COMPARISON OF CLERGYMEN & PSYCHIATRISTS IN THEIR REACTION TO NINE PROBLEM CASES

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Garry J. Geerlings

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COMPARISON OF CLERGYMEN & PSYCHIATRISTS IN THEIR REACTION TO NINE PROBLEM CASES

By

GARRY J. GEERLINGS

AN ABSTRACT OF A THESIS

Submitted to the College of Social Science
Michigan State University of Agriculture and
Applied Science in partial fulfillment of
the requirements for the degree of

MASTER OF ARTS

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AN ABSTRACT

This study was designed to compare clergymen, including a group of senior seminarians, and psychiatrists in their reaction to nine problem cases.

The impetus for the study was the conviction that ministers experiences difficulty in diagnosing mental illness because their training has been primarily a theological one. At the same time, clergymen are the most numerous among therapeutic agents; they see more people with personal problems than other practicioners and should be able to recognize when a troubled person is to be referred to a mental health specialist.

It was hypothesized that 1) ministers without psychological training, when confronted with a problem, do not recognize mental illness which should be referred to a psychiatrist for proper evaluation and possible treatment. It was further hypothesized that 2) senior seminarians with psychological training received in the seminary also experience difficulty recognizing mental illness. Finally, it was hypothesized that 3) senior seminarians because of the benefit received from courses in pastoral psychology will respond better in recognizing mental illness than ministers who have not benefited from this training.

Nine case studies were prepared with the intent of including several clear-cut pathological cases, some borderline cases, and some cases dealing with problems

whose symptoms were not necessarily an indication of pathology, and could, therefore, be helped with the expert counseling of a well-trained minister.

The nine case studies were mailed to ten psychiatrists, requesting the recipient to indicate his professional judgment as to whether or not a problem could be handled by a minister or should be referred to a psychiatrist for proper diagnosis and possible treatment. Thirty ministers of the Reformed Church in America, located in Grand Rapids, were given a set of copies of the case studies. Afterwards, in a personal interview, each minister was asked to answer questions on each case study, including the question whether they felt the person should be referred to a psychiatrist for proper diagnosis and possible treatment. The third group of subjects were thirty senior seminarians who were within one month of graduation. They constituted the entire senior class at Western Theological Seminary in Holland, Michigan.

The first two hypothesis were confirmed in line with the predictions that psychiatrists differ significantly from ministers and senior seminarians in their judgment as to when a problem should be handled by a psychiatrist.

The third hypothesis was not confirmed and in only four cases did the seminarians show a better judgment than the ministers.

These findings seem to indicate also that the ministers, even though they have not benefited from courses specifically designed to aid the clergy in recognizing mental illness, were able to make a judgment which agreed with the judgment of the psychiatrists more than were the seminarians.

A tentative conclusion seems to be that ministers draw from experience rather than theoretical knowledge when dealing with problems in their congregations.

Approved Alfred G. Dietze

Alfred G. Dietze

Date: June 4, 1963

TO MY PARENTS

Who in raising a son, shaped a personality which allows me to approach people as unique individuals without regard to their race, color, or creed.

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G.J.G.

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I. INTRODUCTION

Throughout history, societies have set up institutions to comfort and help their troubled members. In the past, such help was usually a function of religious authorities: oracles, witch doctors, or priests. These people were set apart in their community and were invested with the responsibility for the care of the sick, physically as well as mentally. Their methods of therapy differed greatly and evolved from their religious beliefs and practices.

Those seeking help, regardless of culture, religious beliefs, or powers in which they trusted, had in common the faith that the counsel and help received from their religious leaders would be effective in curing them from their ills.

Modern society, in contrast with the above, has many resources that perform therapeutic functions, each becoming more and more professionalized. Also, the functions of the traditional professions have been expanded to also include psychological counseling. As a result, contemporary professional counselors include clergymen, psychiatrists, psychologists, lawyers, marriage counselors, physicians, vocational guidance workers, social workers, and many others.

When people have problems they must decide where to seek help. Some turn to their doctor or minister. Others turn to specialists in the handling of personal problems: psychiatrists, marriage counselors, social agencies, or clinics.

Of particular interest are the circumstances under which people turn to psychiatrists. Many seek help as a last resort, often as a last attempt to forestall despair. Others, of course, may consult counselors for far less drastic reasons. In either case seeking help is not a casual choice. A person seeking help for a personal problem has, in one way or another, come to at least two realizations about his situation: first, that he has a personal problem which causes him discomfort; and second, that he cannot find a solution for it by himself or with only the help his friends and family can provide.

Once having recognized his trouble as due to problems which he cannot solve on his own, a person can choose from the available resources providing help. At this point many people are not aware that there are clinics, agencies, etc., which provide professional help for those who need it. Gurin, et al, (1960) found that people under these circumstances most frequently consult clergymen, with doctors coming second, and mental health professionals last. His percentages were: clergy 42%, medical doctors 30%, mental health practitioners, including psychiatrists, psychologists, marriage counselors, etc., 28%. In summary, they found that most people seeking help in times of personal distress choose a resource that does not offer psychological guidance as its primary function.

It is indeed interesting to note that professionals in psychological services, e.g., psychiatrists, clinical psychologists, and social workers, are less often consulted than others whose major function is not psychological guidance, such as clergymen and physicians. In commenting on this, Gurin observed that while clergymen are more readily available and more numerous than mental health specialists, it might well be that the greater use of non-psychiatric specialists indicates a lack of readiness of people to consult mental health professionals in time of crisis, or a lack of knowledge about the availability or effectiveness of such services.

Often neglected in accounting for these facts is the consideration that people who find themselves in trouble go to see their clergyman because of an already existing relationship with him. The path to the clergyman is a direct one, almost never mediated by any formal or even informal referral source. Psychiatrists, however, are usually reached through some referral agent. Although the referral source may be a friend or family member, the clergyman is in a unique position to act as a referral agent for individuals who require expert treatment for he is the one most people turn to first with their personal problems. Thus ministers are the important "gatekeepers" in the path from patient to

specialist. They may deal with the patient themselves or send him on to a professional therapist.

Gurin's (1960) findings, however, indicate that clergymen rarely act as referral agents, but perceive themselves as the proper therapeutic agents even more often than other sources, such as physicians, do. Whether or not they do the treatment themselves, or act as referral agents, such findings emphasize the crucial importance of ministers in helping people with psychological problems. They underscore the need for clergymen to receive some psychiatric training, not only to enable them more effectively to offer help, but also for them to know when to refer a troubled soul to an appropriate therapist. Clergymen must often act in a diagnostic capacity. They should know how to discriminate between psychological problems which they may be able to help and those which should be referred to psychiatric specialists. Furthermore, they should be able to handle the resistances of those they refer since many of the people with problems do not see that their difficulties are psychological; and even when they do, they are unable to see that the cause of such problems lies within themselves.

Gurin, et al., (1960) also found in their examination of peoples' perception of their need for help that in most

cases the search for help does not seem to represent any real motivation for therapeutic change. Only a minority of the people who sought help (one in four) explicitly traced the source of their difficulty to some defect in themselves. This explains the choice of the majority of a clergyman or non-psychiatric physician instead of a mental health specialist. People who went to a psychiatrist also tended to be less satisfied with the help they received than people who saw their clergymen. They tended to describe the ways in which they were helped in terms of comfort, reassurance and advice rather than in terms of changes in themselves. Although motivation for change is not always essential for the type of problem that is presented, these data do suggest that where the problem does lie within the person seeking help, any attempt to direct him toward therapy involving change is likely to be met with resistance.

Thus the clergyman has an important role in the treatment process. Clergymen are the most numerous among therapeutic agents: they see more people with personal problems than other practitioners and tend to handle such problems themselves, instead of referring them to specialists. In the capacity of counselor they are most appreciated for their offer of comfort, or, more vaguely, of advice. This substantiates the frequently expressed assertions that clergymen serve as emotional supporters, while psychiatrists are seen as demanding change in the person himself. However,

the first step in the therapeutic process from a psychological standpoint is readiness for self-examination and a desire to change.

People who do not have this point of view are the very ones who are likely to resist the suggestion that they seek help from psychiatric sources. People who seek out ministers are especially likely to have such views and the competent minister must recognize and be prepared to handle their resistance to therapy (Gurin, et al., 1960).

