Chapter 12

RELIGION AND MENTAL DISORDER

> Religion as we know it today serves as an institutionalized defense against anxiety.[1]
>
> God should be brought forth to meet Satan and then Satan could go and teach the people the right. . . . It was my job to start it and get the spirit working. . . . I am the true spirit of God. . . . When I was in the rage, there was something telling me that I was the true spirit of Christ.[2]
>
> She wore a crown of thorns. She scarred her face with pepper so no man would find her attractive. Someone had the bad taste to praise her hands, so she dipped them in lye.[3]
>
> Once in direst distress, no way out, Jesus sat beside me in my car and said "Do not look at me. All will be well."[4]
>
> I was carried outside my body. . . . I saw God, and it seemed his holiness scared me and about four hours later I came back to earth.[5]

PAST AND PRESENT: CONFUSION IN VALUES AND PRACTICES

The association of religion and mental disorder goes well back into antiquity. Biblical citation is antedated by primitive and Asian references, and the Greeks and Romans usually invoked supernatural explanations when psychological aberration was manifested.[6] At no time in history have religious institutions ignored expressions of mental and emotional disturbances.

Not too long ago, mental deviation was defined and controlled by religious authorities operating on the Biblical principle that "the Lord shall smite thee with madness" for not obeying God's commandments (and religious leaders' pronouncements).[7] In reacting to mental disturbance during its first 1,500 years, the Christian tradition combined kindness and compassion with cruelty and punishment. At first, the early church associated tolerance and sympathy with prayer and supportive religious practices.[8] Threats to ecclesiastical authority from competing political and economic forces paralleled a growing concern with sin, confession, repentance, and punishment. Renaissance, Reformation, and Enlightenment ideas brought new challenges to religious institutions, which accordingly often hardened their position even further. One late expression of this conflict may be found in a readiness to make the accusation of witchcraft. Literally thousands of mentally disturbed persons suffered and met their deaths because of such responses from religious communities.[9]

185. Chesen (1972).
186. Pruyser (1977).
187. Stifoss-Hanssen (1994).
188. Culver (1988).
189. Ostow (1990, p. 122).
190. Alsdurf and Alsdurf (1988); Pagelow and Johnson (1988).
191. Higdon (1986).
192. Hartz and Everett (1989, p. 209).
193. Kirkpatrick, Hood, and Hartz (1991).
194. Hartz and Everett (1989, p. 208).
195. Sethi and Seligman (1993).
196. Weaver, Berry, and Pittel (1994).
197. Southard (1956).
198. Pruyser (1977, p. 332).
199. Andreason (1972); Bock and Warren (1972).
200. O'Connell (1961); Mowrer (1961).
201. Miller (1973).
202. Andrews (1987).
203. E. T. Clark (1929); W. H. Clark (1958); Cutten (1908); James (1902/1985).
204. McGinley (1969).
205. Pruyser (1977, pp. 333–334).
206. National Clearinghouse for Mental Health Information (1967).
207. Anderson (1963); Kelley (1961); Rayburn, Richmond, and Rogers (1983, 1986).
208. Rabinowitz (1969).
209. Finch (1965).
210. Christensen (1960).
211. Ranck (1961); Roe (1956); Strunk (1959); Webster (1967).
212. Aloyse (1961); Booth (n.d.); Menges and Dittes (1965, pp. 168–179); Wauck (1957).
213. Christensen (1963).
214. Jahreiss (1942); Kelley (1958).
215. Kelley (1961).
216. Moracco and Richardson (1985); Sammon, Reznikoff, and Geisinger (1985).
217. Daniel and Rogers (1981).
218. Aloyse (1961); Wauck (1957).
219. Stewart (1974, p. 45).
220. Schaffer (1990).
221. Fortune and Poling (1994).
222. Culver (1994); Lebacqz and Barton (1991, p. 69).
223. Fortune and Poling (1994, p. 21).
224. Camargo and Loftus (1993).
225. Hands (1992).
226. Lebacqz and Barton (1991).
227. Hawley (1994a); Horton and Williamson (1988).
228. Kaplan (1983); Landrine (1989).
229. McGuire (1992, p. 112).
230. Miller (1986).
231. Rothblum (1983, p. 88).
232. Holter (1970).
233. Ammerman (1987).
234. Brehony (1983).
235. Bridges and Spilka (1992).
236. Foster and Keating (1990).
237. Nelsen, Cheek, and Au (1985).
238. Bridges and Spilka (1992).
239. Koenig (1992).
240. Koenig (1992, p. 185).
241. Idler (1987).
242. Atkinson and Malony (1994).
243. Pruyser (1986).

244. Dalfiume (1993).
245. Koenig, Smiley, and Gonzales (1988, p. 75).
246. Rosenberg (1962).
247. Argyle (1959); Silberman (1985); Srole et al. (1962).
248. Srole et al. (1962).
249. Becker (1971).
250. Gilman (1984).
251. Gilman (1986).
252. McGuire (1992, p. 112).
253. Roberts (1984).
254. Chalfant, Beckley, and Palmer (1981); Hollingshead and Redlich (1958); Rose and Stub (1955).
255. Malzberg (1973).
256. Dohrenwend and Dohrenwend (1969); Hollingshead and Redlich (1958).
257. Hollingshead and Redlich (1958).
258. Roberts (1984).
259. Auld (1952); Berg (1967); Edwards (1957).
260. Duran (1995).
261. Krause and Van Tranh (1989).
262. Stolz (1940, 1943); Young and Meiburg (1960).
263. Bergin (1980).
264. Bethesda PsycHealth (1994).
265. Propst (1980, 1982, 1992).
266. Propst (1988).
267. Pargament, Steele, and Tyler (1979); VanderPlate (1973).
268. Szasz (1960).

Even though ecclesiastical power in this realm slowly gave way to medicine, psychiatry, and psychology, the notion of sin and wrongdoing as causative of mental problems still has a grip on the popular mind, and such themes even persist among the helping professions.[10] Though the cruder versions of these ideas seem to be fading, some may be found today in certain religiously conservative quarters, particularly in relatively isolated groups.

Intimations of abnormality and psychopathology have plagued the relationship between religion and psychology in the contemporary world.[11] Largely emanating from classical psychoanalysis, this tradition offered the triad of "becoming weak-minded, religious, and credulous."[12] Freud supplemented this judgment with even more pejorative suggestions that "religion is comparable to a childhood neurosis."[13] He and his followers soon argued for an analogy between acts of faith and "obsessional neurosis."[14] The long-range outcome turned out to be a latent (and often not so latent) feeling on the part of many psychologists that to be religious signified at least intellectual and emotional immaturity, and possibly a need for therapy. This view was kept alive by the widespread use of illustrations of religion in mental illness in psychological texts, and even in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).[15] With respect to DSM-III, Kilbourne and Richardson claimed that it had "an implicit and sometimes explicit tendency to devalue experiences common to many religions and to cast them into the pale of psychopathology."[16]

The situation, however, seems to be changing, as the latest edition of the DSM (DSM-IV) recognizes "religious and spiritual difficulties as a distinct mental disorder deserving treatment."[17] As part of this new awareness, religion and spirituality can be considered psychotherapeutic tools. Antireligious statements, such as Ellis's view that "the less religious they [patients] are, the more emotionally healthy they will tend to be,"[18] are apparently becoming passé.

For at least three decades, psychologists and religionists have been replacing previous doubts and antagonisms with a new spirit of mutual concern and cooperation. The rapidly growing pastoral psychology movement has united both lay and religious clinicians in the common endeavor of enhancing human potential. This and similar aspirations are finding considerable support in a thriving research literature on coping and adjustment (see Chapter 11). Among other groups, the Psychology of Religion division of the American Psychological Association plays a central part in furthering these developments. Stern and Marino, in speaking of what they term "psychotheology," claim that "religion and psychology have come to the point of seeing each other as polar ends of a workable compromise."[19] Toward such a goal, Sanborn has written a book entitled *Mental–Spiritual Health Models*, showing ways in which pastoral psychology and theology relate to mental and spiritual health and illness.[20] In a similar manner, many psychoanalytically oriented practitioners currently work toward harmonizing their approach with patients' faith. In this spirit, Linn and Schwarz have written on "ways in which religion and the social sciences, especially psychiatry, may join forces."[21] Contradicting Freud, they present clinical data to the effect "that emotional growth by way of psychoanalysis can result in an upsurge of religious feeling."[22] In sum, the integration of contemporary religion and psychology supports Hiltner's position of "psychology as a theological discipline internal to theology itself."[23] Simply put, we have come full circle to the realization that cooperation between religion and the behavioral sciences is essential to human betterment.

DIRECTIONS, CONCERNS, AND CAUTIONS

The relationship of religion to psychopathology has a long and complex history, which is worthy of study in its own right. Insofar as we are products of our collective past, a full appreciation of this heritage is essential; however, it goes far beyond what we can offer here. The purpose of this chapter is to show the many ways in which faith and psychological problems are interrelated. Among these possibilities are the following:

1. Religion may be an expression of mental disorder.
2. Institutionalized faith can be a socializing and suppressing force, helping (or forcing) people to cope with their difficulties and therefore to function as contributing members of society.
3. Religion can serve as a haven, a protective agency for some disturbed people.
4. Spiritual commitment and involvement may perform therapeutic roles in alleviating mental distress.
5. Religion can be a stressor, a source of problems; in a sense, it can be "hazardous to one's mental health."[24]

In addition to these possible relational patterns, much research has been conducted on connections between personal faith and the following: a variety of behavioral disturbances, such as substance abuse, crime, and delinquency (see Chapter 10 for our treatment of these problems); mild to severe forms of psychopathology; and special areas of concern that have only recently been recognized, such as mental disorder among women, the elderly, and persons who affiliate with what are pejoratively termed "cults." Issues such as sexual abuse among the clergy have received considerable attention in the mass media and are also worthy of examination. There are few matters in the psychology of religion more complex and controversial than the relationship of religion to sexual abuse and other behaviors that are most accurately termed "psychosocial disorders"; this is an area that has been greatly studied, and yet it continues to merit much more investigation. At the outset, however, let us say that the overwhelming mass of research evidence suggests far more beneficial associations between religion and mental well-being than adverse effects of religion on mental health.

Problems of Definition

Although scientists always hope to achieve truly definitive and final answers, they generally consider these unobtainable luxuries. If anything is constant in the scientific community, it is change, and as far as the diagnosis of mental disorder is concerned, measured and orderly change has been an ideal for over 40 years. As already noted, DSM-IV has recently appeared to supplant its predecessor, DSM-III-R. Since research on religion and abnormality spans many decades, the language employed in earlier work may not be in use any more. Translating older terminology into the terms acceptable today may actually not be possible. For example, the more or less generic rubrics "neurosis" and "psychosis" have been out of favor for about 15 years. In addition, within psychology and psychiatry, those who have worked with one classification system for psychopathology are frequently reluctant to adopt new frameworks, and may mix the concepts and ideas with which they are familiar with the latest categories. In other words, the application of diagnostic labels is likely to be considerably less precise than is desirable from either a research or an applied perspective.[25] Much incon-

sistency may be present when clinical identifications are offered. Caution must therefore be the rule in reading about any psychological/psychiatric grouping. For example, over the years the syndrome of schizophrenia has undergone many changes, so that a rough correspondence to what was meant a short time ago obscures new understandings and classifications.

The situation is no better when we review the religious facets of work in this area. Not uncommon are studies that simply designate their respondents as Catholic, Protestant, Jewish, and "other."[26] Once these labels are applied, little or no explanation is provided for variations among these broad groups. Confounding factors such as socioeconomic status or ethnic group are ignored, and both of these factors are very significant correlates of mental disorder. In addition, issues such as degree of religious commitment and church or synagogue participation are not considered. It must also be noted that these classifications are simplifications. Are the Jews Orthodox, Conservative, or Reform? Being an Italian Catholic is sometimes very different from being an Irish Catholic in religious expression. And just what does it mean to be Protestant? The *Yearbook of American and Canadian Churches* lists about 260 religious bodies, of which about 220 are said to be Protestant.[27] The futility of conducting research when the religious variable is poorly defined is obvious. Furthermore, the habit has developed of providing demographic information without a theory that makes such classification meaningful.

