

report no. **48**

**PSYCHIATRY AND RELIGION:
Some Steps Toward Mutual
Understanding and Usefulness**

*formulated by
the committee on psychiatry
and religion*

*Group for the
Advancement of
Psychiatry*

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**PSYCHIATRY AND RELIGION:
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I. INTRODUCTION

A. The GAP Committee on Psychiatry and Religion

The Group for the Advancement of Psychiatry, a working organization of psychiatrists comprising about 200 active and 75 contributing members, has published in the past thirteen years some forty-five reports upon various topics. Although these reports come into being as the result of the deliberations of a single committee, they are released only after such scrutiny as to insure that they shall reasonably well express the consensus of GAP. It is planned that GAP Reports shall represent an authoritative statement of the current position and outlook of psychiatry, insofar as GAP conceives it, in connection with the subject under consideration.

It took many years for GAP to decide to constitute a Committee on Psychiatry and Religion, for the membership recognized that such a juxtaposition might well lead only to a bogging down in useless controversy, to polite platitudes, or to the continuation of traditional misconceptions. However, albeit with some misgivings, a committee was formed in the spring of 1956 with the charge that it consider the psychiatric aspects of an important dimension of life—religion.

There lies a danger of grave misunderstanding at the outset, for many persons hold that religion is not merely one aspect of life, but indeed its essence, while others would vigorously dispute such an emphasis. In either case, however, few would oppose the notion that matters of religious faith and practice play a tremendous role in the patterning of the emotional life, the thinking,

and the behavior of men. Since these are the areas with which psychiatry is primarily concerned, it is its proper task to look most seriously at religion and to learn to take it adequately into account in understanding and treating sick men.

It is not our intent, nor indeed within our province, to say anything about God's existence or about His activity in human life or history.

This committee's first report is addressed to clergymen, to psychiatrists, and to students of each group. We have chosen to present a report in which we think it may be possible for persons of both disciplines to review, together as it were, their own identities and positions as well as those of members of the other group*; and to glimpse together possibilities for work in areas shared by both. It is recognized that this effort to address clergymen and psychiatrists simultaneously will make some portions of the report too elementary for one group or the other; but we do not view this as a constricting disadvantage. Moreover, many readers will find, either because of content or of omissions, that foci of disagreement emerge; and we hope that recognition of these will have a stimulating and productive effect.

As part of this introduction after this brief allusion to the committee and its orientation, an effort is made to delineate the training, viewpoint and work of the psychiatrist as a physician; to sketch historically the changing outlook of religion toward mental illness; and to suggest some kinds of current problems. Following upon this broad introduction there is a chapter on an outlook for the psychiatrist: his personal beliefs and ethics, his approach to religious beliefs in his patient, and his relations with the religious institutions in the community and the culture. The third chapter is devoted to a suggested outlook for the clergyman: toward mental illness, toward psychiatrists, and toward himself *vis a vis* the troubled parishioner who seeks his help. Finally, in the fourth chapter, there are some recommendations concerning what psychiatrists can learn about human behavior from a study of religions and what psychiatry can teach the clergy—

*We realize, of course, that we cannot write about the clergyman with the same authority and thoroughness that we can about the psychiatrist, and we do not pretend to do so.

about human behavior, and about counselling techniques; and, in conclusion, there are recommendations for further collaboration.

B. The Psychiatrist—His Training and His Work

Since this report is intended to reach clergymen, it seems important at the outset that the psychiatrist be introduced. Three significant features will be considered, and from the point of view of the ideal. Ideally, he is expected to be a person who has developed a responsible view of the world, and who is as capable as other healthy individuals of contending with problems of his personal life. Like his fellow man, he may or may not have clearly defined philosophical or religious views, a fact that will be discussed below. His special orientation is that of a physician.* His medical training, which is the same in the years of medical school as that of his colleagues in medicine and surgery, is intended to sharpen his acumen in discerning the presence of illness, and to enhance his skill in promoting recovery. Mankind has recognized for thousands of years that the ill have a tendency toward health—a principle known to the ancients as the *vis medicatrix naturae*, the healing force of nature. No physician can do more than to equip himself as best he may to ally himself with this force, to remove obstacles to its action, and to foster situations where it can work most effectively. These are the true functions of diagnosis and treatment, and however complex the techniques may become, ultimately the physician does no more.