Mental illness has always been a mystery. It is enormously prevalent - more abundant than all other forms of illness put together. It exists in many forms. Every priest, pastor, and rabbi spends a considerable amount of his time listening to parishioners who are in distress because of recognized or unrecognized mental illness. Clergymen, therefore, more than most people, are more aware of the vast extent of misery and suffering in the world. They and psychiatrists share this sharp awareness (B. H. Hall, 1959). Like the psychiatrist, the minister feels impelled to do something to diminish this suffering, not only by advice to the individual, but by the proclamation of principles of living. In their sermons too, they endeavor to offer hope, comfort, encouragement, and reassurance to people in their congregations who need help.

Meanwhile, the psychiatrists are spending their days listening, comforting, correcting, and reassuring. For the mystery of mental illness has begun to yield to science. It began with Freud's discovery that most psychological processes are not conscious ones - that there is a vast organization of mental functioning of which our conscious experiences are only a small part (Menninger, 1954). As Dr. Menninger states it, "we now have methods for looking behind the surface of conscious thinking and overt behavior, there to see formerly unknown intricacies, forces, functions, and processes." "And these methods of looking have provided us with methods of changing the patterns." "The inclusive study of personality is the basic content of modern psychoanalysis and modern psychiatry."

The entrance of the psychiatrist in the field of help for the troubled alarms some clergymen, for it seems to put too much responsibility for personality-molding in secular hands. Many clergymen feel that psychoanalysts have taken upon themselves the responsibility for absolving people from a sense of guilt and that this attempt is contrary to theological precept and moral principles in general. It is the prerogative of the Church to do something about guilt and not the function of the physician. However, they fail to distinguish between <u>guilt</u> and <u>a sense of guilt</u>, and between a sense of guilt related to <u>actual</u> offenses and a guilt

related to imaginary offenses.

From a clinical standpoint, every psychiatrist sees patients every day who feel extremely guilty about something they have not done. If such an individual were to go to a priest or minister, he would be assured that he had never done anything, and, therefore, had no guilt and should not have any sense of guilt. But if he insists on having a sense of guilt even when he has no actual guilt, there is nothing the priest can do about it except to send him to a psychiatrist. A psychiatrist can, with the scientific tools now at his disposal, ascertain the unconscious, invisible reason for a false sense of guilt, attached to a nonexistent sinful or criminal act. It is a common clinical symptom with which every psychiatrist is constantly faced. It might be said that in almost every mental illness there is a very strong component of guilt feeling. For such a symptom psychiatry offers relief and the Church does not (Doniger, 1955).

According to Dr. Karl Menninger (1959), the conflict between psychiatry and religion is a kind of personal conflict related to fears of impaired authority. Both are actually dedicated to the same purpose and, to a considerable extent, attempt to combat trouble in the individual. The approach may be different, but both endeavor to cope with

something which gives those about them pain. "Comparable to sibling rivalry, hostility between children of nearly the same age in one family, it is natural to see psychiatry and religion a little bit suspicious of each other.

Purpose:

We have attempted above to show how crucial the role of the clergyman is in the field of mental health. It is, therefore, the clergy who first of all should have a knowledge about the availability and effectiveness of psychiatric help. They should be able to dispose help themselves, but at the same time should serve as diagnostic agents so that they can properly refer cases which fall outside of their own comptencies. They are the ones who often have to motivate people towards personal change rather than receiving comfort and support. Finally, they must be able to handle the resistances of those whom they refer. Needless to say, this is quite a task for a man who in his seminary training sought mainly the knowledge and skills required of a theologian.

The impetus for the present study was the conviction that ministers are for the most part not adequately trained to serve as diagnosticians when confronted with mental illness in their parishes. They aren't trained to work within a framework necessary to recognize psychopathology.

While most seminaries do offer courses in pastoral counseling, it has been our finding that often such courses attempt to teach future pastors various methods of counseling without providing them with a thorough knowledge of psychological theory on which modern psychiatry is based. Insufficient knowledge of unconscious processes involved in various types of pathology may often result in a minister proceeding with counseling, only to find the situation developing into a very serious one in which he is helpless, or the parishioner breaking off his contact while what at first appeared as a minor symptom develops into full-blown pathology.

Hypothesis:

In the light of the above discussion we wish to test three hypothesis in the present study.

It is hypothesized that ministers, when confronted with a problem, do not recognize mental illness which should be referred to a psychiatrist for proper evaluation and possible treatment. In the form of the null hypothesis for

the type of data we have collected it may be stated as follows:

Hypothesis I:

> When ministers and psychiatrists are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister."

It is hypothesized secondly that senior seminarians, who have had the benefit of courses in pastoral counseling and psychology as part of their curriculum, when confronted with a problem, do not recognize mental illness which should be referred to a psychiatrist for proper evaluation and possible treatment. In the form of the null hypothesis this may be stated as follows:

Hypothesis II:

> When senior seminarians and psychiatrists are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister."

Finally, it is hypothesized that senior seminarians, because of the benefit received from courses in pastoral counseling and psychology as part of their curriculum will

respond better in recognizing mental illness than ministers.

In terms of the null hypothesis this may be stated as:

Hypothesis III:

> When ministers and senior seminarians are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister."

II. EXPERIMENTAL DESIGN

Subjects:

Three groups of subjects were used for the study. The subjects for the first group were ten psychiatrists, members of the Michigan Chapter of the American Psychiatric and Neurological Association. While a larger sample of psychiatrists would have been desirable, the amount of time required by them to respond to our instrument made this impractical. An attempt to obtain a random sample of Michigan psychiatrists would very likely fail for similar reasons and it was necessary to rely on informants that could be contacted upon the recommendation of their colleagues.

The second group of subjects were thirty ordained ministers of the Reformed Church in America. The Church includes 222,500 adult communicant members in 891 churches, mostly in New York, New Jersey, the Middle West and California. According to the teachings of the Church, the only infallible authority for their theology and doctrines is the Word of God, and nothing can be taught or done contrary to it. For additional guidance, it accepts the teachings of John Calvin, the Reformer of the 16th century. Again, because of the amount of time required to respond to our instrument, it was not possible to obtain a random sample of ministers and our sample consists of thirty

Reformed ministers who are presently located in Grand Rapids, Michigan.

The third group of subjects were thirty senior seminarians who were within one month of graduation. They constituted the entire senior class at Western Theological Seminary in Holland, Michigan, one of the two seminaries of the Reformed Church.

Western Theological Seminary has recently instituted a three-credit course in Pastoral Counseling which is now a required course for all students. The seminary also offers as an elective course an orientation to clinical pastoral training. This course is conducted at Pine Rest Christian Hospital in Grand Rapids, Michigan, a hospital for the mentally ill maintained by the Church. This course gives the prospective pastor an orientation to the work of the hospital, and the pastoral ministry in relation to persons suffering from mental and emotional disorders. The course includes lectures by psychiatrists, psychologists, and social workers. Students attend conferences with the resident chaplain, and engage in weekly visitation with patients, the writing of reports, and the reading and recording of interviews. Another elective course offered is designed to enhance the pastor's ministry to families, and considers Biblical teaching on marriage and sex, premarital

counseling, Christian parenthood, and counseling problems in divorce and remarriage. Because of the limited facilities at the hospital, only a small percentage of all seniors can participate in the orientation to clinical pastoral training and in our sample of 30, only eight had the opportunity to take this course.

A Bachelor of Arts degree is the basic requirement for admission to the seminary, with an emphasis on a broad and comprehensive "liberal arts" preparation in college. For the guidance of pre-theological students the seminary recommends courses in English, philosophy, history, foreign language, natural science and social science, while only one half year of psychology is urged to be included in the student's college curriculum. The theological course is three years in length.

Test Materials:

Because the purpose of this study was to see whether or not clergymen and seminarians could recognize psychopathology when confronted with problems, nine case studies were prepared with the intent of including several clear-cut pathological cases, some borderline cases, and some cases dealing with problems whose symptoms were not necessarily an indication of pathology and could, therefore,

be helped with the expert counseling of a well-trained minister.