In Chapter 1, we have discussed the complexity of the religious domain, and we have suggested that categories such as "intrinsic" and "extrinsic" or "committed" and "consensual" faith forms, among other possibilities, might be useful. Unhappily, virtually no study dealing with mental disorder goes beyond some vague breakdown of religiosity based on frequency of church attendance or a designation of individuals as Protestant, Catholic, Jewish, and "other." An interesting variation is to classify persons as orthodox, fundamentalist, evangelical, or Pentecostal. Simplistic indicators of religion often mask a poor understanding of this highly complex realm by researchers. Still, consistency over multiple studies suggests reliable findings, and even when respondents have been poorly classified, such work can offer clues to more sophisticated workers and thus stimulate better research. Unfortunately, this is a costly and time- and energy-consuming path to follow, and a much more efficient approach is possible. This entails the development of adequate theory to guide such studies; more exacting definitions on both sides of the issue of religion and mental disturbance are an essential prerequisite in such work.

A Possible Theoretical Direction

In Chapter 11, coping and adjustment have been related to the assumption that humans have at least three basic needs. Though others can similarly be hypothesized, we have emphasized the elemental desires for meaning, control, and self-esteem. Earlier in this volume, and in its predecessor, discussion has been directed at the cognitive social-psychological idea of attributions. Also in Chapter 11, we have attempted to show that the attributions people make are efforts to maximize meaning, control, and self-esteem. In many instances, religious attributions perform these roles.

Let us now apply these ideas to the realm of religion and mental disorder. The origins of mental disorders are complex, often involving biological factors; however, the translation of their influences into the domain of social conduct is our main concern. As effects, these frequently entail deviant attributions to the world and to the self. They imply that in order to achieve meaning and maintain a sense of control and self-esteem, a person is psy-

chologically forced, usually by the stresses of life, to seek explanations outside of the normal range. Such is the stuff of delusions and reality distortions, and of their expression in the categories of the DSM. This is a rather bare theoretical statement that needs much further specification, but it should suffice as a guide.

Religion may be described in a number of ways that have already been cited: as an expression of mental disorder; as a suppressing or socializing device; as a haven; as therapy; and as a hazard to mental health. These possibilities are not necessarily independent of one another. Suppression/socialization and therapy may at times overlap, and may take place in a haven-like atmosphere. The suppression/socialization functions of faith may act both constructively, keeping a person in the community, and stressfully, creating for the individual an internal struggle; the long-range result of all this may be either positive or negative. Similarly, the haven function of institutionalized religion, with its own rules and regulations that often limit member options, may eventually create severe stress that culminates in serious breakdown. Recognizing such complexity is essential. However, to start our analysis, we must begin on a simpler note, and examine the roles of faith in relation to the way people cope with what Thomas Szasz terms "problems of living."[28]

RELIGION AS AN EXPRESSION OF MENTAL DISORDER

Mystical Experience[29]

The often extremely unusual and graphic nature of religious or mystical experiences can readily lead an observer to conclude that these are signs of mental disturbance. Indeed they may be, but let us first accept a well-established research finding described Chapter 7 on mysticism—namely, that considerable proportions of the U.S. and British populations report such encounters. Depending on the way the question eliciting this information is phrased, up to 50% of those sampled indicate having had such experiences.[30] If religiously active people are selected, the incidence is even higher. In fact, certain religious bodies (usually quite conservative ones) expect their members to have these episodes and to disclose them publicly. In these groups, such experiences help integrate people into the church and therefore support their adjustment. In addition, in both Western and other cultures, reports of such occurrences frequently contribute to the reputations of spiritual figures such as saints.[31] In other words, having a religious experience seems to be quite normal, may aid adjustment, and may be regarded quite positively.

Even though it has been acknowledged that "some mystics are badly disoriented personalities,"[32] a committee of the Group for the Advancement of Psychiatry indicated that it was unable "to make a firm distinction between a mystical state and a psychopathological state."[33] The committee did feel that mysticism "serves certain psychic needs, or that it constitutes an attempt to resolve certain ubiquitous problems."[34] Even though this committee offered some comments on the possibly favorable outcomes of mystical experiences, it was still too strongly attached to classic psychoanalytic and psychiatric views to make a full and truly balanced break with its negative historical tradition. It thus identified mystical behaviors as "intermediate between normality and frank psychosis; a form of ego regression."[35] Other psychiatrists have suggested, however, that mystical experience can be a constructive rejection of aggression or even a suicide preventative.[36] Research has also been conducted that distinguishes between mystical states and schizophrenic thinking and behavior.[37]

The association of religious and mystical episodes with the use of drugs has been widely noted.[38] Insofar as drug use may be activated by abnormality, psychedelic experiences with a religious flavor can be regarded as expressive of deviance in personality.

Almost three-quarters of a century ago, Leuba looked at the role of epilepsy in mystical expression, implying aberrant nervous system function as underlying such experiences in many people. He thus spoke of "the presence in our great mystics of nervous disorders, perhaps of hysteria."[39] Leuba also felt that mental problems such as "neurasthenia" and depression predisposed people to have mystical experiences.

In a highly significant theoretical and research paper, Rodney Stark has offered a breakdown of religious/mystical experiences that range from the normal to the possibly pathological.[40] For example, his "salvational" type is said to be motivated by a sense of "sin and guilt."[41] Of a more extreme nature, with much potential for illustrating a mentally disturbed condition, is what Stark terms the "revelational" experience. It is clearly the rarest and most deviant form he discusses, and finds expression in visual and auditory hallucinations that the individual regards as true messages from the deity, angels, or Satan. It has received some confirmation from work showing that personality and adjustment problems may be associated with religious experiences involving extreme physical and emotional reactions and/or hallucinations.[42] Similar connections have been offered by other scholars.[43]

Summarizing the research literature, Lukoff and his associates point out that "studies have found that people reporting mystical experiences scored lower on psychopathology scales and higher on measures of psychological well-being than controls."[44] There is no doubt that religious and mystical encounters may reflect mental disturbance; however, the weight of the evidence suggests that such experiences are often normal, and even have beneficial effects.[45] This is discussed further in Chapters 6 and 7.

Glossolalia

The phenomenon of glossolalia, or "speaking in tongues," can be quite impressive and awe-inspiring in its effects. Commonly associated with religious experience and found frequently among Pentecostal, revivalist, and charismatic sects, it easily led to interpretations of psychopathology, especially in the past. In some instances, when it is observed outside of its approved religious setting, recommendations for psychiatric involvement are likely to occur.[46] There is reason to believe that the presence of glossolalia may be increasing in more mainline Christian groups. One recent estimate suggests that there are at least 2 million glossolalics in the United States.[47]

The question "Is glossolalia a normal or abnormal behavior?" has been with us for some time. Clinical psychological and psychiatric professionals are inclined toward explanations that stress deviance. Researchers lean toward seeing minor personality differences, or, more commonly, find no distinctions between glossolalics and nonglossolalics. Kildahl has described glossolalics as suggestible, passive, submissive, and dependent.[48] In contrast, Teshome found glossolalics to be more independent and to rely on others less than nonglossolalics.[49] He found few differences between his groups on personality measures.

Taking the deviance perspective, Pattison claims that glossolalic individuals demonstrate "overt psychopathology of a sociopathic, hysterical, or hypochondriacal nature."[50] This certainly indicates serious disorder. Kelsey notes an implied correlation with schizophrenia, but rejects such an identification.[51] He is more willing to accept glossolalia as a lesser neurotic symptom, but also expresses doubt about applying such a label to these people. There is evi-

dence that speaking in tongues usually follows a period of crisis, and works to resolve the resulting anxiety.[52] Similarly, Preus sees glossolalia as a "release from tension and an answer to personal stress and trauma . . . and [it] can be accomplished by almost any person who really wants to. . . ."[53] These last views moderate the extreme position of Pattison, but still maintain some potentially aberrant motivation (i.e., stress and anxiety). Goodman uses the phrase "hyperarousal dissociation," which verbally implies abnormality, but really speaks more to an altered state of consciousness. She further asserts that "beyond the threshold of the conscious there is not disorder but structure."[54]

The confusion about the normality or abnormality of glossolalic behavior is slowly being resolved in the direction of normality. There is currently little doubt that it is learned behavior, which is reinforced in certain group settings into which the person is socialized.[55] Undoubtedly, there are instances of individuals whose glossolalia may be symptomatic of personal problems, but these seem to be the exception rather than the rule. A representative example of research in this area is provided in Research Box 12.1.

Conversion[56]

Like religious experience and glossolalia, which are sometimes associated with conversion, conversion itself has been the object of clinical and psychiatric concern. (In recent years, this has been especially true when a person affiliates with a group pejoratively described as a "cult." This, however, is a topic worthy of consideration in its own right, and it is more extensively discussed in Chapters 8 and 9.) As will be evident, we are concerned here with only one part of the multifaceted phenomenon termed "conversion."

Research Box 12.1. The Psychology of Speaking in Tongues (Kildahl, 1972)

In this study, two groups—one of 20 glossolalics, the other of 20 nonglossolalics—were interviewed in depth about their lives and tongue-speaking experiences. The groups were equated for religiosity, which was evidently high. Three projective tests (the Rorschach ink blot, the Thematic Apperception Test, and the Draw-a-Person) and one objective test (the Minnesota Multiphasic Personality Inventory) were administered to the participants.

It was observed that the nonglossolalics tended to be more independent and autonomous, but also more depressed, than their glossolalic peers. Tongue speaking appeared to be associated with strong trust in a religious group leader. Though no real differences existed between the two groups on mental well-being, the glossolalics were characterized as being more dependent on the guidance of a trusted religious authority. They appeared inclined to relinquish personal independence and control to this leader, and became indifferent to glossolalia or ceased being glossolalic when they lost faith in their spiritual guide.

In his book, Kildahl cited another researcher who asserted that "more than 85 percent of tongue-speakers had experienced a clearly defined anxiety crisis preceding their speaking in tongues" (p. 57). The glossolalia seemed to be constructive and anxiety-reducing in these cases.

Without question, most conversions are not symptomatic of mental disturbance. Some, indeed, do mirror personal problems, but they may also reflect constructive solutions to those difficulties. Even early researchers pointed to both possibilities. Though negative perceptions prevailed in their writings, room was still left for favorable interpretations of the causes and outcomes of conversion. Probably the earliest such study was conducted by E. D. Starbuck in the late 1890s, and it illustrates these considerations well. High among the motives he found to motivate conversion were "fear of Death or Hell," and "Remorse, Conviction for Sin, etc."[57] The most common emotional states he found to be associated with conversion were "depression, sadness, pensiveness," with "restlessness, anxiety, uncertainty" following closely.[58]

In another classic study of over 2,000 people, E. T. Clark reported three kinds of "religious awakening."[59] Two of these, the "definite crisis awakening" and the "emotional stimulus awakening," were judged to have the highest potential of expressing psychological problems. Most often they were accompanied by sin, guilt, and depression, frequently affiliated with sexual problems. Clark's "gradual awakening" type pictured a positive form of conversion.

