds up within each of the four training categories. The numbers of significant differences

out of 20 comparisons within each religious category are: no training--eight out of 20, 1 to 3 hours--seven out of 20, 4 to 6 hours, seven out of 20, and 7 or more hours--five out of 20. There seems to be a slight trend in the data for the effect of religious category to be diminished as the amount of training in pastoral psychology is increased. This trend was not statistically tested.

An impression received from examining all of these first controls is that of the two variables, religion and training, religion is of the greater importance in the responses of clergymen to the case histories.

Training-Extent Controlling Age and Father's Education and Occupation

The variables age, father's education, and father's occupation are controlled in combination. Thus, an analysis of the effect of training on recognition of mental illness symptoms is made using only clergymen over 45 years of age and whose fathers had a high school education or less and are blue collar or farmer by occupation. Then an analysis is done using only clergymen under 35 years of age and whose fathers had at least some college and held a white collar job.

Within the group of clergymen over 45 years and low father education and occupation, there are no differences between the trained and untrained clergymen in judgment of the extent of mental illness in the case histories. Similarly, within the young group with high father education and occupation, only one out of 15 possible significant differences between trained and untrained clergymen is found.

Training-Role Controlling Age and Father's Education and Occupation

No significant differences in professional role concept between

trained and untrained clergymen are found within either the old-low background or the young-high background group. This gives further evidence that the college training received by clergymen in pastoral psychology is of less importance than a complex of other factors, including religious denomination, age, and family background, in determining their proper (from a psychiatric viewpoint) handling of these hypothetical case histories.

Training-Referral Controlling Age and Father's Education and Occupation

Within the young, high background group, no significant differences between trained and untrained clergymen in referral policy are found. Within the older, low background group, five out of the possible 15 significant differences were found. Interestingly, four of these are differences between those with 4 to 6 hours training and those with none.

Religion-Extent Controlling Age and Father's Education and Occupation

The effect of religion on recognition of mental illness symptoms is minimized when these variables are controlled. Within the young, high background group, there are no differences between Fundamental-Conservative and Catholic-Conventional clergymen in this judgment. Within the older, low background group, four out of the 20 significant differences appear. These four differences all come from the case histories involving sexual problems.

Religion-Role Controlling Age and Father's Education and Occupation

Significant differences between Fundamentalist-Conservative and Catholic-Conventional on professional role concept remain after these

variables are controlled. Within the young, high background group there are six out of the 20 possible significant differences; within the older, low background group there are five out of the 20 possible differences. Two of these are opposite to the direction hypothesized.

Religion-Referral Controlling Age and Father's Education and Occupation

Significant differences also remain on referral policy when these variables are controlled. Within the young, high background group there are six out of 20 possible significant differences; within the older, low background group there are four out of the 20 significant differences. Both of these are significant at the .05 level. All differences are in the direction hypothesized.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The principal objective of this study is to test six hypotheses which deal with the effect of training in pastoral psychology and the effects of religious denomination on clergymen's recognition of mental illness symptoms, their professional role concepts, and their referral policies. The subjects involved in this study are 994 Oklahoma clergymen who returned mailed questionnaires in which they evaluated five hypothetical case histories.

Clergymen's responses to three questions about each case history are used to test the hypotheses. The clergymen were asked to judge (1) the extent of mental illness described in each case history, (2) the extent to which they could be of assistance, and (3) the type of person to whom a referral should be made.

In addition, 54 of the 104 Oklahoma psychiatrists listed in the 1963 American Medical Association Directory responded to mailed questionnaires containing the same five case histories. The psychiatrists, however, were asked to indicate how a clergyman should respond ideally to the questions concerning the case histories. These psychiatric responses serve as a standard in determining which sub-groups of clergymen are closest to psychiatric opinion in their handling of the hypothetical case histories.

It is hypothesized that clergymen from Roman Catholic and Conven-

tional Protestant religious denominations and clergymen with college training in pastoral psychology would make the most favorable judgments from the psychiatric point of view. These differences among groups of clergymen are tested using Mann-Whitney U z-scores.

Certain limitations of the study which should be kept in mind in interpreting the findings are given below, followed by the conclusions from the study. First, there is no ultimate standard to which clergymen's responses can be compared in order to determine how adequate these responses are. As stated in Chapter III, psychiatric responses are used for this purpose because psychiatrists are the recognized authority in the field of mental illness. Obviously, this does not mean that psychiatrists are free from personal biases in their judgment of the capability of clergymen as agents in the therapeutic process. Thus, when the responses of a group of clergymen are reported as favorable, this means that they are close to the psychiatric standard, and does not mean that their responses are favorable in any other sense.