Alexander H. Leighton (1959) feels that case studies are very adequate for diagnosing mental illness. According to him, "a case study takes a given person for attention, and, viewing him as a system, attempts to explain a selected aspect of that system in terms of other aspects, in terms of the functioning whole, and in terms of the history of both. Cross-sections of the moment and life-story are thus taken into account together with such components as cognition, affect, basic urges, and sentiments. Analysis of the whole is, of course, conducted in terms of both conscious and unconscious processes. Case studies are, in short, personality studies conducted for the particular purpose of diagnosis and treatment." In writing up the case studies, we attempted to describe the interview as if it took place between a clergymen and a person seeking help. We did not strictly adhere to the more conventional method of writing up case studies since we felt that the situations presented to the clergy should simulate actual interview situations a minister might have encountered in his ministery. Some of the cases are actual publications, or are from the files of psychiatrists and ministers, while some were made up based on theoretical knowledge of symptomatology indicative of psychopathology.

Case A* deals with a compulsive personality who is experiencing a crisis in his marriage. Especially from Mr. P's standpoint, there had been a smoldering marital discord which burst suddenly into flame. This was caused by an accident which had heightened his awareness of mortality. He feared death might overtake him before he had been compensated for a lifetime of self-denial. His demand for remuneration, supported by a self-righteousness built up by years of self-imposed exploitation, was a masochistic one designed to punish his wife and demand her pity. In conscious behavior, and in every wish and thought acceptable to his ego-ideal, Mr. P is a thoroughly humble and virtuous man. But his virtue is serving the function of a reaction-formation against the hostility, the egocentric ambition, and the grandiosity which he expresses only through fantasy. Mr. P does not recognize that the present marital crisis came as an inevitable result of his neurotic personality. (Burton & Harris, 1955)

Case B** deals with the problem of obesity, and concerns a 17-year old girl who is healthy and bright in every way except for one bad habit - she cannot get rid of her over-

*See Appendix A for the case material as prepared for this investigation.

**See Appendix B for the case material as prepared for this investigation.

eating problem. Her physician, who had made numerous diagnostic studies and found all physical and endocrinological studies completely negative, could not understand why a very intelligent normal girl could not stick to a reasonable diet when she is so ashamed of her obesity that at times she goes into the deepest depression and secludes herself to the point of not being willing to go to school. Any effective way of dealing with this girl would involve an interest in her whole personality rather than in one outstanding weakness of her character. The fact of obesity, when no organic causal factor can be found, is enough to diagnose the presence of serious emotional disturbance in which oral fixation and a conflictual mother-child relationship are of essential causal importance. (Burton & Harris, 1955)

Case C* is concerned with the presence of a defective child within the family setting. According to Freud, the course of motherhood, a developmental process, is influenced by the characteristics of the baby, first by its appearance and later by its responses. Significant deviations, such as gross retardation or obvious congenital defects, may limit or interrupt the mother's developing capacity to accept the new child who is totally dependent upon her. (Freud, 1923)

*See Appendix C for the case material as prepared for this investigation.

In a recent article, "Is Grief a Disease?", George L. Engel (1961) draws the attention to the importance of the mourning process in human development. Borrowing from Freud's and Lindemann's work, Engel describes mourning in terms that are useful for the understanding of the mother's reaction when a defective child is born. In the mother's mourning reaction to the loss of the healthy child, her wishes for and expectations of the desired child are crushed by the birth of the defective child. The mourning process enables her to progress from the initial shock to an awareness of the feeling of disappointment and feeling of loss with the affective symptoms to the final phase of the grief reaction in which intense re-experiencing of the memories and expectations gradually reduce the hypercathexis of the wish for the idealized child. In this case study we see a mother experiencing one of the two extreme reactions that are considered pathological, namely extreme guilt feelings which lead to the mother's conscious dedication of herself to the welfare of the child. She wards off her feelings of grief by establishing a guilty, depressed attachment to the child and as a result fails to relate adequately to the other members of the family.

The lack of opportunity to discuss the child's diagnosis can create a situation in which the parents feel overwhelmed and unable to gauge the reality of their child's retarded development. Denial then serves to ward off the anxiety and

depressions. According to Solnit and Start (1959) many physicians feel that once they have conveyed the initial diagnosis to the parents there is a tendency to think the interpretation of mental retardation is completed when it has only begun. The reason for this is that he has not understood the aspect of the mourning process in the mother's reaction. Interpretation is a continuing process which utilizes interviews with the professional person to establish a sense of confidence and trust that will promote the parents' gradual understanding of the child's defect. In this atmosphere of trust and confidence the parents are enabled to express their critical and fearful questions to the therapist. These interviews then, if successful, are to serve two purposes: first, the comprehension of the child's condition, and secondly, enable the parents to realize their inner reactions of disappointment, resentment, humiliation, and loneliness. (Solnit and Stark, 1961)

Case D* deals with the problem of homosexuality. Throughout the history of human development, the fundamental question has always been whether or not homosexuality is a disease or simply a natural form of human behavior which becomes categorized as a disease only in specific cultures.

*See Appendix D for the case material as prepared for this investigation.

Freud assumed that at least the majority of cases were caused exclusively by experiental factors. (Brill, 1938) He regarded homosexuality as related to the three basic phases in the development of object relations, and he correlated the development of object relationships with libidinal phases of development. He saw the child as evolving from autoerotic and narcissistic phases to object love, which he termed the autoerotic phase, the phallic phase, and the Oedipus phase. The particular quality of the libido which is cathected determines the nature of the object relationship; and, in turn, once cathected the object then directs the development, expression, and vicissitudes of that particular phase of libidinal development. He also believed that the sexual practices in the homosexual relationship symbolize regression to the developmental fixation points. (Freud, 1905)

Freud also had some reservations about successful treatment, even though he was always willing to accept a homosexual patient for treatment because he felt analysis might bring the patient harmony, peace of mind, fuller efficiency, whether he remains a homosexual or gets changed. (1935)

Other investigators have held even less optimistic views. The recent report of the Wolfenden Committee (1957), which surveyed the problem of homosexuality in Great Britain, asserted: "We were struck by the fact that none of our

medical witnesses were able, when we saw them, to provide any reference in medical literature to a complete change. Our evidence leads us to the conclusion that a total reorientation from complete homosexuality to complete hetrosexuality is very unlikely indeed." However, Irving Bieber, et al, (1962) is more optimistic. "The therapeutic results of our study provide reason for an optimistic outlook. Many homosexuals became exclusively hetrosexual in psychoanalytic treatment. Although this change may be more easily accomplished by some than by others, in our judgment a hetrosexual shift is a possibility for all homosexuals who are strongly motivated to change. Our findings are optimistic guideposts not only for homosexuals, but for the psychiatrists who treat them. We are firmly convinced that psychoanalysts may well orient themselves to a hetrosexual objective in treating homosexual patients rather than "adjust" even the more recalcitrant patient to a homosexual destiny."

Case E* deals with a marital conflict which at first sight appears to center around infidelity. However, it soon becomes clear that several factors are involved. From all outside appearances it seems that the young man

*See Appendix E for the case material as prepared for this investigation.

is putting all his energies into his career which, because of present-day competitive conditions in the business world, might very well be demanded of him. Because of Mrs. E's teaching position the husband has to do an excessive amount of driving and often finds it necessary to work at home, preventing the couple from spending time together in a relaxed atmosphere. While it is obvious that this couple does not seem able to sit down together to discuss their difficulties, but rather let things drift, the symptoms do not necessarily point to a pathological condition in either wife or husband. It is, of course, very possible that the symptoms are indicative of a more serious problem, but it must be considered that the culture of which these two young people are a part makes this particular phase of their life an extremely difficult one. A frank discussion with someone who is not emotionally involved and an appeal to their intellect might be all that is needed to save this marriage.