More recent work that illustrates the influence of underlying disturbance reveals that persons suffering from affective disorders show an increased likelihood of having conversion and salvational experiences when either ill or well. This has been explained by noting the heightened emotional responsiveness of such individuals. The outcomes of these religious manifestations span the entire range from pain and depression to great personal benefit.[60]

The research of Starbuck and Clark brought to the fore the question of sudden versus gradual conversion. The literature has tended to indict the former as an expression of underlying pathology, while approving of the latter as suggestive of mental health and well-being. The general position has been that, on average, those who convert suddenly tend to be emotionally unstable and are likely to relapse. In many instances, their transformation has been considered superficial, since they may engage in repeated conversions, particularly in revival-type situations.[61] A follow-up of persons who made such "decisions" during a Billy Graham crusade in Great Britain revealed that about half had lapsed during the subsequent year.[62] Another investigation reported that 87% of these converts had reverted within 6 months to their former religious behavior.[63] Apparently, some of these people had converted up to six times. Psychiatrist Leon Salzman termed these sudden and superficial conversions "regressive-pathological."[64]

Other work on the sudden–gradual distinction has fairly consistently shown that the sudden form is associated with higher anxiety and poorer chronic adjustment than is true of those who acquire their faith and commitment over a longer period of time.[65] Severe depression and the potential for suicide have also been components in these sudden conversions.[66] However, as popular as the image of the sudden conversion seems to be in the popular mind, the evidence suggests that it is relatively uncommon, usually affecting about 7% of converts.[67]

Family concerns have often been emphasized by psychologists and psychiatrists in their work on conversion. Christensen reported parent–child difficulties prior to conversion, particularly among persons with early fundamentalist training.[68] Ullman's work on converts to Catholicism, Judaism, Baha'i, and Hare Krishna also resulted in a focus on early family life and pointed at disturbed relationships on the part of the converts with their fathers, plus other signs of a distressed childhood.[69] Salzman had earlier identified his "regressive-pathological" conversions with authority conflicts, notably with one's father.[70] The same theme pervades the work of Allison, whose study of converts also stressed the role of alcoholic, absent, or weak fathers.[71] Though claims such as these are made by knowledgeable clinicians, it is some-

times difficult for readers to reach the same conclusions from the data as those reporting such work. Still, this kind of thinking is popular in certain psychological/psychiatric quarters. Especially illustrative is an extensive and informative case history in which Levin and Zegans viewed the conversion of a young man as a "replacement for his deficient, weak father."[72] This theme of conversion reflecting paternal problems is commonly found among psychoanalytically oriented scholars, but needs confirmation by more exacting research. This is part of a broader negative view of conversion as "generally a regressive, disintegrative, pathological phenomenon."[73] This position has, however, failed to gain any substantial support in almost a century of research.

We may say that conversion, though often graphically impressive, is infrequently a manifestation of underlying psychological disturbance. Most large-scale studies demonstrate that conversions are positive and constructive events.[74] The rapid acquisition of a new religious faith is apparently more likely than its gradual counterpart to reflect problems in coping with impulses and relating to others and the world.

Scrupulosity

A rather clear example of mental pathology being manifested in religious thinking and behavior has been termed "scrupulosity."[75] Simply put, it has been called "the religious manifestation of Obsessive–Compulsive Disorder, and is regarded in DSM-IV as one of the Anxiety Disorders."[76] Specifically, it is considered "a condition involving continuous worry about religious issues or compulsions to perform religious rituals."[77] Askin and her colleagues have been able to develop a relatively short objective measure of scrupulosity that correlates very strongly with indices of obsessive–compulsiveness.[78] Similar findings have been reported for a group of disturbed Catholic children.[79]

Primary among the expressions associated with scrupulosity are a fear of sin and compulsive doubt.[80] Those suffering from this condition are continually seeking assurance from religious authorities. In addition, they engage in rigid ritualistic observances and practices in order to gain some sense of purification—a sense that they can never attain. This is because of their views of the self as bad and sinful, and of the deity as unforgiving and tolerating no deviation from the most extreme religious strictures that can be imagined.

The Religion of Mentally Disordered Persons

Psychopathology can affect religious expression in many ways. Many illustrations can be found in textbooks on abnormal psychology and psychiatry.[81] Furthermore, we have noted that DSM-III focused unduly on case study religious illustrations for a wide variety of disorders, probably as a partial reflection of antireligious bias. This prejudice is a function of the highly questionable psychoanalytic inference of "similarities between mental illness and religion."[82]

Since religious identification, beliefs, and practices are very normal (though highly variable) in every known culture, if they mirror abnormal mental states, distinctions between such conditions and customary religious expressions may be evident. This has been shown to be true. There is little doubt that mental deviance has its parallels in spiritual aberrance. Argyle has pointed out that religious mental patients often manifest their faith in troubled and bizarre ways.[83] Oates found that psychotics who believed religion was involved in their problems had distorted memories of religion in their early years.[84] Reifsnyder and Campbell

claimed that the religion of psychiatric patients was often inconsistent, shallow, and confused.[85] Apparently, many disturbed people commonly perceive their deity as controlling, vindictive, and unforgiving, ready to punish those who violate godly prescriptions. A consonant perception is that these individuals are themselves sinners and transgressors, and deserving of divine punishment.[86]

That the situation is more complex than these findings imply is illustrated by Lowe and Braaten's research,[87] which is presented in Research Box 12.2. We may, however, conclude that the faith of mentally disturbed persons has a high probability of also being deviant. We must also agree with Beit-Hallahmi, who wisely observes that "the specific content of psychiatric symptoms seems to be determined by social background factors. Individual psychodynamics determine the appearance of symptoms, but their particular form will be the result of these background factors, one of which is religion."[88]

RELIGION AS A SOCIALIZING AND SUPPRESSING AGENT

The Control Functions of the Religious Community

As a sociocultural institution, religion may function to actively socialize, suppress, and inhibit what the community defines as deviant and unacceptable behavior. Both sociologists and psychologists affirm that churchgoers overwhelmingly represent the more conservative and conforming members of the North American social order.[89] Stark and Glock refer to "churches as moral communities"; as such, mental deviance is often redefined as a moral problem, since it threatens social cohesion.[90] Whether a religious institution is socially regarded as liberal or conservative, it attempts to suppress conflict among its own adherents even if this increases dissension in the larger community.[91] This can extend into all aspects of an individual's life, not the least of which are child-rearing practices that attempt to con-

Research Box 12.2. Differences in Religious Attitudes in Mental Illness (Lowe & Braaten, 1966)

Inferring that "religious concern and conflict characterize patients in psychiatric hospitals" (p. 435), these researchers attempted to determine objectively the religious attitudes of 508 hospitalized mental patients. A 27-item religion questionnaire was developed, 18 items of which dealt with religion in relation to the patient's pathology.

No differences were found in the religious attitudes of patients with different diagnoses. A major influence was the time a patient had spent in the hospital; this related positively to self-concern and negatively to religious influence. When those who had been patients for more than 7 years were compared with their peers who had been hospitalized for less than this time, the former expressed more doubts about the existence of God, were less certain that God loved them, and felt that their faith was less comforting and less likely to provide a sense of purpose. They were, however, more apt to feel that it was an aid for self-improvement. The researchers felt that the longer people were in the hospital, the greater their withdrawal from the world. Viewing religion as a form of social interest, they concluded that religious involvement and ideas suffered during hospitalization, along with other social commitments.

trol displeasing and socially inappropriate behavior (e.g., aggression).[92] Studying maladaptive behavior among mainline Protestants, MacDonald and Luckett suggested that failures to adapt in this core group may result from early exposure at home to overly strong and repressive controls. Such experiences, rather than aiding adjustment to reality, may foster rigid identifications with ideals that simply may not be realizable in modern life.[93]

Social disapproval and ostracism are strong weapons for shaping thought and action. Little is more distressing than the loss of friendships and affectional support. When an individual departs from group norms, pressure is exerted to bring the person into line with social standards. If that fails, contact with the offender is reduced until the person is isolated.[94] By such means, the religious community creates a learning environment that can direct abnormal thinking and activity into approved channels. This is mediated both through the social values and responses of the church members and through religious doctrines. Socializing an individual by these means apparently strengthens impulse controls and counters deviant tendencies.[95] This is evidently true for Hare Krishna members, whose adjustment improves with the length of time that they are affiliated with this group. The social controls exercised by this organization clearly constitute a learning environment for its adherents.[96]

A considerable research literature also shows that the social environment of a religious group can suppress undesirable delinquent behavior and the use of drugs and alcohol (see also Chapter 10).[97] Among Jews, as one goes from Reform to Orthodox groups, intoxication decreases.[98] The traditional Orthodox Jewish home tightly circumscribes the use of alcohol, primarily permitting it to be used in religious rituals. In contrast, among more liberal Reform Jews, the strong identification that is made with general North American values permits considerable social drinking, with a greater likelihood of alcohol abuse.[99]

The Control Functions of Religious Ideas and Institutions

In the preceding section, we have been concerned with the internalization of the control functions of religion. As Pruyser has noted, religion is "a perennial form of wish-fulfillment and need gratification . . . it condones [infantile wishes] by symbolic satisfactions."[100] The implication is that mental disturbance may be socially shaped, focused, and controlled by religious ideas and their embodiment in the form of churches and their representatives.

Institutionalized faith lives by both formal and informal rules and referents—the Ten Commandments, the Golden Rule, the Bible, papal statements, interpretations and decisions of denominational conclaves, and so forth. The ecclesiastical climate also sponsors notions of how a "good Jew" or a "good Christian" thinks and acts. These are supported by images of God's love, mercy, or vengeance—which are not taken lightly by the faithful, whether they be normal or disordered individuals. When adopted as guides for personal action, they may be very effective forces for the suppression and socialization of abnormal impulses.

Even if psychopathology comes to the surface, the argument has often been made that the use of religion may prevent worse things from happening. One paper suggests that "occasionally religiosity in paranoid schizophrenia might itself be a mechanism to control underlying hostility and aggressive behavior."[101] In a case study, two psychiatrists claimed that a patient's "religious conversion enabled him to find a new and potentially viable self-definition."[102] It apparently functioned as a substitute for the "overwhelming panic of his acute psychosis."[103] In a similar manner, Allison refers to intense religious experiences and conversion as "adaptive regression" that may "help reorganize a weakened ego."[104]

The power of religious doctrine is nowhere more evident than in the association of faith and suicide. There is no need to document the very negative attitude of Western religious institutions toward suicide. Dublin has emphasized that "suicide . . . is infrequent where the guidance and authority of religion are accepted without question, where the church forms the background of communal life, where duties are rigidly prescribed."[105] This relationship is most evident in such bodies as Roman Catholicism, Greek Orthodoxy, and Orthodox Judaism. Countries in which these faiths predominate report the lowest suicide rates. The greater emphasis of Protestantism on individualism and personal freedom may work to set the troubled person adrift in an anomic world; hence suicide rates for Protestants are two to three times higher than for Jews and Catholics.[106] There is, of course, the confounding factor that a religious setting that condemns suicide is not likely to produce medical and civil authorities who are willing to define a death as suicide, except when the evidence is irrefutable and/or has become public knowledge.[107]

There are both historical and contemporary examples of the extremes to which religious leaders may go when exercising control over their followers. Most of us may look in admiring awe at the self-sacrifice carried out at Masada in 73 A.D., when a group of Jewish Zealots, in their quest for freedom, left only their corpses to greet the Roman conquerors. Quite different was the mass suicide of those in Jim Jones's People's Temple movement, where socioreligious control appears to have resulted partly from the megalomania of its leader.[108] The more recent example of David Koresh and the mass death of his Branch Davidians may be another tragic example of this same abuse of power.

The socializing function of religious doctrine has been well summarized by Feifel: "Religion . . . tries to school us in those wise restraints—self-discipline, the capacity for sacrifice and service to others—that make the repressive control of impulses unnecessary."[109] This is an ideal that many disturbed people attempt to realize.

Religious Role Models

Children and adults often learn how to behave by modeling themselves after those whom they admire or who represent ideas and ideals that speak to success in attaining desired goals. In other words, they learn by observing others who serve as models. These others may be people with whom children and adults interact or about whom they read, hear, or are informed. Social learning theory suggests that "the power of a moral model . . . can be an important component in the development of self-control."[110] In other words, one can learn to be "normal" or "abnormal" by emulating others.