Second, psychiatrists were asked how clergymen should respond to the case histories, which precluded any recognition, on the psychiatrists' part, of individual differences among clergymen. In other words, it was implicitly assumed that psychiatrists view clergymen as a single category. Psychiatrists were not asked how any particular clergyman should respond. Each clergyman, however, was asked how he as an individual would deal with the persons described in each case history.

Third, the sample of clergymen has certain limiting factors. In the first place, the sample includes only clergymen from one state. Questionnaires were mailed to one half of the state's clergymen and 36 per cent of state clergymen returned the questionnaires mailed to them.

Those groups of clergymen who are posited to be near the psychiatric standard had higher return rates than did those groups expected to be farther from the psychiatric norm. It could therefore be speculated that those clergymen within each group who returned questionnaires had more favorable judgments than did those clergymen within each group who did not return questionnaires. Although early returns were compared with late returns in an attempt to measure the extent of non-response bias, and numerous comparisons show no difference between early and late returns, the possibility of bias, however, should still be kept in mind.

Fourth, it should also be noted that these results came from the interpretation of hypothetical case histories contained in a questionnaire, not from actual people who came to the clergymen for help. Whether the clergymen's behavior in response to actual cases would be identical to their responses to the hypothetical case histories cannot be determined in terms of the data in this study.

The fifth limitation comes from the statistical analysis of the study. Mann-Whitney U, while it is a powerful statistic, was used in comparing only two groups at a time. Although a bivariate extension of the U statistic exists, the computer program was not available to the researcher. It was, therefore, not possible to compare two sub-groups of clergymen with the psychiatric norm in one step. Instead, all clergymen had to be compared to the standard, then comparisons were made between sub-groups of clergymen. Relative closeness to the psychiatric standard had to be inferred through inspection by examining the size of the Mann-Whitney U z-scores for the sub-groups and relating these to the psychiatric standard. This procedure was effective however since

relative closeness to the psychiatric standard was ascertained by this method on 58 of the 60 significant differences found in the original tests of the six hypotheses.

Conclusions

Since both clergymen and psychiatrists play important, ideally complementary, roles in the therapeutic process, concensus between them in certain areas would seem to be important. It was hypothesized in this study that training in pastoral psychology and religious denominations would influence the degree of concensus in three of these areas: recognition of mental illness symptoms, definition of clergymen's professional role, and referral policies of clergymen.

The results indicate that the effect of religious denomination overshadows the effect of training in pastoral psychology. It should be pointed out, however, that the training received in college does not cut across denominational lines. In other words, the training received is to some extent a function of religious denomination, and is thus likely to reinforce earlier conceptions rather than to liberate the clergymen from them. This is inferred from the fact that the effect of training in pastoral psychology is minimized when religious denomination of the clergymen is controlled, and that controlling training does not have the same effect on religious denomination.

This is not to say that training in pastoral psychology has no effect on the clergymen's responses to the questionnaire. Clergymen with this training do differ significantly from untrained clergymen in all three areas investigated. The relationship between training and recognition of symptoms however is much weaker than might be anticipated,

and the relationship between training and professional role concepts is opposite to that hypothesized, that is, those clergymen with training in pastoral psychology are farther from the psychiatric standard in defining their professional role concepts than are clergymen without the training. As mentioned in Chapter IV, this is due to the trained clergymen defining a larger role for himself in the therapeutic process than is conceded him by psychiatrists. The question as to whether the clergyman is competent in a larger capacity is not approached in this study.

The effect of training in pastoral psychology is most evident in referral policies of clergymen. The data indicate that those with training are much more likely to make a referral to a psychiatrist or a psychiatrically oriented professional person (for example, a clinical psychologist or psychiatric social worker) than are untrained clergymen. Evidently, training in pastoral psychology has the effect of reducing clerical distrust of psychiatry.

Religious denomination of clergymen is more potent as a discriminating variable than is training. Although some precision is lost in combining denominations into categories, some real differences appear among these categories. The clergy of Roman Catholic and Conventional Protestant denominations more closely approximate the judgments of psychiatrists as to the extent of mental illness of the persons described in the case histories. The same finding holds true for the professional role concepts of clergymen.

In both of these areas, however, on the case histories involving sexual problems the Catholic priests differ from their pattern of r e sponses on the non-sexual case histories. Psychiatrists judge

symptoms as being more severe than do all four groups of clergymen on the non-sexual case histories and judge the sexual symptoms less severely than do all groups except Catholics. Catholics do not differ significantly from psychiatrists on the Nymphomaniac case, and Catholics view the symptoms described in the Homosexual case less severely than do the psychiatrists. In the area of professional role concept, Catholics are closer to the psychiatric standard on the non-sexual cases than are Fundamentalists and Conservatives, but on the two sexual case histories the Catholics move farther than these groups from the psychiatric standard.