Such a simplification in the description of the physician's role, however honest and inspiring of humility, does nothing to lessen his task, for his work requires a continuous search for refined understanding of the nature and source of the disorder, and of the steps and techniques that can be devised for making recovery pos-

*Nowadays the specialized training of the psychiatrist commences after he has earned his M.D., and after at least one year of internship in a general hospital. It consists of a minimum of three years of work as a resident physician, during which time he follows an approved program of study in psychiatry, and of bedside and office work, under supervision. (Often, following the residency, further time is devoted to additional training, for instance, in child psychiatry or in psychoanalysis.) After the residency, two more years of work in his specialty make him eligible to take examinations given by the American Board of Psychiatry and Neurology, and thus to earn his Diploma in Psychiatry. Eligibility for Board Examination is necessary also for membership in the American Psychoanalytic Association.

sible and more complete. Often enough, treatment is hit upon before diagnosis is definitive, as when it was learned that limes eaten aboard ship on long voyages would prevent scurvy; and sometimes diagnostic skill must sadly await treatment, as was true for pneumonia until twenty years ago. The area of mental illness—the particular province of the psychiatrist—has been a source of bewilderment to physicians for hundreds of years. However, just as the unprecedented progress during the past century of all of medicine rested upon the adoption by physicians of scientific principles in diagnosis and treatment, so also, in two senses, psychiatry came to benefit from a scientific approach. The first sense is a very general one, and has to do with the whole strategy, using every possible avenue of approach, of seeking solutions for the problems of mental disorder. The second sense is quite specific, and has to do with a scientific approach to the phenomena of psychology. It is important to differentiate these two, and examples follow.

The Psychiatrist as a Scientist

In the general sense, the psychiatrist's active scientific interest is taken up with *any* procedure or measure that promises to add to his capacity to help his patient. He is eager to learn from psychologic, neurologic, physiologic, or any other sources (including non-medical ones such as history, sociology, anthropology, and religion); and drugs, electrical procedures, or surgical operations are eagerly (but cautiously) considered for what they may contribute to diagnosis or therapy. Often treatment of this variety appears to be useful even in the absence of adequate explanation of its effect, as is true with electrical shock therapy. Often, too, a treatment which helps relieve grave or troublesome symptoms may leave a residue of less distressing ones that require other measures, or that must, in the present state of knowledge, remain untreated. The situation is analogous to one that may occur in general medicine: the onset of a serious overt illness, indicated by falling into coma, may be the initial reason for summoning the physician. He may be able to treat the patient in such a way that recovery from the coma is accomplished; but the task of overcoming the underlying illness may remain for some time a baffling

problem. However, neither the psychiatrist nor any other physician is satisfied with using poorly understood procedures or therapies, helpful though they may appear to be, for he senses or suspects lurking disorder that has not been adequately resolved.

The second, and *specific* sense, in which psychiatry came to profit (from the scientific approach) derives from the application of this method to the *psychology* of mental illness. Psychiatrists began, about seventy-five years ago, the laborious and often uncomfortable task of exploring in a new way the functioning and structure of the mind. The psychiatrist became, for medical purposes (that is, with diagnostic and therapeutic intent), an investigator in psychology. This kind of research involved a careful, objective scrutiny of feelings, attitudes, thinking and behavior, as thorough and critical as the physical and laboratory examination by the internist or surgeon.

It had been known for generations that hidden strivings, hesitations, and inhibitions—forces vaguely apprehended by sensitive persons—often interfere with human aims and expressed intentions. The sources, strengths, and manner of working of these forces now became the interest of the psychiatrist; and the problems, also, of how they came to be and how they might be related to illness or disorder. The accumulation of information in this area has been amazingly rapid, and has resulted in a wholly new view of psychology and of mental functioning. It is almost as remarkable as if, in the short space of seventy-five years, and using only such surface manifestations as the appearance of the skin and lips, and changes in the pulse and respiration (that is, without any access to dissection), physicians had been able to infer and then to describe the working of the circulatory system and the action of the heart, including the main ways these could go wrong. Since 1900, remarkable as it may seem, psychiatry has come into possession of a knowledge and view of mental and emotional growth and functioning, and of their disorders, that are really new under the sun.