Ministers, priests, rabbis, Biblical heroes, Jesus and his apostles, saints, and so forth, stand as sanctified models to be imitated. Explicitly and implicitly, these figures enact roles that may significantly influence the behavior and thinking of religious people along approved lines. In one study of over 3,000 children and adolescents, clergy were rated as more supportive than parents, suggesting the potential of priests and ministers as positive role models.[111] In all likelihood, these images may serve as significant referents for some mentally disturbed individuals. As Bandura affirms, "modeling influences can strengthen or weaken inhibitions over behavior."[112]

This role model approach to controlling behavior has recently been formalized in the study of religious experience by the Swedish scholar Hjalmar Sunden. His role theory (which has also been discussed in Chapter 6) appears applicable to religious behavior in general as it stresses perception, motivation, and learning. Holm points out that "these roles need not

necessarily always be socially given models but can equally well be literary or mythical narratives."[113] He adds that "when an individual in a certain religious tradition absorbs descriptions from sacred history, he learns models for his attitudes toward the supernatural."[114] We are told that "this description will function as a structuring role pattern."[115] Here is a theoretical framework that usefully connects religious role models with the socialized control of thinking and behavior on the part of the mentally distressed person.

Religion and Control: When Does It Work?

It has been well established that religious activity is negatively associated with deviance in both cognition and action. Stark has shown that mentally disturbed persons who continue to live in a community outside of an institution assign less personal importance to religion and are less active than more normal citizens.[116] He theorizes that "psychopathology seems to *impede* the manifestation of conventional religious beliefs and activities."[117] This confirms the findings of a number of researchers who have reported that the faith of mentally disordered individuals is itself disturbed and deviant.[118] Other work indicates that the more severe the psychopathology, the less the involvement of the individual in both personal and organized religious activity.[119]

In a number of areas in which the line between mental disorder and morality is not always easily drawn—particularly crime, drug and alcohol usage, and sexual promiscuity—the findings reveal some confusion (see also Chapter 10). Sometimes these behaviors correlate negatively with religiosity; at other times they appear to be independent of religion. Bainbridge explains some of these results by referring to what he calls "the Stark effect." Stark observed that crime and delinquency rates were low in communities where organized religion was strong, but not where it was weak. In cases where few people in the community were religious, neither individual nor community religiousness had the power to inhibit deviance, even among religious youths.[120]

Bainbridge's own research has suggested an even more complicated explanation. Examining a variety of data, he indicates that individual religiousness suppresses deviance when the person is part of a religious community, even if the overall community is religiously weak.[121] In all probability, community effects will hold not only for immoral responses, but for a wide variety of mental aberrations that mark the individual's behavior as psychologically disordered.

Another approach to this problem of controlling abnormality relates to the way people view themselves. It is not unexpected that deviant behavior may both result from and contribute to the social ostracism of disturbed persons, and, furthermore, that such people possess negative views of themselves. We also know that unfavorable self-attributions parallel similar attributions for the deity and religion.[122] In some instances, this pattern may prevent these individuals from benefiting either from their personal faith or from association with similar others in religious institutions. Jensen and Erickson suggest that strict religious group attitudes, along with the positive role models provided by clergy and coreligionists, may act both to socialize and to restrain expressions of abnormality.[123]

It is evident that religious systems and their supporters can suppress abnormal thinking and behavior, and thus can help mentally disordered people to become part of the larger community. Such social and ideological sustenance may also contribute to ego strength and integration. Stated differently, adherence to a faith that is in line with cultural norms can reduce abnormality and psychopathology. Stark's work, which is presented in Research Box 12.3, illustrates this principle.

Research Box 12.3. Psychopathology and Religious Commitment (Stark, 1971)

Theorizing that conventional religious involvement would be incompatible with deviant thinking and behavior, Rodney Stark hypothesized a negative relationship between these two variables. In his study, 100 mentally disturbed persons were carefully matched with 100 normals and compared on a variety of religious items. The basic findings were as follows:

Percentage claiming	Mentally ill	Normals
No religious affiliation	16	3
Religion not important at all	16	4
Not belonging to any church	54	40
Never attending church	21	5

Note. Adapted from Stark (1971). Copyright 1971 by the Religious Research Association. Adapted by permission.

The hypothesis was clearly confirmed, as the mentally disturbed persons demonstrated less conventional religious involvement than the normal sample. In another part of this study, a national sample of Protestants and Catholics who scored low on indices of psychic difficulties were more likely to be religiously orthodox and to attend church frequently than those revealing such problems. Again, the hypothesis was supported.

RELIGION AS A HAVEN

Religion has been known to offer mentally distressed individuals a refuge from the stresses of daily life—a safe harbor from the turmoil and turbulence of living. This can take place in three ways: (1) Everyday existence may be circumscribed and controlled by rules that leave little doubt about how to behave; (2) being part of a religious organization may alleviate fears of social isolation and rejection; and (3) strong identification with a religious body can provide the mentally disordered with the perceived security of divine protection. It can also do this within three different types of religious organizations: (1) groups or movements that are out of the religious mainstream (so-called "sects" or "cults"); (2) encapsulated religious communities, such as the Amish and the Hutterites; and (3) separate communities within mainline religions, such as sisterhoods of nuns.

Groups or Movements That Are Out of the Mainstream

"Deviant" religious movements can attract mentally disturbed individuals (see Chapter 9). We have noted above that if such persons are not socialized by mainline churches, they may become estranged from traditional religion. This is a two-way street: The average churchgoer is probably sympathetic to the plight of the mentally disordered, but may still prefer not to be associated with such people. The inability of the mentally disturbed to fit in may cause them to respond in a reciprocal manner and to reject conventional beliefs and believers. They may, however, find a home in religious or spiritual subcultures that are out of the mainstream—the so-called "sects" or "cults." Since members of these groups often feel that they are ostracized by society (and in many instances they actually are), they may find com-

mon cause with others who are rejected for reasons of individual mental deviance. If the latter are seeking divine guidance and support, so much the better, from the viewpoint of those with missionary zeal.

It is very important at this point to recognize that the majority of members of what are socially regarded as deviant religious groups are quite normal and mentally healthy.[124] Most of those who join such bodies do not suffer from psychological problems. Some individuals may, of course, find a haven that functions as a source of meaning and a framework of needed control in these religious groups, but this is probably the exception and not the rule.[125]

Alienated individuals can be attracted by a wide variety of religious and ecclesiastical elements. Unquestioning attachment to a spiritual leader may reflect emotional immaturity and extreme dependency needs. The charismatic quality of some of the founders of these groups can entice persons whose reality contacts are weak. One study of the Unification Church (pejoratively called the "Moonies") revealed that about 40% admitted having mental difficulties prior to joining the church, a third had sought professional help, and 6% had been hospitalized.[126] As Research Box 12.4 (below) notes, the outcome of affiliation with the Unification Church was psychologically beneficial.

Snelling and Whitley studied four of what they termed "problem-solving groups," including a Hare Krishna temple. They suggested that, instead of obvious abnormality predominating, there seemed to be "a noticeable strain or predisposition toward reductionism in the sense of cutting down or narrowing the 'size' of the world in order to make it more manageable."[127] Though such a reaction may indicate some coping difficulties, it may be a rather wise choice on the part of some devotees; also, since the great majority of these individuals return to society, their experience in such "manageable" environments may permit them needed time to develop better ways to adjust to the world.

Another example of the way in which sects or cults may serve a temporary haven function is implied by work showing that some young people who affiliate with these bodies come from troubled homes and families.[128] Such a religious group may serve as a substitute family, offering needed social and psychological backing until the person is able to cope with a North American milieu that highly values personal autonomy.

The haven role not only offers a defense against a possibly unappreciative and potentially threatening society outside of the chosen religious group, but also usually provides much positive acceptance and support. We see this in Kildahl's description of the fellowship of glossolalics. He cited them as exhibiting "a tremendous openness, concern, and care for one another . . . they bore each other's burdens . . . were with each other in spirit and in physical presence."[129]

A variation on this theme may exist among Jehovah's Witnesses, a religiously conservative and strongly proselytizing group. Said to have an incidence of schizophrenia three to four times higher than that found in the general population (a finding that needs further confirmation), it may appeal to some distressed people who feel they need a spiritual foundation that incorporates a very strict moral code.[130] This may protect such individuals from life stresses and temptations, while helping them to internalize necessary controls that permit a modicum of adjustment. The research of Galanter and his associates, which illustrates such a tendency in the Unification Church, is presented in Research Box 12.4.

Finding a spiritual haven is not easy. Especially among the cults and sects, troubled people frequently move rather easily from one such group to another. The unstable membership of these bodies is well documented.[131] There are, however, some data suggesting that these shifts of commitment increase with the severity of mental problems.[132] Still, such mov-

Research Box 12.4. The Moonies: A Study of Conversion and Membership (Galanter, Rabkin, Rabkin, & Deutsch, 1979)

With the cooperation of the Unification Church, an extensive questionnaire dealing with mental health issues was administered to 237 church members. A pattern of disruption and emotional difficulties preceded their joining the church in many instances; about one-third had sought professional help for these problems, and 6% had been hospitalized. Psychological distress scores for the time prior to church affiliation were 48% higher than at the time the testing took place. In addition, church members still showed more personal disturbance than was found in the general population. Though there were indications that adjustment initially declined when conversion to the church took place, as religious and communal ties to the group increased, so did psychological well-being. The greater a person's religious involvement and commitment, the less distress was evidenced.

ing about may also benefit seekers in their search for meaning, control, and self-esteem. Sometimes satisfactory answers are elusive.

Encapsulated Religious Communities: The Amish and the Hutterites

Though they are usually considered sects, their long history of relative isolation, combined with a reasonable degree of acceptance by the general society, makes groups like the Amish and Hutterites of special interest to mental health researchers. The nature of their separation allows social scientists to regard them as "laboratory-like" sociocultural cases, worthy of much study. Neither group has attempted to bring in new members by proselytizing. People are born into these groups; rarely do they seek to join from the outside. Because of these bodies' isolation and the formal and informal controls they exercise over their adherents, they manifest the haven functions of religion well. They also provide information on some of the causes of various kinds of mental disorder.

Among the Amish, the doctrine of separation is evident in the proscription against marrying outsiders or even entering business partnerships with non-Amish persons. Basically, this view holds for any deep or long-lasting social involvement or contact with any outsiders.[133] Such self-segregation, when combined with very strict internal controls on behavior, creates great stress for many Amish. The expectations these rules engender have been cited as a cause of anxiety, and may in part account for an incidence of suicidal tendencies above the national average among Amish hospitalized for mental problems.[134] Unfortunately, there is not enough information available to indicate whether the incidence of neurotic or psychotic disorders is unusual. The community acts as a haven, preferring to care for its own whenever possible.

The Hutterites are a different matter; good observational data have been collected from them. Eaton and Weil carried out a highly regarded study on religion and mental disorder with this group more than 40 years ago.[135] Like the Amish, the Hutterites are a separationist Anabaptist sect; they live in relatively isolated communities in southern Canada and along the northwest tier of the United States from the Dakotas westward. Because the group is a close-knit and highly supportive communal organization, the authors expected low rates of

mental disturbance. Where such disturbance does occur, as with the Amish, a loving community with its own apparently constructive therapeutic views is present to aid the distressed individual.

Eaton and Weil found that the frequency of the less severe neurotic states tended to be low, particularly those in which aggressive or antisocial expressions were primary. In lieu of these symptoms, guilt and depression were commonly found; these seemed to be a product of both the highly controlling social milieu and failure to live up to the strict expectations of the community. Moreover, the low rates of neurotic disorders were countered by a high incidence of severe psychotic disorders. Four centuries of relative isolation may have concentrated the genetic and constitutional potential for such illnesses; these propensities could also be activated by the often inflexible demands of daily life. Furthermore, Eaton and Weil had reason to believe that the Hutterite communities they studied might operate much better as refuges for the less disturbed group members than for their more seriously affected counterparts.