The final set of conclusions deals with religious differences in referral policies. Here the findings are as hypothesized: clergymen from Roman Catholic and Conventional Protestant denominations show more willingness than Fundamentalist and Conservative Protestant clergymen to make a referral to a psychiatrist or some other psychiatrically oriented professional person.

Summarizing these conclusions, clergymen from religious denominations classified as Catholic or Conventional are closer to psychiatric standards than Fundamentalist or Conservative clergymen in all three areas of pastoral counseling examined in this study. Clergymen with training in pastoral counseling are more favorable in recognition of symptoms and referral policies than are untrained clergymen, but are farther from the psychiatric standard than untrained clergymen in professional role concepts. When other variables are controlled, religion emerges as a stronger variable than training in discriminating between favorable and unfavorable responses in all three dimensions of the clerical role in the therapeutic process.

Suggested Further Research

The findings of this study indicate that the strongest reference group of a clergyman is his particular religious denomination. Clergymen who have had training in pastoral psychology are more likely to regard psychiatrists as a secondary reference group, however, than are untrained clergymen. This is indicated by the accuracy of trained clergymen's judgments of the symptoms, by their overinvolvement (from a psychiatric point of view) in helping the described persons in the case histories, and by their willingness to make a referral to a psychiatrist. Thus, further research into religio-psychiatric relations from the viewpoint of reference group theory might be fruitful.

It was mentioned earlier in this chapter that training received in pastoral psychology varies quantitatively by denomination, and probably varies qualitatively also. Since training in pastoral psychology is associated with more favorable psychiatric attitudes in clergymen, research into the content and effect of various training programs is suggested.

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APPENDIX A

S U R V E Y O F O K L A H O M A P S Y C H I A T R I S T S

conducted at

Department of Sociology

Oklahoma State University, April, 1965

INSTRUCTIONS: Below are six hypothetical case histories in which a member of a church or synagogue goes to his or her clergyman for advice. Please read each case carefully and then circle the answers which from your standpoint as a psychiatrist you think a clergyman ideally should give. Because we are interested in knowing if the sex of the person who seeks advice is an important variable, there are two response columns for each case--one for a male and one for a female. Please answer each question by first circling one answer for the male and then one answer for the female. NOTE: We realize that the lists of possible answers may not contain the alternative which you would prefer, but in order to standardize questions and answers, it is necessary to restrict yourself to these alternatives. Any comments you might make would be appreciated.

CASE ONE: Mr. Smith (Mrs. Smith) is a pleasant man (woman) in his (her) forties. He has been very active in church or synagogue affairs and is considered a good man. He states that he conversed with God shortly after seeing a strange star a few weeks ago. Later, in a vision he saw and heard God talking with His angels. He also got a glimpse of the devil and the fires of hell. He repeatedly hears a strange voice telling him what to do and how to behave. Mr. Smith wants to know whether he should obey the voice.

1. Concerning the extent to which Smith is emotionally disturbed, which of the following answers should a clergyman give according to your standards as a psychiatrist? (Circle one number in each column)	Male	Female
a. There is no apparent evidence of an emotional disturbance.	1	1
b. There is evidence of a mild emotional disturbance.	2	2
c. There is evidence of a moderate emotional disturbance	3	3
d. There is evidence of a severe emotional disturbance	4	4

2. Concerning the extent to which a clergyman could help Smith, which of the following answers should a clergyman give according to your standards as a psychiatrist? (Circle one number in each column)

	Male	Female
a. I could handle the case <u>alone</u> (i.e., I have adequate training to handle cases of this sort) . . .	1	1
b. I could provide <u>major</u> assistance in conjunction with properly trained professional people.	2	2
c. I could provide <u>some</u> assistance in conjunction with properly trained professional people.	3	3
d. I am <u>not</u> adequately trained to handle cases of this sort other than to refer to professional people	4	4

3. In terms of referral, as a psychiatrist is there anyone to whom you think a clergyman should recommend that Smith go? (Circle one number in each column)

	Male	Female
a. No	1	1
b. Another member of the clergy	2	2
c. Family physician	3	3
d. Psychiatrist	4	4
e. Other (specify: _____). .	5	5

The remaining case histories and response categories on the psychiatrist questionnaire followed the above format.

VITA

Bradford Hitch Gray

Candidate for the Degree of

Master of Science

Thesis: SOME SOCIO-CULTURAL DETERMINANTS OF CLERGYMEN'S ROLE CONCEPTS IN THE THERAPEUTIC SETTING

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