It is of paramount importance to understand this aspect of the outlook of the psychiatrist if one is to grasp the special reasons for his professional interest in religion, with which we shall be concerned. We wish to make it quite clear that the emphasis in

this report will be on those mental illnesses called "psychogenic." * Other psychiatric disorders, now known to arise from structural disease of the brain, or from endocrine or chemical sources, are not considered relevant to the central issues that are to be addressed. This exclusion is not meant to imply a prejudice as to the general etiology of mental illness. It is simply that the excluded group of illnesses, although of salient clinical importance, is not so intimately involved with the problem of mutual understanding between psychiatry and religion as are the "psychogenic" illnesses. The psychological aspects of psychiatry are stressed because of their overlap with areas familiar to and of concern to the clergy.

In his study of psychodynamics (interplay of forces within the mind) the psychiatrist has learned that many of the most pressing motivational forces are outside awareness, and that mental illness, though the fact is often hidden behind visible, external difficulties, is generally the expression of *unconscious* psychological conflicts. He has further discovered that the application of certain techniques to clinical data will penetrate the barrier and disclose these unconscious forces and conflicts; and that assisting the neurotic individual, through his relation with the therapist, to become *aware in himself* of these hitherto unknown mental processes helps him to gain control over them, thus blunting the edge of his neurotic suffering, or dispelling it entirely.

Ideally, then, the psychiatrist will be a physician versed in the special skills required in the diagnosis of disorders deriving from unconscious conflicts,—and in assisting the patient in his tendency to master these conflicts to get well. As this occurs the patient's conscious feelings, attitudes, and thinking will also change. When what is changed is a deep depression, a lack of conscientiousness, or a disabling obsession, that is cause for rejoicing; but the outcome of treatment is seldom so simple and discrete. In other areas of medicine there is no telling beforehand what a crippled man may do with his new found vigor when he is cured. The patient bedridden with tuberculosis may regain his strength and go on

*¹ American Psychiatric Association Mental Hospital Service: *Diagnostical and Statistical Manual: Disorders of Psychogenic Origin* (p. 24), Washington, D.C., 1952.

to be either a worthy citizen or a confirmed criminal. The doctor cannot foretell; and if he could, it would still be his proper task to cure the tuberculosis, and to leave the rest to the criminologist, the educator, the sociologist, and the clergyman. (Perhaps the psychiatrist might also be of assistance.) In psychiatry, the concern of the physician is to help in the correction of the mental disorder; and he cannot take the responsibility for deciding what the patient shall be like once this has been removed. It is, nevertheless, his general experience that sufferers from mental illness who regain their health remain or become, by their own choosing, reasonably good members of society.

Respect for the Patient

The third significant feature therefore is that, *ideally*, as far as an end point of therapy is concerned, the psychiatrist's respect for the person he is treating precludes his attempting to persuade his patient toward any particular attitude or way of behaving other than a generally realistic or appropriate one. During treatment—that is, while the disorder is still present—he may suggest, prohibit, chide, admonish, persuade; but all of these will be knowledgeably done with the intent of enhancing progress toward resolving the unconscious conflict, and not primarily as educational or uplifting endeavors in the usual social sense.*

It is important to re-emphasize that it is the *ideal* that has been presented. In many cases it is necessary to depart from this stringent ideal; to modify the therapeutic approach. There are two sorts of compromise possible: one in which the patient is permitted to leave treatment with a feeling of restored or improved well being, although the physician knows that there are still evidences of unresolved unconscious conflict; and the second, in which the physician's authority is used directly to get the patient into a different state of mind. Often these two are combined.

The first compromise is the result of many factors: the scarcity of psychiatric care, the varying levels of psychiatric skill and expe-

* Since the clergyman has multiple functions, and works as an educator and social activist, there will frequently be occasions when he and the psycho-therapist will completely agree; but even so, it is advisable to keep in mind the fact that the psychiatrist's central aim is treatment rather than education.

rience, the realities of the patient's life situation, and the susceptibility of the illness to treatment. These factors mean, quite baldly, that elements of time and the number of ill patients make it impossible in the mid-Twentieth Century for every patient to be offered the maximum in psychiatric treatment. It is highly unlikely that it will ever be possible. This is a hard statement, but it is true. The situation is similar to what has frequently happened before in medicine: a new and effective treatment is devised, but the quantity available is less than the demand or the need. When such problems are purely technical they are often quickly solved, as was, for example, that of producing sufficient penicillin. However, when a scarcity of personnel exists, the qualified physicians do what they can for those who come to them; but the less needful and the less promising cases are treated less thoroughly. These persons are benefited and are not cheated—except in the sense that they were born at the wrong time. The main point, however, is that this sort of compromise does not involve any notion that the patient is cured. He may be relieved of the most troublesome aspects of his problem, and then must endure what remains, perhaps returning for further treatment if a crisis arises. (Ironically, some patients who could have treatment do not accept it, or leave it before it is completed).