Separate Communities within Mainline Religious Groups

Some mentally disturbed persons may believe that they are "called" to a religious vocation, and subsequently may find a haven in a religious community that separates them from the world. This view has been confirmed by Kelley, who studied Catholic nuns. Finding a variety of disordered states among the sisters, she concluded that these were a function of preexisting difficulties rather than of the chosen religious life.[136] Reference has also been made to a high frequency of hypochondriacal complaints.[137] Similar findings have been reported in other studies of nuns.[138] Research Box 12.5 describes Kelley's significant study.

Additional work on disturbed sisters attributes their motivation to enter orders to a desire for security because of emotional starvation and/or a view of the world as dangerous. These needs are frustrated by organizational pressures and restraints, which are thought to exacerbate the nuns' tenuous grip on reality.[139] Kurth has claimed that two factors should be recognized as contributing to this situation. First, "many mentally ill individuals seek to

Research Box 12.5. Hospitalized Mental Illness among Religious Sisters (Kelley, 1958)

Kelley, a nun herself, gathered data from 357 U.S. private and public mental hospitals regarding 783 Catholic sisters who were hospitalized for mental disorders in 1956. High rates for depression and schizophrenia were observed; yet, prior to being committed, the sisters had spent an average of 17 to 20 years in their order.

The incidence of severe disorders among sisters who performed domestic functions was over seven times higher than the rate for those involved in teaching. The rates for cloistered nuns were also higher than for those in noncloistered orders. Among the hospitalized nuns, 80% suffered from psychotic states, 65% of which were schizophrenic. Depressive symptomatology was also quite common. Kelley theorized that the highly structured life in these religious communities often led to feelings of failure and ensuing breakdown on the part of those unable to cope with the stringent demands of such an existence.

enter religious life. Such neurotic and pre-psychotic individuals are especially attracted to cloistered life, which by its very nature caters to the needs of schizoid individuals."[140] Second, according to Kurth, "too many Superiors of convents in the United States think that all their candidates are psychologically sound and enjoy good mental health."[141]

In some instances, the requirement of chastity and celibacy is too much of a psychological burden for priests and nuns to bear, and abnormal expressions of anxiety and other behaviors may result.[142] Toward the end of this chapter, we take up this theme again when we look specifically at the mental health of the clergy.

RELIGION AS THERAPY

We have seen that the suppression/socialization functions of religion may work to inhibit deviant mental expression, if not to improve abnormal mental states. The constructive role of religion, however, continues beyond this limited possibility and can actually be therapeutic. Specifically, therapeutic roles may be played by such activities as ritual, prayer, religious experience, glossolalia, and conversion.

Ritual

The early psychoanalytic approach to religion identified ritual with abnormality. Ritual was viewed as an expression of religion as "obsessional neurosis," designed to alleviate unconscious guilt.[143] This view has been strongly rejected by later psychologists of religion, some of whom have viewed religious ritual as performing healing and beneficial roles.[144] Its compulsive cathartic nature, the implication of appeasement, and the exercise of control are seen as reducing fear and anxiety; repressed motives are said to be worked through, expressed, and dispelled.[145] Kiev points out that such ritual explicitly promotes "therapeutic emotional reactions" via the opportunity to "express in socially approved ways ordinarily inhibited impulses and desires."[146]

Central to these therapeutic possibilities is the relation of ritual to emotion. Pruyser suggests that ritual is adaptive when it creates a "structure for emotional expression" or performs "dynamically as a defense against the intensity of any emotion or the unpleasantness of some."[147] Scheff sees the critical function of ritual as "distancing" a person from emotion, particularly affect that is universal (e.g., that which may be aroused by death concerns).[148] Such emotions are actually confronted in group rituals; however, the setting is both secure and social, permitting individuals to deal safely with their feelings.

Jacobs stresses the social aspect of ritual, in that it strengthens one's connections to significant and powerful figures in the community.[149] She emphasizes the cathartic role of ritual as countering shame and guilt and as supporting self-esteem. Attention is also directed at the control of, and distancing from, emotion in healing and mourning rituals.

A study committee of the Group for the Advancement of Psychiatry has compared ritual to psychoanalytic therapy, in that both have the "intention of facilitating growth. . . . Ritual not only stimulates regression, but controls and guides it."[150] Erik Erikson spoke of ritualization as "creative formalization" that controls both impulsiveness and compulsive restrictiveness, such as in constructive play.[151] Because of such channeling, parallels have been drawn between pastoral care and counseling and ritualistic expression.[152]

The rather ubiquitous nature of religious ritual is well demonstrated by Moberg, who covers the range from the individual level through family, churches, and synagogues to liter-

ally nationwide forms that utilize the mass media.[153] Given such possibilities, the healing and therapeutic possibilities inherent in rites and ceremonies must be regarded as very impressive.

There can be little doubt about the theoretical importance of ritual. The observations of astute anthropologists and clinicians concerning its theoretical effects are quite striking; however, it must be noted that objective empirical work in this realm is lacking. It is a topic worthy of considerable study by rigorous research psychologists.

Prayer

In Chapter 11, we have described the essentially supportive and therapeutic place of prayer in one's personal armamentarium. Because of this, only a few major points need to be made here. Publicly and privately, prayer is probably the most commonly employed religious rite, with approximately 90% of the U.S. population engaging in this activity.[154] We accept the view of Holahan and Moos that prayer is an active, cognitive coping strategy.[155] In other words, it is most often an attempt to deal with distress—a kind of self-therapy. Much research has been conducted on the beneficial uses of prayer by the elderly, the seriously ill, and average persons in a wide variety of circumstances (again, see Chapter 11).

Psychiatrist Kenneth Appel claims that prayer plays a personality-integrative role in life.[156] Kidorf views the *shiva*, a collective Jewish mourning ceremony, as a form of group therapy.[157] Generally, in death-related situations, the incidence of prayer increases and helps the bereaved cope with loss.[158]

The therapeutic role of prayer needs little further explication, but readers should recognize that this is only one of its major functions. Its complexity in this and other domains is well detailed in the fine scholarly works of Brown and Buttrick.[159] Research Box 12.6 presents Parker and Brown's study on coping with depression; the role of prayer in this work is significant.

Religious Experience

We have also described in Chapter 11 the constructively therapeutic role of religious experience. In recent work, it was shown that the vast majority of distressed people who reported

Research Box 12.6. Coping Behaviors that Mediate between Life Events and Depression (Parker & Brown, 1982)

In an initial study, 176 general medical patients responded to items indicating factors that made them feel depressed, plus behaviors that seemed effective in reducing these stresses. After the initial measures were refined, a new sample of 103 patients was obtained. Using factor analysis, the authors found that the inclination to pray contributed strongly to a problem-solving dimension. A subsample of 20 clinically depressed patients was then compared with a control group; this revealed that the problem-solving behaviors were more likely to be used by the control group. Prayer therefore related positively to the percentage of those reporting prayer as increasing behavioral change and as effective in the process. The implication is that prayer can be a significant element in coping with depression.

such incidents benefited greatly from them.[160] This has been known for some time. In 1936 Anton Boisen viewed psychotic behavior as an effort at problem-solving that is "closely related to certain types of religious experience."[161] He then documented many cases testifying to the curative and restorative possibilities inherent in religious experience. Research by Bergin confirms Boisen's examples.[162] Bergin observed that participants in his study who were not coping well "appeared to have their adjustment level boosted considerably by intense religious experiences that were like Maslow's peak experiences."[163] Maslow himself compared his "peak experiences" to religious and mystical encounters, taking a positive view of their outcomes, and explicitly interpreting these events as therapeutic.[164] Unhappily, this is not always true, as many distressing and terrifying religious experiences have also been reported.[165]

Specific therapeutic outcomes for religious experience have included reductions in guilt feelings, a heightened sense of security and belonging, improved control of aggression and hostility, and suicide prevention.[166] Drug-induced religious experience has also been cited positively with regard to its influence on alcoholics, narcotic addicts, neurotics, and terminal cancer patients.[167] Clark feels that these positive effects are enhanced when the experiencer explicitly denotes these events as religious.[168] Mystical encounters have further been likened to creative experiences as "attempts at integration or reintegration by people who have not achieved satisfying results in identity formation."[169]

Prince puts religious experience back into its social context by noting that it may be defined as pathological or therapeutic, depending on culture and group values. In situations where they are approved manifestations, he claims that some "may be channeled into socially valuable roles."[170] This seems to be true among Pentecostal sects that encourage mystical encounters. Hine suggests that these aid adjustment and integrate people into their groups, which also provide quite supportive environments.[171]

Glossolalia

Glossolalia, like mystical experience and conversion, is not only a possible expression of mental disorder, but may operate therapeutically as well. For example, many open-minded observers subscribe to what Brown calls "a benign form of the 'abnormal theory,'"[172]—namely, that speaking in tongues is adaptive. In addition to its social function of integrating a glossolalic individual into a religious group that places such behavior in a positive light, it has been associated with increased well-being, social sensitivity, religious maturity, the resolution of neurotic conflicts, and the reduction of anxiety and tension.[173] It would appear, therefore, to be therapeutic. Although this possibility must not be dismissed, some research has failed to support any of these findings.[174] Much good work has already been undertaken in this area, but there is still a need to resolve the pathology–therapy issue.

Conversion

The beneficial and therapeutic effects of conversion have been celebrated for millenia. We hear about being "born again," "twice born," "finding God," "coming home," and so forth. Almost a century ago, Starbuck claimed that for converts "the joy, the relief, and the acceptance are qualities of feeling, perhaps, which give the truest picture of what is going on in conversion—the free exercise of new powers, and escape from something, and the birth into Larger Life. . . ."[175] Though clinicians might employ different language, these are unquestioningly therapeutic goals.

Invariably, the psychological bias has been toward viewing conversion as the outgrowth and resolution of personal crisis.[176] Jones and Cesarman offer illustrations of the alleviation of sexual and other conflicts, which are then replaced by an "inner calm."[177] Though there may be both positive and negative outcomes to conversion (as discussed earlier in this chapter), on the positive side there are indications of increased openness, improved contacts with the world and others, greater emotional responsivity, a heightened sense of personal satisfaction and happiness, conflict resolution, and productive identity formation.[178] On another level, conversion among Mexican-Americans from Catholicism to Protestantism relates positively to a success/achievement orientation that is valued in mainstream U.S. society.[179]

It must be noted that these beneficial effects of conversion are not restricted to the well-accepted and established churches in the North American social order, but also extend to cults, such as the Unification Church and Hare Krishna.[180] Richardson summarizes this work simply: "The personality assessments of these groups reveals that life in the new religions is often therapeutic instead of harmful."[181]

In more than a few instances, conversion may be explicitly associated with or play a role in psychotherapy.[182] Both can also be regarded as forms of cognitive restructuring.[183] Though there may be many reasons for conversion, clinicians are becoming increasingly sensitive to both the potential benefits and the adverse effects of conversion experiences.[184]

RELIGION AS A HAZARD TO MENTAL HEALTH

As we have already commented, in the history of psychology, the dominant view of faith has been to associate it with psychopathology. Thus far, the opposite has been demonstrated. However, religious institutions and doctrines are not always beneficial; they can create stress and cause psychological problems. Indeed, there is truth in the title of one book, *Religion Can Be Hazardous to Your Health.*[185] In a similar vein, Pruyser has referred in an article title to "The Seamy Side of Current Religious Beliefs."[186] The message is simply that religion contains elements that can adversely affect the mental well-being of its adherents.