Case F* deals with a problem which is known to every person who is asked to help people, namely loneliness. Fundamentally, just people are never enough. Activities are not sufficient. A busy social life can be a barren,

*See Appendix F for the case material as prepared for this investigation.

isolated, bitter one. In order to avoid more than that degree of loneliness occasioned by the fact that people are discreet individuals living within their own depths and are unable ever to communicate fully with one another, there must be a few key relationships which persist and cut below the level of social exchange to become part of a living, growing, emotional life. In order for contact to become a relationship there must be continuity of exchange, freedom of communication, repetition of meeting. The ability to be a friend must be learned and the feelings must be gained by example and by experience. There are people occasionally who have been deprived the opportunity to copy ways of behaving in order to get closer to people or who have been hurt so often by death, disillusionment, or removal that they have forgotten how to open up and invite friendship and love. They have become fearful of further hurt and have retreated behind a safe wall. The primary point of Jane's story is that one can go through the motions of friendliness without the emotions, can make the gestures which go with belongingness and remain an alien. It might well be that this feeling of no value, no real existence, is the beginning phase of a real psychopathological condition, namely schizophrenia. However, it might also be that because of the advancement of age in this woman and the loss of close relatives, loneliness has become something of which she is

realistically aware and wants changed, not being afraid to ask for help. Enabling this woman to form a relationship which has continuity, repetitiveness, frequency of contact, and meaningfullness, might be the beginning of a more adequate life which involves real emotion and meaningful relationships. (Greer)

Case G* deals with a 52-year old married man who experiences a psychotic breakdown and uses religion as a part of his symptom formation. Very often we hear the question "Is religion a help or a hinderance in the search for the meaning of life and the direction of a person's work?" In a case like this, the judgment is often a negative one. However, it must be remembered that the religious patient often "uses" his religion to express his unconscious conflict. Close examination of Mr. G's case study reveals many conflicts, such as his daughter's approaching marriage and his impending retirement, to which he hardly desires to pay any attention. However, a psychiatrist might well ask if the feeling of committing the unpardonable sin has any possible connection with his daughter's marriage in the near future. The answer to the question whether or not there is any relation between the conscious feeling of being beyond the forgiveness of God

*See Appendix G for the case material as prepared for this investigation.

and the possibility of guilt feelings because of unconscious wishes and desires, as well as hostility, in connection with his daughter's approaching marriage, might be a revealing one.

Drugs, rightly administered, can bring health and renew life, but ineptly administered, may bring disaster. Religion is just like that, equally as dangerous as it is useful. Therefore, the psychiatrist is wise in recognizing that religion <u>can</u> be dangerous to his patients; he calls the attention of the teachers of religion to that which he tends to forget: the dynamic character of the religion he professes and teaches. Religious educators, being reminded of the power of religion to hurt as well as to heal, have begun to re-examine not only the theological nature of the gospel proclaimed, but the ways in which that gospel is communicated and administered to the growing lives of children and adults. (Oates, 1957)

<u>Case H</u>* is a more complicated case because Mrs. Z has already had two years of supportive psychotherapy. According to the philosophy of therapeutic intervention, she has received no advice, and only explored her capacity for growth. From the fact that the psychiatrist has terminated therapy, we may assume that he felt she had gone as far as possible in

*See Appendix H for the case material as prepared for this investigation.

working through her difficulties which are primarily related to a disturbed father-daughter relationship. The psychiatrist might well be very satisfied with the results obtained in that Mrs. Z is now able to live with her husband without much difficulty and hold down a job in the businessworld. We do not know the condition as it existed when Mrs. Z first sought help, but the fact that she has not conformed to the image of an American housewife, as it exists in our culture, does not mean that the therapy was not successful. However, as often is the case, people turn to their minister when they have to make a decision. This happens frequently after therapy has been completed because of the unwillingness of the therapist to make concrete recommendations.

It must be realized that it is possible that Mrs. Z will always remain what is termed an "inadequate personality" who cannot be expected to accept the role her culture describes for her. Therapy, however, has allowed her to explore the possibilities of living a life which gives her the fullest measure of satisfaction possible in her condition.

When therapy has done all it can for a person with this type of a disorder, it would seem that the help of a well-trained minister might be of great help and assistance to a person like Mrs. Z. However, if a minister is to handle this he should be well aware of the implications. If he has only the desire to make her conform to the duties of a

mother as he knows it, he must accept the possibility that Mrs. Z might regress to a point where she will be completely useless to her husband and children and instead become a burden. On the other hand, the minister has a wonderful opportunity to counsel a person like this if he is able to deal with Mrs. Z's guilt feelings as she undoubtedly experiences them because she knows she is not facing up to her responsibilities as no doubt many people have made her aware of. Positive advice to pull her family together and build a family life which might be somewhat different from the established pattern, would allow this young woman to continue to live a meaningful life. This may well mean obtaining somebody to take care of the children and do the housework while Mrs. Z works in the business world. If the minister's attitude is one of understanding about the real limitations of this person, rather than excercising controls over her in an effort to make her see her "duty" as a Christian mother and wife, this marriage might well continue without mental illness disrupting the life of this family.

Case I* is a well-known story to most ministers. They are often asked to mediate in what appears to be an intolerable relationship between a parent and adolescent child. These

*See Appendix I for the case material as prepared for this investigation.

are the trying years for every parent and parents often feel they are at the end of their rope and cannot continue in the manner in which they are, all of a sudden to find their children grown up and accepting that which they have rebelled against these growing years. In this case, however, we are dealing with a very intelligent woman who seems to have fought a good fight against her feelings of hostility (and not without some success), but she apparently has gone as far as she can in the direction of sheer willpower and self control without any idea of what she is fighting. Yet for her own sake, as well as for her daughter, it would appear to be desirable for her to be freed from this hostility and her attendant guilt about it. It might be that this hostility is a true one springing from some as yet unknown cause. Or it may be that the hostility represents some sort of unconscious defense against other feelings which she cannot tolerate. Her occasional feelings of sexual repulsion toward her husband, with whom she has had a satisfying and happy marriage for many years according to her own statement, might well be related to this problem of hostility towards her daughter.

Procedure

A copy of each case study, along with a letter explaining the nature and purpose of the study* was mailed

*See Appendix J for a copy of the letter mailed to each psychiatrist.

to the ten psychiatrists we planned to include in our sample. Attached to each case was a questionnaire* which requested the recipient to indicate his professional judgment as to whether or not a problem could be handled by a minister or should be referred to a psychiatrist for proper diagnoses and possible treatment. To provide as natural a situation as possible for our professional respondents, provision was made on each questionnaire for comments which the recipients might feel desirable.

At an official meeting of the Reformed ministers in Grand Rapids, Michigan, the writer was given an opportunity to request the cooperation of the clergy in providing data for this study. The group voted unanimously to cooperate. Thirty ministers accepted a set of copies of the case studies, while four declined because of urgent commitments which would take them out of town for a number of weeks. The ministers were requested not to discuss these cases with anyone and appointments were made for personal interviews with each minister. This was done to avoid the chance that our questions would be answered with the help of professional experts, books, journals, etc. Each visit took place in the minister's study and allowed for the utmost of privacy. During the visit the minister was asked to answer the questions

*See Appendix K for a copy of the questionnaire.

listed on the questionnaire* especially prepared for this study. They were given one questionnaire for each of the nine case studies. This questionnaire was more elaborate than the one prepared for the psychiatrists and contains additional questions which might supply information about attitude toward mental illness, experience with mental illness, knowledge of community resources, and typical manner of dealing with problem cases they feel adequate to handle themselves.

*See Appendix L for a copy of the questionnaire.

III. RESULTS AND DISCUSSION

To test Hypotheses I and II proposed in this research, eighteen Chi Squares were computed, including a procedure commonly known as Yates' correction. (Walker and Lev, 1953) This "correction" was used to offset the possibility of obtaining too large a value which would lead to the rejection of the hypotheses too often than if the direct computation of probability by factorials were used. This was necessary because of the relatively small sample, the low number of observations in one cell, and because there is only one degree of freedom.

Table I and II give the results of the chi-square test of significance of the difference between psychiatrists, ministers, and senior seminarians when asked to judge whether a case should be handled by a psychiatrist or a clergyman.

Hypothesis I: It was predicted that when ministers and psychiatrists are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister." Table I shows that the ministers differed significantly from the psychiatrists for Cases "A", "B", "C", "E", and "F", while the statistical analysis showed that they did not differ significantly on Cases "D", "G", "H", and "I". Thus, the ministers were able

TABLE I

Comparison Between
Psychiatrists, Ministers and Senior Seminarians
in their Responses to Nine Problem Cases

Cases	Psychiatrists N=10		Ministers N=30		Seminarians N=30	
	Refer to Psych.	Handle by Min.	Refer to Psych.	Handle by Min.	Refer to Psych.	Handle by Min.
A	1	9	21	9	16	14
B	10	0	14	16	21	9
C	9	1	11	19	12	18
D	10	0	20	10	10	20
E	10	0	11	19	6	24
F	9	1	5	25	11	19
G	10	0	25	5	18	12
H	2	8	18	12	21	9
I	9	1	17	13	15	15

TABLE II

Chi-Square Test Results
of Significance of the Difference Between
Ministers and Psychiatrists, and Senior Seminarians
and Psychiatrists in Their Responses
to Nine Problem Cases

	Ministers & Psychiatrists	Seminarians & Psychiatrists
Problem Case "A"	8.702*	4.102*
Problem Case "B"	6.805*	2.341
Problem Case "C"	6.533*	5.647*
Problem Case "D"	2.844	18.000*
Problem Case "E"	7.026*	16.802*
Problem Case "F"	7.026*	6.533*
Problem Case "G"	0.685	3.968*
Problem Case "H"	3.333	5.762*
Problem Case "I"	2.344	3.472

* Significant at the .05 level of confidence. df 1

to judge correctly (considering the professional judgment of the psychiatrists as a valid and proper diagnosis) only four cases out of a total of nine cases.