The second compromise is less realistic, although it may seem to be dictated by reality. Here the patient, instead of working out things for himself, is *influenced* to accept a solution. This may often be easily done, since many people would rather grasp at an easy solution than work at a hard one. Sometimes the difficulty of the situation moves the psychiatrist rightly or wrongly to use stringent or dramatic measures of command, suggestion or modification of the patient's life. In such instances, there may be no resolution of any underlying problem of an unconscious sort—a symptom or a group of symptoms will have been set aside, and nothing more.

Compromises are being discussed because, practically speaking, all psychiatrists must make them. The degree of skill of psychiatrists varies, and, besides, not all of them are interested in attempting full scale review of the personality for the sake of getting thoroughly at unconscious conflicts; reality of time and number of

cases, as has been said, is a factor. By no means does every complaint or symptom warrant full scale treatment, and not a few patients are too ill to be cured—as is true everywhere in medicine—although they may be somewhat, often greatly, helped.

We have been trying to describe the viewpoint of American psychiatry taken as a whole. When we focus on any individual psychiatrist we find, of course, that his orientation, his favorite field of endeavor, and his skills, cover only one or a few aspects of the total area. Some psychiatrists favor an organic approach to diagnosis, therapy and theory, others a psychologic. In the former group there are those whose interests are primarily chemical, those whose interests are primarily physiological, and those who think in biological terms; while in the latter, there are the psychoanalysts of the school of Freud, and psychotherapists who employ techniques of other schools of psychology. The clergyman dealing with a psychiatrist must keep it in mind, therefore, that the point of view he encounters may be quite different from the overall picture we have sketched here.

In this report, we have touched on practical matters of treatment only to acquaint the reader with the general area of psychiatric practice. Having done that, we can now take up as our main theme not psychotherapeutic techniques, but the broad topic of approaching some mutual concerns of psychiatrists and clergymen which emerge from a consideration of mental illness.

C. Historical Relationship of Psychiatry and Religion

The past quarter century has witnessed a rapid expansion of interest on the parts of both clergy and psychiatrists in the interrelations of their fields. As one looks further back, however, it is clear that the precursors of present-day psychiatrists, and the predecessors of our modern ministers, priests, and rabbis, have for a long time enjoyed (or endured) together a pattern of interaction worthy of serious study—and productive of important implications for present practices and investigations. At different times psychiatric and religious interests fuse, clash, or interact dynamically. They may parallel one another and avail themselves of varying degrees of inter-communication.^{1p.142ff}

In ancient times, as today among so-called primitive peoples,

the healer, shaman, witch-doctor, or priest was responsible for the health of body, mind and spirit of those who came to him. He may or may not have made sharp distinction among his fields himself, and he certainly did not see them as unrelated or conceivably incompatible.^{1,pp.16-25; 15,pp.87-76; 24,pp.17-27.}

As time passed, the position, as religious healers, of such temple priests as those of Epidaurus gave way to an emphasis on more specialized functions, and we begin to see in history the medically educated priest and the theologically informed physician; but they were two different persons. The sick might be taken to either; and the overlap of their roles included the care of the mentally ill, who were viewed from the side of the body as afflicted by humours, or equally well from the side of the world of religion and supernatural beings as possessed by spirits or victimized by demons.^{1,pp.70-90; 2:15,pp.187-227; 24,pp.86-118.}

With the progressive exclusion, from both religion and medicine, of what moderns see as the more obviously magical elements, there developed, paradoxically, a tendency to *blame* the mentally ill person for his affliction, and to see it as a visitation of punishment for his misdoings. In other words, the frame of reference began to shift from the strictly magical to the magical-moralistic. This change had its advantages and disadvantages. In a way, it was a move toward aiding the afflicted person to identify his pain as his own, and to take some responsibility for his own condition and recovery, instead of regarding himself as simply a passive victim. On the other hand, it gave rise to a moralistic-judgmental approach toward the sufferer, which involved an anti-consolation, often anti-priestly, and generally punitive *mien vis a vis* the patient.^{1,pp.43-96; 24,pp.118-176.}