Religion as a Source of Abnormal Mental Content

The doctrines and sources of institutional faith sometimes contain the seeds of psychopathology. Though most individuals who accept religious mandates live happy and fruitful lives, there are those who misinterpret and misapply the core elements of their faith. Others are, in a sense, victimized by parents, clergy, or influential others who misuse religion to gain power and personal gratification. This can happen when people deal with religious precepts in a rigid and inflexible manner.[187] One study dealing with some mental disorder correlates of "rigid religiosity" is described in Research Box 12.7. Simply put, clinicians perceive strict religious upbringing as an element in the development of emotional disorders, depression, suicidal potential, and a generally fearful response to life.[188]

The inability to interpret church tenets and scripture for modern life is an accusation that has usually been directed at fundamentalist groups and conservative religious bodies, often in an unbalanced manner. In fact, such research, particularly on fundamentalism, suffers from a wide variety of biases. At the same time, some individuals are attracted to these bodies because of what Ostow calls an "illusory defense against reality."[189]

The great reliance of orthodox groups on scripture may be one of those defenses. For

Research Box 12.7. Rigid Religiosity and Mental Health (Stifoss-Hanssen, 1994)

Religious bodies possess rules and regulations that people can often interpret in ways ranging from an easy flexibility to a rigid absolutism. The latter has been defined in one major study as a "law-orientation."[a] In the present study, a scale of rigid–flexible religiosity was developed and administered to 56 volunteer hospitalized neurotic patients and a control group of 70 nonpatients. The first group scored significantly higher than the controls on the scale, demonstrating that a rigid religiosity is a correlate of, at least, severely neurotic thinking and behavior. The author is inclined to suggest a positive relationship between mental disturbance and an extrinsic religious orientation.

[a]Strommen, Brekke, Underwager, and Johnson (1972).

example, it has been used to justify the abuse of women and children, and some officials in these churches have also supported such behavior.[190] Partner and child abuse in these groups has been associated with much conflict about sexual issues and with the blaming of victims. These tendencies have been invoked to explain the claim of high rates of multiple personality disorder in families with fundamentalist religious backgrounds.[191]

Fundamentalist religion is often quite authoritarian in its structure, endowing its leaders with the image of having a special relationship with the deity. Control and the suppression of dissent are seen as the natural prerogatives of those holding high church positions. These factors have been used to explain the anxiety, "guilt, low self-esteem, sexual inhibitions, and vivid fears of divine punishment" noted among individuals who leave these churches.[192] The argument is made that the absolutist structure and dictates of these churches produce a "fundamentalist mindset" that creates adjustment problems for their members.[193] This has been further described as involving extreme dogmatism and a need for simplistic "quick fixes for problems involving marriage, children, sexuality, or society."[194]

Despite all of these unpleasant inferences, research supporting such ideas is rather sparse, and these claims have yet to be convincingly demonstrated. In fact, in Chapter 11, we have noted work suggesting the association of fundamentalism with an optimistic outlook on life.[195] Similarly, recent research has failed to provide any evidence of any adverse effects on the ego development or adaptive capacity of fundamentalists.[196] When such contradictions exist, the only answer is to call for more research; however, we must keep in mind that this is a very controversial area, and objectivity is imperative.

Religious doctrines are rich sources of ideas for use by mentally disturbed persons. Southard has shown how identification with higher powers may help such individuals to deny reality and counter therapy; he described one patient who used hymn singing to frustrate psychotherapy.[197] The presentation of miracles and other unusual occurrences found in religious writings can stimulate magical thinking that is suggestive of psychopathology.

Commonly, religious groups and doctrines offer their members meanings that make life bearable, but at a cost—namely, a "sacrifice of intellect."[198] Complex matters are often simplified into a dichotomy of good versus evil. Difficult and intricate issues are denied attempts at understanding by reference to such clichés as "God works in mysterious ways."

At times, however, objective need and cognitive dissonance may cause individuals to challenge polarized beliefs and "stop thinking" phrases. The outcome in such instances may be a serious crisis of faith, extreme personal stress, depression, and the potential for suicide.

Religion as a Source of Abnormal Mental Motives

Religious systems affect the motives and behaviors of their followers. Just as they can strengthen moral commitments, they may stimulate disordered thinking and action.[199] We see this in religion's concern with sin. A book chapter by O'Connell asks, "Is Mental Illness a Result of Sin?", and the well-known psychologist O. H. Mowrer attempted to bring the sin concept into psychotherapy.[200] It was thus examined positively and negatively—as a constructive control on behavior, and as an activator of guilt, depression, and distress. Obsession with sin and guilt seems to be a correlate of religious frameworks that stress moral perfection.[201] An emphasis on perfection often incites feelings of low self-esteem and worthlessness, which can contribute to mental disorders.[202] We also find the presence of sin and associated guilt in the motivation for mysticism, conversion, prayer, scrupulosity, confession, bizarre rituals, self-denial, and self-mutilation.[203]

The need to expunge sin and reduce guilt is a powerful motive, and one that may eventuate in serious mental pathology. McGinley's fascinating presentation of the behavior of saints abounds in examples of grotesque, brutal, and painful masochistic behavior, which today we would regard as indicative of profound psychopathology.[204]

Religious institutions and leaders that demand absolute subservience and unquestioning obedience from followers frequently use punitive threats and devices to eliminate individuality. Pruyser points out that those subject to such control must suspend any semblance of critical reasoning and substitute "unbridled and untutored fantasy."[205] Blind faith of this sort requires an immature, if not extremely childish, denial of reality for its maintenance. The pathetic extremes to which such belief may drive people have been evidenced many times in recent years. We need only consider such tragedies as the mass suicides and deaths of those in the People's Temple in Guyana, the Branch Davidians in Texas, and the Solar Temple group in Europe and Canada.

TOPICS OF SPECIAL CONCERN

Even with all its shortcomings, one of the hallmarks of present-day Western society has been an increasing openness and receptivity about matters to which previous generations closed their eyes. Platitudes such as "That's life," "That's the way things are," or some variation on "It's the natural scheme of things" have given way to a new awareness of what was either ignored, denied, taken for granted, or blindly not even recognized. Among these concerns are the mental health of clergy, and the plight of women and the elderly. Religion plays significant roles for all three groups.

The Mental Health of the Clergy

The mental state of those who have formally and professionally committed their lives to their faith merits special attention. Because members of the clergy are often among the most admired and respected members of their community, their parishioners and others frequently

regard them as somehow above the daily struggle and not subject to the strains and pressures of everyday life. A closer look rapidly shatters this idyllic picture, however. One small bibliography on religion and mental health that only covered a 4-year period listed 42 research and discussion books and papers dealing with abnormality among the clergy.[206] If we can conclude anything regarding this topic, it is (1) that being a minister, priest, rabbi, or nun is stressful, and (2) that emotional conflicts among the clergy are increasing.[207]

Personality and Psychological Problems

In terms of personality and psychological difficulties, the problem was initially studied in theological students. Claims of deviant findings have dominated this literature; for instance, one researcher asserted that Catholic seminarians are poorly integrated and show depressive tendencies, in addition to possessing a variety of interpersonal and identity problems.[208] Finch has emphasized that circumstances can lead mentally disordered individuals to feel that they should become clergy.[209] Also noted are early parental conflicts, ambivalent attitudes of parents toward their children, possible rejection of the children, and maternal dominance and control.[210] Other studies of seminary students have indicated that they score higher on indices of neuroticism, are in poorer mental health than nonseminarians, and tend to be either somewhat aggressive or quite submissive and dependent.[211] In other words, anything that implies some psychological difficulty has been inferred at one time or another. Increasingly, seminaries are using mental tests in order to eliminate applicants with emotional problems. Apparently, many if not most troubled individuals withdraw themselves from clerical training programs.[212]

There is also an extensive literature on the mental status of active clergy; as in the work on seminary students, the entire range of possible findings on personality and psychological problems has been offered. In a sample of disturbed ministers, similar early life influences were supplemented by a late adolescence choice of a clerical future after the arousal of considerable guilt over a sexual encounter.[213] As noted earlier, work on nuns suggests high rates of schizophrenia, with the incidence being greater for cloistered than for active orders. The suggestion has been made that a life that values meditation and withdrawal from the community may appeal to schizophrenic women.[214] Signs of depression have also been reported in such groups.[215]

Where psychological and emotional problems have been identified among the clergy, it is not clear whether such difficulties motivate persons to become clerics, or result from the considerable stress that has been observed in this profession.[216] Recent writing, for example, has pointed to the issue of "burnout" potential among pastors.[217]

Sexual Abuse by Clergy

As troubling as these indications are, a much more distressing situation has come to the fore in recent years—namely, the issue of sexual abuse by members of the clergy. This is a problem caught between morality and mental disturbance; though we treat it in greater detail here, it has repercussions for the area of religion and morality, and is thus briefly mentioned in Chapter 10. We are, however, not simply speaking about socially irresponsible and illegal behavior, but what lies behind it. Much that is counter to the law is properly excused when mental aberration that can be defined by the courts as insanity is present. In most instances, this does not appear to be true here.

The potential for sexual abuse may have been initially detected in research over 30 years ago that used the very widely employed psychological test, the Minnesota Multiphasic Personality Inventory (MMPI). At that time, note was made in two studies of elevated clerical MMPI Psychopathic Deviate scores.[218] This language gave way to the term "character disorder," which Stewart observes appears to be increasing in the clergy as various neurotic expressions decrease.[219] Persons so affected are not regarded as mentally disturbed, in that they know right from wrong and possess adequate control over their impulses. They may, however, be described as egocentric, immature, and narcissistic individuals who want gratification of their desires as rapidly as possible, without concern for the needs and feelings of others. As is known, the rates of such individuals in prisons tend to be high. It may therefore be argued that this condition, though it is indeed deviant, is not usually considered a form of mental disorder. Unfortunately, more time and energy have been spent on documenting the prevalence of clergy sexual abuse than on formally conducting research and gathering data on those who have engaged in abusive behavior. One effort is described in Research Box 12.8.

The situation is, however, more complicated than simple reference to a pattern of personality traits can explain. For example, it has been pointed out that the clerical profession exposes clergy to sexual temptation—women or men who "fall in love" with their pastors, or parishioners who bare their most intimate problems to ministers, rabbis, or priests. Such actions make both the clergy and those who seek their help vulnerable to exploitation. Given

Research Box 12.8. Clergy Sexual Involvement with Young People: Distinctive Characteristics (Camargo & Loftus, 1993)

This sophisticated statistical study of clerics (primarily Catholic priests) who sexually abused young people attempted to determine demographic, personality, and intellectual factors that would distinguish among five different groups: (1) a "youth-sexual" group (male clergy sexually involved with youths—also designated the "age-inappropriate" group) ($n = 117$); (2) adult heterosexuals exclusively involved with adults ($n = 133$); (3) adult homosexuals exclusively involved with adult homosexuals ($n = 121$); (4) bisexuals ($n = 38$); and (5) controls (no sexual activity or nonspecified sexual activity) ($n = 140$).

Relative to the other groups, the youth-sexual clergy tended to be lowest in socioeconomic status; were mostly Catholic diocesan priests; and scored high on a passivity pattern versus low on an angry cluster of traits, or vice versa. On the Minnesota Multiphasic Personality Inventory (MMPI) and some associated measures, the youth-sexual group were lowest in hypochondriasis, depression, masculinity, obsessive–compulsivity, social introversion, and anxiety. They scored highest in ego strength. Comparisons among the groups implied the possibility of distinguishing potential youth abusers from the other groups of abusers and from the control group.