Hypothesis II: It was predicted that when senior seminarians and psychiatrists are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister." Table I shows that the seminarians differed significantly from the psychiatrists for Cases "A", "C", "D", "E", "F", "G", and "H", while the statistical analysis showed that they did not differ significantly on Cases "B" and "I". Thus, the seminarians were able to judge correctly only two cases out of a total of nine cases.

The statistical analysis of the differences between the psychiatrists and the ministers, as well as the differences between the psychiatrists and the seminarians are significant at the .05 level of confidence with one degree of freedom.

Hypothesis III: It was predicted that when ministers and senior seminarians are required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to psychiatrist" or "can be handled by a minister." To test Hypothesis III, the sign test was chosen for the comparison of the two groups (Siegel, 1956). While the study does not provide quantitative data, it was possible to use plus and minus signs to show

differences in judgment. Table III shows that it was decided in each of the nine cases whether the seminarians or ministers numerically differed in their judgment with the psychiatrists' judgment. If more seminarians than ministers agreed, this was expressed by a plus sign, while if more ministers than seminarians agreed, this was expressed by a minus sign. While the null hypothesis stated simply that the frequencies with which the two signs occur will not be significantly different, the prediction was that the seminarians because of different training would be better judges than the ministers. For this reason, a one-tailed test was used, predicting that seminarians will be better judges than the ministers, or, the plus sign will occur more frequently.

In all nine cases there was a difference in judgment, but in only four cases did the seminarians show a better judgment than the ministers and thus received a plus sign. For the data in Table III, x = the number of fewer signs = 4, and N, the number of cases showing a difference in judgment, is 9. For N = 9, an x - 4 has a one-tailed probability of occurence under H_0 of p = .500. This value is in the region of acceptance, thus the null hypothesis cannot be rejected. We tentatively conclude that seminarians and ministers when required to respond to briefly described problem cases, the former will not differ from the latter in the proportion responding "refer to

TABLE III

MINISTERS AND SEMINARIANS JUDGMENTS
OF NINE PROBLEM CASES

Cases	Agreed with Psych. Min.	Agreed with Psych. Sem.	Direction of Difference	Sign
Case "A"	9	14	$X_m < X_s$	+
Case "B"	14	21	$X_m < X_s$	+
Case "C"	11	12	$X_m < X_s$	+
Case "D"	20	10	$X_m > X_s$	-
Case "E"	11	6	$X_m > X_s$	-
Case "F"	5	11	$X_m < X_s$	+
Case "G"	25	18	$X_m > X_s$	-
Case "H"	12	9	$X_m > X_s$	-
Case "I"	17	15	$X_m > X_s$	-

X_m = number of ministers agreeing with psychiatrists

X_s = number of seminarians agreeing with psychiatrists

psychiatrist" or "can be handled by a minister."

In examining the comparison between the ministers and the seminarians, it is found that they agree in their judgment on five out of nine cases, namely Cases "A", "C", "E", "F", and "I". It should be noted that these five cases on which the ministers and seminarians are agreed in their judgment, all disagree with the judgment of the psychiatrists.

It is suggested that these findings indicate that the psychiatrists, ministers, and senior seminarians differ in their responses to briefly described problem cases, and that only for Case "I" a significant agreement was reached by all three groups.

These findings also suggest that the ministers, even though they have not benefited from courses specifically designed to aid the clergy in recognizing mental illness, were able to make a judgment which agreed with the judgment of the psychiatrists more than were the seminarians.

It should especially be noted that the psychiatrists judged that four of the nine problem cases could be adequately handled by a clergyman, while the ministers only felt capable of handling one of these cases, namely Case "H". On the other hand, the seminarians judged themselves incapable of handling any of the four cases the psychiatrists suggested clergymen could handle. It is suggested that this might be

indicative of the fact that the additional training these students received in the area of psychopathology has made them too cautious with the result that they tend to over-refer.

Case "B" deals with the problem of Obesity which the ministers were unable to recognize as a severe emotional problem, while the seminarians were able to diagnose this condition as a severe mental problem. Case "D" is clearly a Homosexual problem and the ministers recognize it as one they should not deal with, while the seminarians feel they are capable of handling this particular problem. Case "G" indicates that the patient is experiencing a psychotic break, and the psychiatrists reach a 100% agreement in their diagnosis, while the ministers are in almost perfect agreement with this, but the seminarians do not recognize this as such and attempt to deal with it as if it represents a religious problem.

These last findings seem to suggest that ministers may tend to draw on their experience to a greater extent than on a theoretical knowledge in their counseling situations, while seminarians who have not had adequate parish experience and are able to recognize clear-cut pathology without much difficulty, are unable to recognize it when disguised in religious as well as day-to-day rationalizations and/or symptoms.

The results of this exploratory study call for caution in interpreting because of certain methodological limitations

present. If we grant adequate reliability and validity for our findings, our results suggest the conclusion that ministers of the Reformed Church differ significantly from psychiatrists in their responses to briefly described problem cases as to whether they should be referred to a psychiatrist or handled by a minister, while senior seminarians of the Reformed Church differ even more in their judgments even though this difference is not statistically significant.

A tentative conclusion also seems to be that ministers draw from experience rather than theoretical knowledge, while the seminarians can recognize clearly defined pathology, but are unable to do so when "religious" symptoms are used to express the illness, probably because they have not been confronted with this aspect of mental illness in the community.

Some additional questions asked supply some additional information which, though not statistically analyzed, is of interest.

Both ministers and seminarians obviously show a knowledge of the fact that some problems indicate mental illness which is outside of the realm of their capabilities and training. However, as soon as the symptomatology includes a moral problem, they show their inability to clearly understand and accept this as a part of the illness and show a strong desire to bring the patient in a "right relationship

with God," fully expecting the symptoms to be alleviated. They do not seem to grasp that for many mental patients, their reach for religion is nothing else than the desire to limit their own being and to strengthen this limitation through the power of religion. Even if religion does not lead to or does not directly support pathological self reduction, it can reduce the openness of man to reality, above all to the reality which is himself. In this way religion can protect and feed a potentially neurotic state. (Tillich, 1952)

Both ministers and seminarians showed a complete lack of knowledge of the community resources available for mental patients. All respondents mentioned their church supported mental hospital, while a majority also preferred to refer to a "Christian" psychiatrist, while five showed open hostility to the whole area of psychiatry by stating they never referred to psychiatrists for the simple reason that they "didn't believe in them." Patients and their families often seek the advice of their ministers in the approaching necessity of seeking psychiatric treatment for nervous and mental diseases. With a monotonous repetition they ask about the religious attitudes and convictions of the psychiatrist. This is most important from the patient's point of view. The questions may reflect religious insecurity, but the patient who is sick enough to need

psychiatric help cannot be expected to be so secure religiously as to warrant complete rejection of the validity of his questions. He has no right, however, to expect his psychiatrist to be a trained theologian any more than he has to think of his pastor as a diagnostician of nervous and mental diseases. If the patient can be reassured that his doctor will take a clinically reverent attitude toward his religion as having relaity and meaning to the patient himself, then he has the security he needs. However, the presupposition of the question, "Is the psychiatrist a Christian?" on the part of the clergy, often imply this kind of expectation as clearly observed in their responses. But, more subtle than this, such a referral might well reflect a "passing of the buck" for the pastoral care, religious instruction, and theological guidance of the patient from the minister to the psychiatrist. Therefore, at the point of the psychiatric referral, an essentially religious issue at stake is this: Is this a subtle abandonment of the patient to psychiatry, referring him <u>away</u> from the Church? To the contrary, it should be the Church calling in specialized help in its ministry to the person as a whole. It naturally follows that in the process of therapy, therefore, the role of religion as a positive force becomes intensely relevant as the minister and the Church take their place in vital relation to the psychiatrist and the hospital,

respectively. Competent referral ability is a most important ministerial asset. However, at the same time, while referring a parishioner to another person for more specialized treatment, the minister does not wash his hands of the parishioner, but maintains a continuing ministry to him. (Oates, 1957) Besides insisting on a "Christian Psychiatrist," only four ministers ever indicated their desire to work as a team with the psychiatrist on a given case, while the seminarians' responses seemed to indicate they wanted nothing at all to do with a parishioner who is mentally disturbed but rather wanted him in a hospital where his religious needs would also be taken care of by a chaplain.