The rabbinic literature of the Talmud (200 BC—500 AD) tended to rise above the superstitious view of illness and healing that prevailed in the Middle East at that time, and encouraged, rather, a humanitarian-scientific view.²¹

Jesus took the position, some infer, that not all sickness was necessarily the result of sin, although He implied some connection between the two. His work was founded squarely on the Hebraic holistic view of man.²⁰ St. Paul introduced some Greek ideas, perhaps; but the Greek dualistic view of man, already influencing

Judaism through Philo and other Alexandrians, was to become of real importance only much later. The weight of these Greek ideas was, at most, moderate throughout the period of the early church fathers (roughly the first five centuries A.D.), but in due time became massive during the period of the Scholastics (twelfth to fifteenth centuries). The tension between the existential, holistic, concrete early Hebrew and Christian emphasis, and the Greek idealistic, dualistic, rationalistic emphasis, is one of the major themes in the history of the Judaeo-Christian religions, and in their relation to medicine. Religion has found itself veering sometimes one way and sometimes the other—and with medicine variously contending on the same side as the church or on the opposite. The clinical proclivity of medicine tends always to rescue it from an arid intellectualism while the pastoral concerns of religion serve the same function for it. Concern for and involvement with the sufferer, however, are not sufficient to insure healing: they demand supplementation, complementation, and correction by the critical, insightful, and theoretical dimension (the scientific approach) which derives largely from the Greek side of the polarity.^{19,pp.43-76, 97-108:21}

The vicissitudes of the historical relation between psychiatry and religion are expressed only partially in arguments about the empirical versus the theoretical and the concrete versus the abstract. Other aspects include the problem of the relation to one another in terms of subject matter, source of knowledge and power, control of either by the other, and common subjection to authority. Another aspect could be expressed most succinctly in terms of the gradual secularization of the world. The salient fact is that there has been a progressive tackling by scientific thought of more and more complicated areas of concern. Science moved from the world of things to the world of human bodies, and (in the past century) to the world of persons—as sources and repositories of attitudes, feelings, ideas and behavior.

D. Current Problems

There are clearly many issues and concepts to be discussed that concern both religion and psychiatry, a fact that is reflected in the increasing interest, and work, in areas of their contiguity.

Any one of these issues might be the subject of research or speculation. Examples are the similarities and dissimilarities in views and valuations of suffering; or the concept of character and the concept of soul; or a consideration of differing views of anxiety—as stemming from a disordered relationship with God (however conceived), or as stemming from an (unconscious) psychological conflict; or of differing views of guilt and its sources. We shall be initially taken up here, however, with some efforts at clarification of professional attitudes and functions of psychiatrists and clergymen in the framework of our own culture, which we hope may foster continuing fruitful communication, and, as we suggest in Section IV, mutual interest, and collaboration in specific areas.

II. AN OUTLOOK FOR THE PSYCHIATRIST

A. The Psychiatrist's Religious and Ethical Position

It has been said above that, like his fellow man, the psychiatrist may or may not have clearly defined religious or philosophical views. He should certainly, however, be aware of his position or seeming lack of one; and while it is to be expected that the information and experience that his discipline affords him will find reflections in his philosophy of life, the ways in which these reflections occur will be a function of himself as an individual person, not of the psychiatric discipline as such. In the same way, one astronomer may reflect the experiences of his work by affirming the more feelingly that "the heavens declare the glory of God"; while his colleague is all the more confirmed in *his* opinion that the vastness of the universe betokens only that:

"—we are here upon a darkling plain
Swept with confused alarms of struggle and flight,
Where ignorant armies clash by night."

In the matter of actual usable information, there are no known data of any degree of completeness on the institutional religious affiliations or stated religious preferences of American psychiatrists. If available, they might or might not be useful. Certainly, if the data were collected, they would not reveal much about the quality and intensity of religious beliefs and practices as those affect everyday behavior. It seems reasonable to assert that, as an individual, the totality of his religious beliefs is something about which the psychiatrist is entitled to maintain whatever degree of privacy he chooses. The relevant issue pertains specifically to his function as a psychiatrist dealing with people. In anticipation of its later discussion in this report, a basic view is here proposed that if a patient's religious belief is tied up with his psychiatric illness,

that belief will usually be affected (changed, strengthened or weakened) by treatment, no matter what the psychiatrist believes; the less direct is the connection between his religious belief and his illness, the less likely is the former to be modified.