This is a very brief summary of a highly complex piece of research, and it suggests (to us, at least) the possibility of character disorder even if the Psychopathic Deviate scale of the MMPI failed to demonstrate statistical significance. This could be a function of the nature of the groups that were compared. Comparative data on a "real" control group of successful nonabusing clergy currently working in parish settings might have been more helpful. Still, this is an impressive piece of research.

such encounters, it may not come as a surprise that one study of 1,500 Catholic priests over a 25-year period indicated that about half had violated their celibacy vows.[220] Other work reports that between 47% and 77% of female clergy claim that they have been sexually harassed or abused.[221] Though some estimates suggest that up to one-third of North American ministers admit to having engaged in sexual misconduct, most work indicates that about 25% of pastors have had some kind of sexual involvement with a parishioner. Actual intercourse rates between 10% and 15% are usually found.[222] In the 1983–1993 decade, one concerned organization documented over 1,150 such incidents.[223]

Despite these numbers, efforts at psychological characterization of clergy abusers have met with limited success, in part because of the variety of such abuse. These episodes involve both heterosexual and homosexual behavior, and the mistreatment of both children and adults. Among other possibilities, one scheme identifies what might be termed "passive/neurotic" abusers and "angry/impulsive" abusers.[224] Another framework distinguishes six different types, but we still do not know how to recognize any of these clerics before they do damage.[225] The application of psychological and psychiatric labels has not proven useful, for although such behavior is unacceptable, individual cases often reveal many unique (if not tragic) circumstances that also influence average people.[226] This is a problem that seems to be increasing, and clearly demands continuing study and action.

In any profession, perfection is an unrealizable ideal. This fact is especially distressing where religion is concerned. The population frequently looks to the clergy as ideal role models, forgetting that clerics are subject to the same stresses, problems, motives, and shortcomings that parishioners and congregants themselves possess. Better procedures are needed to select those who enter the religious professions; however, screening processes will undoubtedly contain a fair amount of error for some time to come. Psychological and character disorders will therefore persist in religious institutions. Little, however, can be done about such difficulties until they become evident; the tragedy is that when they do come to light, there will be victims—clerics and laity alike.

Religion and the Mental Health of Women

The women's movement of the past 30 years has highlighted the many forms of economic, political, social, and familial injustice and discrimination that have plagued women throughout the world for millenia. In essence, these are fundamental to basic sociocultural institutions, and therefore involve religion at its most elemental levels. The inevitable consequence of these inequities has been the subjection of women to extreme stress, the outcome of which can be mental disorder.

We have seen a few of the more blatant roles of religion in female victimization and abuse when men justify their actions and power over women by reference to scripture and church tenets.[227] Theological considerations are buttressed by more subtle social and psychological ones. For example, DSM-III and DSM III-R have been shown to contain gender biases that disadvantage women.[228]

The association of religion with female mental health begins with early childhood socialization. As McGuire observes, "religious symbols and images . . . shape the individual's gender role concept."[229] Future women are thus taught their socially approved identity, and variation from accepted role expectations may result in guilt, poor self-evaluations, and the self-attribution of abnormality.[230] Rothblum further asserts that "women are socialized to be unassertive, passive, or helpless, all of which behaviors lead to depression rather than action under stress."[231]

Both the socialization practices described above and traditional gender roles relate positively to religious commitment.[232] In extreme situations, such as those often existing in fundamentalist families, great frustration, anger, and depression have been reported among wives who have to deal with the severe religious norms of their group.[233] This "homebound behavior" has been indicted in the development of agoraphobia (the pathological fear of open spaces).[234] The best evidence suggests that the combination of traditional sex roles and a strict religious framework is a notable risk factor for depression.[235]

An interesting side issue concerns the fact that the dominant God image in North American society is masculine. Foster and Keating claim that identification with such a deity is easier for males and accords them high esteem; the opposite is said to be true for females.[236] Other research suggests that such a disadvantage can be mitigated by women's viewing a male God as a supportive rather than a punitive figure.[237] Research Box 12.9 offers some insight into the way this issue may be studied.

There is little doubt that in sponsoring traditional sex roles, religion can be an impediment to female aspirations, empowerment, and mental health. Concurrently, as Chapter 11 indicates, faith may be an aid in coping with adversity. Obviously, this is a complex issue, both sides of which have been extensively discussed.[238]

Religion and the Mental Health of the Elderly

Old age carries with it many mental and physical health perils, not the least of which is that no one gets out of this world alive. People of all ages think of aging and death as going together, and faith constitutes one of the strongest defenses against the fear of death.

Religious involvement (e.g., church attendance, worship, prayer, Bible reading, etc.) apparently counter suicide, depression, death anxiety, poor adjustment to bereavement, and aggression and hostility among the elderly.[239] Work among the old who are medically ill similarly reveals that religious coping protects such individuals against mild to severe depressive conditions.[240] Public expressions of religiosity, however, seem best for older women, whereas

Research Box 12.9. The Male God Concept and Self-Esteem (Foster & Keating, 1990)

A total of 89 males and females were asked to write a story about meeting and having a conversation with either a male or a female God. Under the assumption that this would activate a schema of God as male or female, the respondents were then asked to fill out a number of questionnaires that dealt with self-esteem, masculinity, and femininity.

A significant interaction was found between participant gender and God gender. After relating to a female God, the women scored higher on a femininity scale, whereas the men scored lower. In this God condition, the tendency to respond stereotypically was reduced for both males and females, though much more for the latter. Lastly, for the male God condition, women scored higher on masculinity; when the God was female, as noted above, they scored higher on femininity. The implication is that even though direct measures of self-esteem were not affected by the gender of the God schema, participants' personal orientations toward their sexual identification were influenced by the "encounter" with a male or female deity.

their male peers benefit more from private religiousness.[241] In addition, the more religious coping behavior is used, the more effective faith appears to be in combating depression and anxiety.[242]

It has been theorized that one of the advantages of religion for the elderly is that it offers them hope.[243] Empirically, hope per se relates negatively to depression and positively to self-esteem and optimism.[244]

In addition, religious doctrines function as a bulwark against life's adversities, and institutional involvement brings in social support and personal help, often from individuals in similar life circumstances. The effects of these influences are discussed in Chapter 11. The entire topic is, however, well summarized by Koenig, Smiley, and Gonzales, who conclude that "religious activity, particularly group-related, is inversely associated with mental illness such as depression and its consequences."[245] This is indirectly evidenced in the study described in Research Box 12.10.

RELIGION, PERSONALITY, AND MENTAL DISORDER: ISSUES AND CONCERNS

Personality and the Religious Context: The Jewish Example

Biases in psychology regarding the role of religion in mental health initially directed researchers to search for negative religious influences. Early studies suggested such adverse effects, but the more refined studies of recent decades have increasingly observed the opposite. Contemporary work has also attempted to understand personality and abnormality in relation to the social context. A good illustration of this kind of research was undertaken by Rosenberg, who noted that stress may be a function of the relationship of one's group to the broader social setting.[246] Since different groups possess different values and expectations for people, a collective may find itself at variance with others if it resides in an area in which it is a minority. Rosenberg termed this "contextual dissonance." He observed that children reared in such an environment (one in which their faith differs from that of their more numerous neighbors) are likely to evidence low self-esteem, anxiety, and emotional distress.

Research Box 12.10. The Use of Religion and Other Emotion-Regulating Coping Strategies (Koenig, George, & Siegler, 1988)

In this large-sample study, over 800 people ranging in age from 55 to 94 completed a number of questionnaires. These dealt with formal, organizational ritual activity and nonorganizational, personal religiosity. Other measures dealt with coping success and morale. The latter contained three subscales designed to assess agitation, attitude toward one's aging, and loneliness/dissatisfaction.

All of the religiosity variables correlated positively and significantly with the morale measure. These relationships held for both those under and over the age of 75, but they tended to be stronger for women than for men. Noting the association between morale and depression, the authors see their findings as supporting the view that religion is likely to counter depression among the elderly.

In virtually all nations, Israel excepted, this is the situation in which Jews find themselves. Moreover, they have been victims of prejudice, discrimination, and persecution for over two millenia. If ever a group lived in a state of contextual dissonance, it has been the Jewish minority. In terms of Rosenberg's hypothesis, we might therefore expect higher rates of mental disturbance among Jews than among their Christian peers; there are data that support this proposition, but it must be qualified. These statistics show that higher rates of mental disturbance may be found among Jews for mild to moderate conditions, but not for the more severe forms of psychopathology.[247]

Various explanations may be offered for this observation. For example, we may ask whether Jews are more likely than other religionists to seek aid and therapy early in the breakdown process, reducing the likelihood of more serious difficulties. Is it also possible that Jews may not show up in the public hospital statistics because they seek help from private agencies and practitioners? These remain unresolved questions. Srole and his colleagues have suggested that Jewish religious and familial supports may protect individuals from developing more profound forms of disorder.[248] Yet another thesis intimates that a long history of dealing with prejudice and discrimination may somehow act as an immunizing force against severe disorder.[249] The possible influence of socioeconomic differences can also be posited; this is discussed below.

The Rosenberg dissonance hypothesis may gain support from the long history of anti-Semitism. Images of a high incidence of mental and physical illnesses have been part of this past, and these may have been internalized by many Jews. They may have also subtly become a stimulus for Jews to enter medicine and psychiatry.[250] This background of victimization can prepare the way for a negative view of oneself and one's heritage and group; such has been evidenced in the well-known phenomenon of Jewish self-hatred. It has also been proposed as a factor contributing to the development of mental disorder among Jews.[251]

As this example has demonstrated, when we are looking at religion in relation to mental disorder, we cannot take the social context lightly. It is clearly significant on many levels—the level of the immediate group; that of its place in society and valuation in the culture at large; and finally that of its place in history.

Confounding Factors: Gender, Socioeconomic Status, and Ethnicity

Just as religion per se may influence personality and the development of mental disorder, so within cultures, the interaction of faith with other broad sociocultural factors can affect both abnormality and religion.

Gender

We have already discussed the bias that considerations of gender bring to the evaluation of abnormality. McGuire points out that "women's versions of a certain religion are probably very different from men's versions."[252] Comparing gender to a caste system, particularly within a religious framework, McGuire further makes us aware that male–female status differences and concomitant exploitation are endemic in religious systems. The accompanying gender-associated learning and stress involve long-term adjustments that have a high likelihood of resulting in disturbed thinking and behavior. Psychiatric and psychological biases compound the problem and can define the observed actions as normal or abnormal, depending on their potential disrupting effects on the social system rather than the individual. Chal-

lenges to the existing power structure, often legitimated by religion, are not usually accepted easily. We are, however, living in a time when women's movements and feminist theology are bringing such issues to the fore; these developments may, in the not too distant future, benefit the coping behavior and adjustment of women. In the interim, when religion is related to mental disorder in men and women, it may be important to look more closely at sex roles as disposing factors in psychopathology.

Socioeconomic Status

For some time, sociologists have demonstrated that religious groups and expressions are affiliated with class distinctions. We know that Episcopalians, Presbyterians, and Jews tend to be high in socioeconomic status, whereas Catholics, Pentecostal sects, and Baptist bodies are much lower on the class ladder.[253] The same holds true for educational attainment.

The association of these same distinctions with mental disorder has also been repeatedly shown. That is, the religious groups higher in socioeconomic status and educational attainment have lower rates of disorder, and vice versa.[254] We do, however, need research that is also more sophisticated in understanding even the demographics of religion. For example, in one study, first admissions for mental disorders are classified by religion as Protestants, Catholics, Jews, and "other." The last category is totally undefined,[255] permitting us to speculate that we may be less informed with this information than without it.

The plot thickens further when we note that the rates of serious disorder decline for groups higher up the class ladder.[256] Unhappily, this work is probably marred by diagnostic biases, as clinicians appear to assign more severe diagnoses to clients who are unlike themselves in ethnic group and class level. Those coming from poorer backgrounds are therefore more often regarded as suffering from serious abnormality than their upper-class peers.[257] In addition, the latter may fail to show up in the statistics, because they go to private practitioners and undergo outpatient therapy more often.