From their descriptions of how they would handle a particular case, it is clear that a majority of ministers tend to deal with the presented problems in a clear-cut very definite authoritative manner, where as the seminarians seemed to favor the non-directive but supportive approach.

This study is limited to the Grand Rapids ministers of the Reformed Church in America and statistical inference should be considered in that light. However, it should be noted that the average stay of a minister in any one town is approximately four to six years which means that even though we do not have a truly random sample of the ministers in the Reformed Church, our findings and inference is some-

what more valid because of this. Also, the training of these ministers does not vary greatly from the training most ministers receive at other theological seminaries of different denominations. This is especially true if only "fundamentalists" are being considered. However, as already pointed out, this must be considered an exploratory study calling for cautious interpretations of the results. If this study but stimulates further research on this topic it will be considered successful.

APPENDIX A

1

[illegible]

APPENDIX B

B.

Mrs. D. has come in with her 17-year old daughter because she feels that she is at the end of her rope. The mother claims insistently that Nancy's difficulty is "lack of willpower". At present Nancy is a girl of low average height, weighs about 200 lbs. and all the efforts on the part of her mother as well as physicians have failed to effect any consistent change in Nancy's eating [illegible] of food she eats and [illegible]. [illegible] for lunch, or half an apple pie [illegible] of [illegible] she [illegible] coming home. There is a state of constant [illegible] between mother and daughter, the mother blaming Nancy for lack of discipline, and Nancy [illegible] desperate about her [illegible] mother's continuous nagging and scenes, [illegible] life [illegible]

Physical and endocrinological examinations are all completely [illegible]. Since all reasonable explanations failed, it was the mother's [illegible] the minister can talk some sense into Nancy's head as she had [illegible]

It was a pitiful sight to see them in the waiting room: an [illegible] fat little girl in a black skirt and black sweater with tears [illegible] rolling down her cheeks, nervously twisting her handkerchief; next to her the mother, quite slim, neatly dressed, in rather frilly clothes for a woman of middle-age, red fingernails, flowery hat -- the kind of [illegible] sophisticated overdressed look one associates with small town [illegible] on Sundays.

In one [illegible] Mrs. D. wanted to "clarify a few things". She expressed her sincere doubt that anybody could really help an unmanageable girl as Nancy was, but she always was very faithful in attending church [illegible] even though her parents didn't attend church, and saying her prayers at home, so she decided to give the preacher a try as [illegible] he could teach her some self-control as there's [illegible] for. Mrs. D. needed no prompting to tell all her complaints. She [illegible] of this interview [illegible] counselor. Nancy the criminal, and [illegible] the [illegible]. There was no detectable sign of a mother asking for help [illegible] child. Every statement was [illegible] in terms of [illegible] arguments. Nancy was weak, self-indulgent, [illegible] and listen to advice, but kept on eating, secretly [illegible] had been participating in any social life. [illegible] of anybody the [illegible], even her own mother, [illegible] unwilling to do the simplest thing and [illegible]. Mrs. D. expressed amazement at the fact that she [illegible] and would never allow [illegible] a daughter like that. She feels she [illegible] her only child. She aimed to her marriage [illegible] give a nice home to her daughter. [illegible] her good for nothing alcoholic husband, [illegible] never got ahead in business. [illegible] spend way above their means [illegible]

sent to an exclusive private school because nothing "the right kind of people" was essential for a successful life. Of course, this meant expensive clothes, but nothing would show on Nancy. She is an ungrateful girl, who never showed appreciation for all the sacrifices that the mother made for her.

True, she is bright, and a very good student in school, but what does that do to her social prestige to succeed by her appearance and shyness? She, the mother, is ashamed in fact: the neighbors because of the remarks they might make about her daughter. All her life she hoped to be proud of her only daughter, and here she is ashamed to walk with her on the street. The only explanation she can think of is that Nancy has inherited her father's reckless, undisciplined character.

Like a parrot, Nancy repeated her mother's request for help and asked if you would please help her because life was so miserable and she felt so ashamed that she could not use her willpower as they so often discussed in Sunday School.

APPENDIX C

[illegible]

C

This brings them to their reason for calling you in at this time. Mr. H. points out that he feels a crisis has arisen within the family. Mrs. H. is unable to take care of her son Jim, now one year old, who is normal, because of her devotion to Sally. It has become necessary for the maternal grandmother, a widow, to come and live with the couple, in order to organize their household and to care for Jimmy shortly after he was born. It is mainly the father's dissatisfaction with this arrangement which is causing the disturbance in their marriage.

Sally has indeed developed extremely slow and needs her mother constantly to wait on her. She cries a lot whenever her mother is not in sight and still is unable to talk at the age of 5. The father feels that it is high time they put Sally in an institution so that the child will at least get a minimum of training. He also feels that Sally's presence is disrupting the family harmony because of the mother's "abnormal" devotion to her defective child, while completely neglecting her one-year old normal son, who is a very cute baby, but who is primarily brought up by the grandmother and father.

At the mentioning of the institutionalizing of Sally, Mrs. H. will break out in tears and call everybody "unchristian" and threatens to divorce her husband so that she will be able to devote her entire life to her daughter.

APPENDIX D

D.

Paul H. comes up to you after the service and asks if he can come and see you some time during Christmas vacation. It seems as if he is extremely serious when asking for a formal interview which strikes you as rather strange because Paul has never been that way before. He certainly never was a leader in his church group or at school, but on the other hand, also was not an extraordinarily quiet person. He was the type of boy who is friendly and courteous, never caused to cause any trouble or difficulty, and rather well liked by his peers.

When he comes in for his appointment, it is soon obvious that Paul is extremely nervous and upset, but trying very hard to cover it up by joking and laughing about unimportant matters. He talks about college, how nice it has been to get away from home, how he was so homesick at first, his social life, his studies, and his desire to become a doctor if his grades hold up during his senior year.

After 25 minutes of small talk you come to the point and ask Paul if he would like to discuss his particular problem for which he has asked to see you. Paul's face changes color, he pales, and stops talking, and his eyes look at the floor of your office. You almost feel as if you have lost complete contact with a boy you have known so well for so many years. Ever since Paul's father died when he was only seven years old, you have tried to spend some extra time with the boy in an effort to allow the boy some contact with an understanding man. It is only too well known that Paul's mother is a rather aggressive woman who has always ruled her family with an iron hand, even before her husband's untimely death in a car accident.

How is it that Paul now finds it so difficult to speak to you? You reassure him of your respect for his confidence and ask him again to confide in you. With a soft voice Paul then begins to talk about his experiences at school. His first year was fine, he got along well with his roommate and they were always together, studying together, eating together, and also often double-dating together. Paul's eyes seem to light up a bit when remembering this first year. However, he goes on, his roommate had to drop out of school after the first year and he had not seen him for two years. The second year he had a roommate who was much quieter, and did not care to go places and either as actively in the school activities. Here Paul's voice grows soft again as he goes on to say with great difficulty, and with much hesitation, that he and Bob have drifted into a homosexual relationship. Paul goes on to say that he does not feel it is his fault and he blames Bob for it as he seems to have started this whole thing one evening after both had gone to the school's hangout to have a beer. However, what started as a joke has now grown into a real relationship and Paul relates his guilt feelings about this, especially when he returns home and meets all the people he has known for so many years. Both at home and at school he finds it very difficult to go to church because he realizes that what is going on in his life is not right.

You ask him if this is the first time this ever happened and Paul hurries on to tell you that he has not had anything like this happen to him before. He states how he once tried to "joke around" with his former roommate when they first started school and showered together, but he felt this was more of a joke and his roommate had laughed at him and he had never tried to do anything like that again with him. Anyway, Paul goes on to say, that boy isn't like Bob who is such a wonderful person and for whom I'd do anything in the world. At times, Paul goes on to say, I feel he is like God, so strong and so good. He plan to go to Medical School together and will remain roommates for years to come which he feels gives him a great feeling.

On the other hand, he relates how he cannot understand why he feels so guilty, especially when he is home and comes to your church. He has the feeling you can "look right through him". Once at school he feels he isn't quite so guilty because he knows about all the dirty sex activities that the other boys get involved in with their girls on their dates. Paul declares he is keeping himself away from girls so that he will not devile any girl, but later, when financially able, can start to date and consumate a quick marriage. He feels that a homosexual relation will prevent his getting into trouble as it releases so much pent-up energy. This way he will not get into trouble with a girl which would prevent his finishing Medical School.

When you ask him why he has come to you to discuss this at all if he is so convinced that this is actually "helping" him, he starts to cry and relates how he really hates himself for getting involved with Bob and that he is not really happy. He has tried to break off with Bob several times, but finds himself unable to do so. His studies suffer and his grades are going down because he is constantly worrying whether or not his other friends can tell he is so deeply involved.

He states how he hates himself for being so "dirty" and for even enjoying his being with Bob, and begs you to counsel him get over these feelings.

APPENDIX E

E.

Mr. and Mrs. E. are a young couple who have recently moved into the community and they are recent college graduates. Mr. C. had been the President of the Student Body when a Senior, and now works as a Jr. Executive with IBM. Mrs. C. majored in Education and also was very active in school. She now teaches in a local grade school. It is for this reason that Mr. C. has to travel 80 miles a day to and from work, as this was the only teaching position open at the time. Mr. C's job is highly competitive and he often is forced to take work home at night which gives him very little time to spend with his wife. They do very little together and she is the only one presently attending church as Mr. C. claims to be "too tired to get up on Sunday morning."

In all her loneliness and feelings of being a burden to her husband, she had very recently drifted into an affair with another teacher at the school who was single and able to give her a lot of undivided attention. However, she had now cut off this relation voluntarily because of her feelings of guilt. She had confessed to her husband and even though he was very bitter and disappointed, he had forgiven her and been willing to give their marriage another try.

She goes on to tell you how things were alright again for a while and their sexual relations were very satisfying to her, but too infrequent because of her husband's fatigue and business worries. She had hoped to become pregnant, but so far had not been successful even though the doctor had told them there was no reason why they should not have children.

Last week, however, her whole world had crashed. They had attended a party and completely unexpectedly her husband had spent the entire evening in blatant and overt attention toward another woman. She had seen them both go upstairs and when she followed them found the bedroom locked.

The next morning Mrs. C. had left her husband and moved in with a girl-friend with the firm conviction that she wanted to divorce her husband immediately.

She has come to you because she has been attending your church and she and Hank were married in the church. She wants to know what your feelings on the whole deal are as she hates to admit failure, but recognizes that she and her husband are not psychologically strong enough to hold their marriage together. She also worries whether she is capable of holding a husband at all or if she is unable to love him in such a way that he would be completely happy with her.

APPENDIX F

F.

Jane, who is a middle-aged single woman, drifted into your office one day, and before she had removed her coat, exclaim : I'm nothing but a tool! People just use me when they want something done and in between they never think of me any more than they would of a paring knife! They won't let me be real. I want to be a person, not just someone to do chores or hold offices."

All this is surprising, for Jane's a very warm, attractive, outgoing, and friendly person always full of quips, amusing stories, and enthusiastic accounts of what she has been doing. While she lives alone and has no relatives, she works in a store, is secretary of her club, treasurer of a study group at your church, president of the Sunday School, and always deeply involved in all areas of the life of the church. She seems to get along well with her fellow workers; the customers like her and ask for her. You also know that she has many friends and often goes out, she attends many concerts, usually with somebody from church or with a friend or her landlady. She has a very pleasant apartment, and drives herown car. She certainly has a good job and you remember her telling you just recently that she had been granted a considerable increase in salary, and how happy she appeared about her employer being so open in his praise for her.

Outwardly, there is nothing to account for such bitterness or for her feeling that she means nothing to anybody. As she goes on talking about her resentment and feeling of being negated and dehumanized by her environment, it becomes clear that she is isolated in the midst of a crowd. She is rarely alone and always on the go, but no companion holds over from one activity to another. All her contacts are fortuitos ones, shifting as rapidly as two rivulets of water on a windowpane. She always eats lunch with one of her co-workers, but the choice depends upon who is in the cloakroom when she goes for her coat. It is usually she who buys the tickets for the concert and suggests going, and after it is over she and the friend separate with promises to "call each other up some time".

Jane's mother died ten years ago and you remember well what a great loss this was for Jane. Her mother had been a widow and an invalid for 20 years and Jane has spend most of her life taking care of her mother, often foresaking friends and opportunities for dating because she felt her mother needed her. At the time of the mother's death you had suggested that she become active in churchwork, to get rid of the house in the country and obtain a lovely apartment within the city, hoping that this would fill the emptiness and loneliness in this girl's life. She had done all these things and became active in church and joined a number of organizations, developed a host of new interests, and made many social contacts.

Jane had always seemed so happy and adjusted and never complained, always ready to take on added responsibilities in the church whenever you requested it. You now realize, however, that all of her contacts were

surface contacts, carried on in the framework of token relationships on the level of polite social exchange. No group was organic, fixed, lasting. All were tenuous clusters of individuals who met momentarily for a common purpose and then dispersed, to meet with another cluster for another purpose and another goal. She had, as an only child, no relatives, no one with whom she meshed, of whose life she was an integral part, whose role could not be well filled by another. If she lunched with a girl, it was with a co-worker, and they talked over the affairs of the store. As secretary of her club she often met with the president, but it was a secretary and a president making plans, not Jane and another human being making friends. She went to a concert, but she was paying back a social debt or "making a gesture" toward friendship.

In other words, all her relationships were status relationships. All her behavior was role behavior. As the President of the Sunday School she fulfilled certain duties and was responded to in a certain way, but was forgotten until the next week rolled around. She was a good clerk, a conscientious secretary, an accurate treasurer, a faithful Sunday School teacher. But there was no one to whom she meant anything.

Jane had begun to realize all this and was in your office for help. She felt she has come to the end of her rope and feels she cannot go on like this.

APPENDIX G

G.

Mr. K., 52 years old, and happily married, with four children, two sons married, one boy in college, and a girl in High School, is a deacon is your church. One night at 10 o'clock at night he calls and asks if he can come and see you because there is something which he is unable to discuss over the phone, but which disturbes him to the point that he feels he must see you immediately.

When he arrives he is obviously in a state of excitement. He finds it difficult to sit down and keeps pacing the floor, continually muttering to himself that he is lost, dammed for eternity, and very likely will go to hell when he dies.

You finally succeed in calming him down so that he is able to converse with you, even though he remains very excited and hardly can keep his voice down. He starts by saying that this is not a problem which has started tonight, but it is something that has been bothering him for a long time, at least six to eight months. He has been unable to discuss this with his wife because he didn't want to "involve" her in this. After another ten minutes of talking in the same manner, Mr. K. is finally able to tell you that he is convinced that he has committed the "unpardonable sin". He immediately quotes the Bible text from Mark 3 :29,30, "But whoever blasphemes against the Holy Spirit never has forgiveness, but is guilty of an eternal sin -- for they had said, "He has an unclean spirit."

Mr. K. goes on to say that he has had a feeling for a number of months now that he is unable to get through to God. He finds it impossible to pray in private and can only participate in the family prayers and even then with the greatest difficulty. Every time he tries to pray it seems as if "cursing thoughts" toward God run through his mind. He fully recognizes he is beyond the forgiveness of God and he feels that he is not able to get saved.

You point out that the interpretation of spripture quoted by him is quite different from what Mr. K. has been telling him and that these words are not directed against sins of unbelief, but against the malignant moral blindness which deliberately affirms that that which is good is evil.

You soon realize that this doesnot comfort Mr. K. as he still "feels" lost and wants to resign from his office as a deacon in the church because he is not worthy to serve a God he curses daily. He must await his final fearful judgment and he relates how he often thinks of the fire which will consume him. When he attempts to go to sleep at night he imagines that the flames are leaking around his bed, ready to get at him as a punishment from God.