Another supportive influence may merit attention here. Roberts summarizes a number of observations indicating that lower-class churches stress sin and guilt—tendencies that may produce stress and activate latent psychopathology. In contrast, higher-class religious institutions more often support one's sense of personal dignity, self-worth, and self-esteem.[258] Could such be involved in the suppression functions of religion discussed earlier?

Significant questions must be raised when psychological tests are used to diagnose abnormality. The appearance of objectivity may be only skin-deep. Many, if not most, of these instruments have been standardized on middle- and upper-middle-class persons, and penalize deviance from these referent groups. Since many tests are also susceptible to social desirability response biases, particularly in terms of what the middle class considers approved thinking and behavior, those from lower-class settings may never have learned the "right" answers.[259]

Ethnicity

The influence of ethnic group on mental disorder has often been studied, but rarely in relation to religion. This realm is very often confounded with socioeconomic status and questions about the degree to which an ethnic group is acculturated into general North American society. For example, studies of Hispanic groups in the United States definitely suggest the influence of culture. Depression and psychosomatic disorders among Mexican-American women reveal a complex pattern of associations with abuse and acculturation. Theoretically,

religion may support the continued existence of abusive marriage and home situations, but objective data on such possibilities have yet to be obtained.[260] The fact that Hispanics are overwhelmingly Catholic implies a role for Catholicism in understanding mental disorder in this group. However, we must ask whether this faith is differently understood by the various Hispanic peoples in the United States, and, if so, how such differences might influence adjustment and coping behavior. Unfortunately, data on these issues are also lacking.

Similar questions may be raised about religion in African-American groups. The importance of faith and religious activities such as prayer has been shown in Chapter 11 to be of great importance in the coping efforts of older, poor blacks.[261] Though most African-Americans embrace Protestantism, many indigenous ethnic expressions are found in these churches; again, however, we do not know of research relating these religious styles to mental disorder. Obviously, acculturation and poverty must be considered when such work is conducted. This is clearly an area worthy of investigation.

RELIGION AND PSYCHOTHERAPY

No treatment of the domain of religion and mental disorder would be complete without some mention of the increasing role of religious ideas and practitioners in treating psychological problems. The widespread use of pastoral care and pastoral counseling has for a long time been supplemented by such concepts as Biblical and spiritual therapies. Some of these ideas go back more than 50 years.[262] We have also noted that religious problems are now included in DSM-IV, bringing a new perspective to mainstream clinical psychology and psychiatry regarding the place of religion in personal life. Bergin poignantly observes the need for clinical psychology to broaden its perspectives on religion, as the religious outlooks of clients and therapists are often markedly discrepant.[263] Research Box 12.11 summarizes a recent survey of a private mental health facility's staff and patients in regard to such matters. This study reveals a growing recognition of the need to consider religious and spiritual issues.[264]

As a final consideration, attention needs to be directed to the fine research of Propst on the place and uses of religion in the therapeutic process.[265] Propst has also been able to offer guidance to clinicians and clergy on how a cognitive-behavioral type of psychotherapy can utilize patients' faith to beneficial and constructive ends.[266]

OVERVIEW

The realm of religion and mental disorder is obviously vast and growing rapidly. Students of this area still have to examine faith in its many expressions, though some work along these lines has already been reported.[267] To date, however, research has not been organized along productive theoretical lines. Those who employ coping approaches and see mental disorders as fundamentally "problems of living" seem to be establishing some potentially fruitful avenues for future exploration.[268] Such directions are described in Chapter 11.

Serious defects exist in many of the earlier studies—defects that often stemmed from antireligious perspectives. The more modern view is that religion functions largely as a means of countering abnormal thinking and behavior. Personal religious expressions may still reflect underlying mental disturbance, and for some, institutional faith remains a danger to their mental health. In most instances, however, faith buttresses people's sense of control and

Research Box 12.11. Religion and Psychotherapy (Bethesda PsycHealth, 1994)

A survey dealing with religious/spiritual issues was administered to 60 professional staff members (physicians, etc.), 50 line staff members (aides, etc.), and 51 patients of a private mental health facility. Some representative questions and responses are as follows.

1. "How important to you is the inclusion of a spiritual focus as a part of the psychotherapy process?" Percentages responding "somewhat to very important": professional staff, 73%; line staff, 55%; patients, 72%.
2. "Is there a need to increase medical/professional staff's awareness of the use of a spiritual focus in psychotherapy?" Percentages responding "some to much need": professional staff, 66%; line staff, 80%.
3. "What percentage of your patients would benefit from a spiritual focus as part of the psychotherapy process?" Percentages mentioned: professional staff, 34%; line staff, 54%. (When patients were asked whether their spiritual beliefs helped in their recovery, 45% said "yes.")
4. "How important do you consider spiritual values to be?" Percentages responding "moderately to very important": professional staff, 78%; line staff, 90%.

Note that even though 73% of the medical and professional staff considered a spiritual approach important, they still felt that only 34% of their patients would benefit from this approach. This discrepancy might be worthy of further investigation.

This is only a small sampling of the questions asked. In addition, detailed open-ended responses were also obtained. For the samples obtained here, the importance of a religious/spiritual approach in therapy is apparent.

self-esteem, offers meanings that oppose anxiety, provides hope, sanctions socially facilitating behavior, enhances personal well-being, and promotes social integration. All of these possibilities work to the benefit of distressed persons; ideally, they will be increasingly employed by mental health professionals, to the advantage of those who seek their aid.

NOTES

1. Symonds (1946, p. 187).
2. Interviewee quoted in Boisen (1936, pp. 168–169).
3. McGinley (1969, p. 129).
4. Respondent quoted in Beardsworth (1977, p. 71).
5. Interviewee quoted in Clark (1929, p. 131).
6. McNeill (1951); Zilboorg and Henry (1941).
7. Deuteronomy 28:28 (*The Holy Bible*, Authorized King James Version).
8. McNeill (1951); Zilboorg and Henry (1941).
9. Bromberg (1937); Deutsch (1946).
10. Kirk and Kutchins (1992); Mowrer (1961); Ramsey and Seipp (1948); Rotenberg (1978).
11. Freud (1907/1924).
12. Freud (1933/1953, p. 107).
13. Freud (1927/1961, p. 53).

14. Freud (1907/1924); Reik (1946).
15. Coleman, Butcher, and Carson (1984); American Psychiatric Association (1980); Richardson (1993b).
16. Kilbourne and Richardson (1984b, p. 2).
17. Sleek (1994, p. 8). See American Psychiatric Association (1994).
18. Ellis (1980, p. 637).
19. Stern and Marino (1970, p. 1).
20. Sanborn (1979).
21. Linn and Schwarz (1958, p. vii).
22. Linn and Schwartz (1958, p. 20).
23. Hiltner (1961, p. 251).
24. With the exception of the last role for religion, we are deeply indebted to Dr. James E. Dittes for this scheme, which was first used in Spilka and Werme (1971).
25. Kirk and Kutchins (1992).
26. Hollingshead and Redlich (1958); Rose (1955); Srole, Langner, Michael, Opler, and Rennie (1962).
27. Bedell (1994).
28. Szasz (1960).
29. Some pertinent discussion of material that bears on the relationship of mystical experience and psychopathology may be found in Chapter 7, "Mysticism," and readers may want to coordinate that information with what is mentioned here.
30. Greeley (1974); Hardy (1979); Hay and Morisy (1978); Thomas and Cooper (1978).
31. Prince (1992).
32. Greeley (1974, p. 81).
33. Group for the Advancement of Psychiatry (1976, p. 815).
34. Group for the Advancement of Psychiatry (1976, p. 715).
35. Group for the Advancement of Psychiatry (1976, p. 731).
36. Horton (1973); *Roche Report: Frontiers of Psychiatry* (1972).
37. Siglag (1987).
38. Batson, Schoenrade, and Ventis (1993); Bridges (1970).
39. Leuba (1925, p. 191).
40. Stark (1965).
41. Stark (1965, p. 102).
42. Jackson and Spilka (1980).
43. Boisen (1936); Spilka, Brown, and Cassidy (1993); Prince (1992).
44. Lukoff, Lu, and Turner (1992).
45. Beit-Hallahmi and Argyle (1977).
46. Prince (1992, pp. 286–287).
47. Greenberg and Witztum (1992).
48. Kildahl (1972).
49. Teshome (1992).
50. Pattison (1968, p. 76).
51. Kelsey (1964).
52. Kildahl (1972, p. 57).
53. Preus (1982, p. 290).
54. Goodman (1972, p. 152).
55. Goodman (1972); Preus (1982); Samarin (1959).
56. Readers are referred to Chapter 8, "Conversion." Some of the present ideas are developed in greater detail there. In addition, the complexity of conversion must be appreciated; this complexity is well beyond our ability to describe in the present chapter.
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58. Starbuck (1899, p. 63).
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67. Clark (1929); Starbuck (1899).

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72. Levin and Zegans (1974).
73. Rambo (1982, p. 155).
74. Srole et al. (1962, see especially pp. 314–315).
75. Mora (1969).
76. Askin, Paultre, White, and Van Ornum (1993, p. 3).
77. Askin et al. (1993, pp. 3–4).
78. Askin et al. (1993); Askin, Paultre, Van Ornum, and White (1992).
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81. Beit-Hallahmi and Argyle (1977, p. 26).
82. Group for the Advancement of Psychiatry (1968, p. 654).
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84. Oates (1955).
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87. Lowe and Braaten (1966).
88. Beit-Hallahmi (1977, p. 29).
89. Adorno, Frenkel-Brunswik, Levinson, and Sanford (1950); Glock and Stark (1965); Herberg (1960); McGuire (1992); Stark and Glock (1968).
90. Stark and Glock (1968, pp. 163–173).
91. McGuire (1992, pp. 175–211).
92. Bateman and Jensen (1958); Nunn (1964).
93. MacDonald and Luckett (1983).
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95. Rohrbaugh and Jessor (1975).
96. Ross (1983).
97. Bainbridge (1992); Benson (1992b).
98. Snyder (1962).
99. Snyder (1962).
100. Pruyser (1971, p. 79).
101. MacDonald and Luckett (1983, p. 33).
102. Levin and Zegans (1974, p. 80).
103. Levin and Zegans (1974, p. 79).
104. Allison (1968, p. 459).
105. Dublin (1963, p. 74).
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108. Levi (1982).
109. Feifel, quoted in Mowrer (1958, p. 579).
110. Casey and Burton (1986, p. 82).
111. Nelsen, Potvin, and Shields (1976).
112. Bandura (1977, p. 49).
113. Holm (1987, p. 41).
114. Holm (1987, p. 41).
115. Holm (1987, p. 41).
116. Stark (1971).
117. Stark (1971, p. 175). Emphasis in original.
118. Hardt (1963); Lowe (1955); Lowe and Braaten (1966); Reifsnyder and Campbell (1960).
119. MacDonald and Luckett (1983, p. 15).
120. Bainbridge (1992).
121. Bainbridge (1992, p. 203).
122. Benson and Spilka (1973).
123. Jensen and Erickson (1979).
124. Richardson (1995); Rovner (1983).
125. Ross (1983).

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129. Kildahl (1972, p. 299).
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131. McLoughlin (1978); Sasaki (1979); Wood (1965).
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141. Kurth (1961, p. 23).
142. Gratton (1959), cited in Menges and Dittes (1965); Sipe (1990); Slawson (1973).
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147. Pruyser (1968, p. 143).
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152. Couture (1990, p. 1090).
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161. Boisen (1936, p. 53).
162. Bergin (1994).
163. Bergin (1994, p. 88).
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172. Brown (1987, p. 158).
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177. Jones (1937, p. 171); Cesarman (1957).
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181. Richardson (1992, p. 233).
182. Bergman (1953); Levin and Zegans (1974); Propst (1988).
183. Batson et al. (1993); Propst (1988).
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