In an attempt to find out if there is anything behind all this, I ask Mr. L. about his business and his family during the last year or so. Has anything outstanding happened. While still very optimistic he goes on to tell you that everything has been going quite well. His oldest son is ready to take an active part in the management of his business, so he and his wife may will be able to take things a bit easier. He has spent most of his life with his business and feels that the time has come to change this. He and Mary have been talking about a summer trip to Europe. Although a trip abroad which he has never been able to do up to now.

The only difficulty they have experienced, but which has been resolved over now, was about the future plans of his daughter Joan. He had always hoped that Joan would, just like the boys, go to college. Instead, she had surprised her parents by announcing that she planned to be married this summer right after graduating from high school. While he had been very much upset about this, he was very much relieved to see that his wife was very happy about the forthcoming event. The boy might be a promising college junior, he still feels that Joan could have done much better if she had waited a few years. He would have very much liked to have taken her to Europe with his wife this summer. Also, for what he felt was a really unexplainable reason, he did not really like the boy she was going to marry and explained that he would have picked out somebody quite different for his daughter. She was really only a baby and much too young to get married.

When relating all this and starts to cry, stating again that it doesn't really matter since he has less and less with which real to make something of himself. He confesses how it is high time that his boy takes over the business because it is beginning to take the worries of his present job and otherwise very short life own personal activities. It is impossible to concentrate on business and several times a day start to slack in his office when he almost feels the "Hour of Need" starting to run. He really doesn't feel you can help as he has required help, but still believes there is something you can do that will give him a true peace of mind. Also, he hopes you will be able to stand by his family, wife, and dear children, in their hour of need.

APPENDIX H

H.

Mrs. Z. wants to talk to you about the feasibility of continuing her marriage. She is a very attractive 25 year old woman who dresses extremely well and is very relaxed and easy-going. She, however, has lived with a problem in that she has been unable to take care of her two children asshe experiences deep feelings of being an inadequate mother. The youngest child, has been living with her in-laws, in a distant city, and she gets to see him only occasionally. Her oldest son, 4 years old, lives with his parents, but Mrs. Z. works and has a babysitter for the child. She feels this works out very satisfactorily as she loves working downtown and is unable to stay home because she becomes so upset and nervous that her husband and children suffer.

She has been working for two years and feels much better since that time. She has also had two years of psycho-therapy from a local competent psychiatrist and feels that this has been very helpful in understanding herproblem which is related to her father and it also has helped her to control somewhat her feelings of inadequacy in coping with being a wife and mother. Therapy had now come to an end as the psychiatrist felt he had done as much for her as he could, telling her that many people with a neurotic conflict are unable to ever cope with the task of a wife and mother as society demands it.

Her husband has now been promoted and as a result they will be moving to the east coast where her husband is to start a training program in an executive school of a large company. He has told her that if she cannot be a mother to both their children they should be divorced so that he can be married again and have his children with him. He has long been very angry for not having his youngest child at home. He also feels very bitter because the psychiatrist has never consulted with him and told him what to do or expect in the future. He has wanted to help her but just doesn't know how.

Mrs. Z. is now faced with the decision of pulling her family together and move into a new home and start living a more normal family life with her two children and the possibility of having additional children in the future. On the other hand she faces the possibility of divorce which will relieve her of the responsibilities she feels she cannot handle.

She states how guilty she would feel if her marriage broke up as she has always believed a Christian marriage is for keeps. She is willing to try and with God's help make the best of it. She feels that if her husband will let her work she has a much better chance because the sense of achievement in her work helps her tremendously at home. However, people frown on working women with children and her husband does not like it either.

APPENDIX I

I.

Mrs. B. is a highly intelligent, well-educated woman in her late forties. Her husband is the Administrator of the local Hospital. They are both very active in the Church, he a Sunday School teacher and a deacon, while she is the organist and President of one of the Guilds. Mr. and Mrs. B. have three children, a girl thirteen, a boy ten, and another girl seven. Mr. and Mrs. B. are both regarded as leaders in the civic affairs of their community and lead a very active social life. They have an intimate and easy-going relationship with you, their minister, and they have known you ever since their first child was born.

Mrs. B. comes to see you to express her strong concern for uncontrollable feelings of hostility towards her oldest child. She is aware of her being over-demanding with the girl, always expecting adult maturity and behavior. However, despite this awareness, she finds that very frequently she is unable to change her high expectation of the daughter. The girl is very bright and high-spirited and fights back with her mother. She gets very angry with her mother when too much is expected of her and of late has ran away to her girlgfriend's house on numerous occasions. All this has created an atmosphere of tension and resentment between mother and daughter which makes for unpleasantness in the home.

All this has become increasingly more intolerable to Mrs. B. and she would like you to help her. She has prayed about these angry feelings, but still feels that she is losing the battle every time she loses control of herself and gets angry. At times, will-power and self-control seems to work for a while, but in the end her excessive demands and anger get the better of her anyway.

After listening to Mrs. B. talk for a while and offering some words of confort she suddenly blurts out that there is something else which she doesn't understand within herself. However, she finds it difficult to discuss this with anyone. After reassuring her and waiting for her to speak up she finally states that she is very much bothered by occasional feelings of sexual repulsion toward her husband. She then expresses her opinion that she feels that somehow this is contributary to her problem with her daughter. She is at a loss to understand these feelings of repulsion as she considers herself happily married and her husband is a very good-looking man who is always very well groomed, very attentive toward her and does anything to make her happy. She continues to say that she worries a great deal about her daughter as she wonders how she will turn out having a mother like her who so frequently gets angry with her and continually nags her about matters that really are of no importance, and being unable to show very much her feelings of love for this girl.

APPENDIX J

109 Owen Hall, M.S.U.
East Lansing, Michigan
May 10, 1962

You might well be aware of recent research findings (Gurin, et al, "Americans View Their Mental Health", 1960) which indicate the crucial role of the American Clergy as one of the helping resources for people in distress. Of persons sampled who sought "mental health help", 42% turned to their clergymen.

These findings make it extremely important that ministers are capable of making proper referrals to psychiatrists when confronted with mental illness.

I am presently involved in a research project dealing with just this problem. We are attempting to find out whether ministers are able to recognize pathology, especially when moral issues are involved, or whether they would attempt to go ahead and treat these people themselves.

Enclosed you will find nine case histories, each one presenting a definite plea for help from the minister. It is felt that some of these can possibly be dealt with by a clergymen, while others because of the nature of the pathology, should be referred to a psychiatrist.

I would very much appreciate your cooperation by please reading these cases and check one of the two questions on each questionaire accompanying each case. As you will note, space has been provided in case you care to make any comments on the case, even though this is not a requirement.

Please return the questionaires only in the enclosed stamped self-addressed envelope at your earliest convenience.

I deeply appreciate your kind cooperation in this matter and trust that this type of a study might be of some value to the field of Mental Health.

Sincerely yours,

Garry J. Geerlings
Graduate Student Clinical Psychology
Michigan State University

APPENDIX K

[illegible] for this [illegible]:

a) should be referred to a psychiatrist for evaluation and possible treatment ( )
b) could adequately be dealt with by counseling with a clergyman ( )

Since our goal is to assess the presence of a psychiatric disorder, and since we would like to define this as that order of phenomena which psychiatrists commonly treat, we ask that you make your cutting point one that includes those whose degree of symptom pattern is such as to lead you to think that further investigation would, with a high degree of probability, lead to a diagnosis. Ask yourself, "If this person came to me with such symptoms, would I as a psychiatrist, think it appropriate to accept him/her as a patient?"

Comments: (If desired)

APPENDIX L

Now that you have finished reading this case, please answer the following questions:

1. State briefly your own reaction and feelings about this particular problem.

2. Do you feel this problem is:

   a) somewhat similar to a problem you have counseled in the past ( )
   b) the case history of a mental patient ( )
   c) a problem involving difficulties which might be overcome by faith, prayer, and counseling with a minister ( )

3. Would you:

   a) Handle this case yourself ( )
   b) Seek the advice of a psychiatrist in regards to further steps ( )
   c) Refer this person to a psychiatrist ( )

4. If you decided to handle this yourself, please state briefly how you would plan to go about this:

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