However, in the matter of the psychiatrist's own attitudes, there may be several areas around which legitimate requests for explanation are to be expected from interested people. The first, probably of dominant interest, concerns his attitude toward the religious beliefs of others, and especially, of course, of his patients. This will be dealt with below. Another concerns the attitude which he takes toward his own religious beliefs; and a third pertains to the limits upon his behavior, as a therapist, within which the psychiatrist can be said to operate—that is, his systems of ethics and values, and their connection, if any, with religious considerations.

The second of the above areas—the psychiatrist's attitude toward his personal position—will be dealt with first. Earlier in this report, it was stated that matters of religious faith and practice contribute to and reflect the formation and maintenance of attitudes, thinking and behavior of men, and that these are also the interest of psychiatry. Furthermore, it was stated that emotional factors ordinarily beyond our ken are influential in all aspects of behavior and thought. Consequently, it behooves the psychiatrist to have optimal awareness of the way his own emotional life and development interdigitate with his position concerning religion. He should, when it is indicated, be prepared to scrutinize further or again the psychological significance of his own beliefs and practices, or his disbeliefs, whenever this seems relevant in work with particular patients.

Such self-examination would include recognition that there can be blurring of those distinctions that must be made between sanctity and sanctimoniousness, righteousness and self-righteousness, or neutrality and apathy—when these apply either to himself or to his evaluation of his patient. A somewhat subtler aspect of his own attitude has to do with skepticism. Skepticism defined as "suspension of judgment" is second nature to him as a practitioner and researcher. This he should not confuse with skepticism as a philosophical viewpoint, which holds that all knowledge

is uncertain. Such confusion might lead a psychiatrist to attempt to impose philosophic skepticism on his patient. *Neither this nor any other philosophical viewpoint should be imposed on any patient.* In further connection with such considerations, the choice of some psychiatrists to proselytize within their practice cannot be condoned, since it amounts to an exploitation of the psychotherapeutic relationship. To do so obligates the psychiatrist to examine his motives, to inform his patients of his intent, and to ponder the fact that in so doing he is not functioning as a psychiatrist.

The psychiatrist strives constantly to reduce even inadvertent influences on his patient to a minimum. On the other hand, these admonitions are not to be construed as discouraging him from confronting his patient with inconsistencies in religious belief or behavior, even at the risk of a change in the patient's beliefs. It is to be noted that the same principles hold in connection with political, civic, filial, parental, marital, financial, or any other highly charged grouping of attitudes and behavior.

Here is a place where clarity is desirable within the psychiatrist's mind as to what he includes for himself under the rubric of "religion". He should know and differentiate that which is "revealed", that which is dogma, or directly derived from or connected with dogma, and that which need not be so considered. (For example, he may or may not have a sense of conviction about a Christian dogma, such as the Trinity; but the same person may have no qualms about subscribing to the ethical principles inherent in Christianity. Conversely, a man may embrace a dogma, but eschew the ethics it implies. In either case it is important to be cognizant of the distinction). If a psychiatrist is going to deal temperately and objectively with the beliefs of his patient, he should know at least when or where he is himself unsettled, just as he should in regard to other areas of life.

Such a distinction as between those aspects of religion having to do with dogma and those having to do with ethics is of relevance to the third area, suggested above, which relates to the boundaries of medical behavior. This does not have to be seen strictly in connection with the total religious belief of psychiatrists. Generally speaking, it may be granted that within the limits of good practice the psychiatrist's adherence or non-adherence to a specific

theological orientation is irrelevant. But even when this is granted, there could follow a demand to know by what practical principle does it become irrelevant. The general question can be: By what binding customs or rules *does* the psychiatrist see himself affected as he strives toward his goal of the cure of illness or bettering the welfare of his patient—to what regulations or ethical precepts does he subscribe? Possibly he would assert that the only significant criterion is professional proficiency. That is, he may hold that proper development of and adherence to technique constitutes an adequate safeguard for his department with his patient, and should satisfy society's demands for assurance concerning his ethical outlook. Indeed, in much of actual practice this principle is a general working assumption of most clinicians.

Nevertheless, there are two classes of reasons why "technical proficiency" is not enough to settle the question. One class includes such considerations as the following: Psychiatric treatment is usually conducted on an intensely private basis; the consent "secrecy" can stimulate the imagination and fears of interested people (and of the psychiatrist); the results of treatment are diverse and not always to the liking of the onlooker; the goals are changeable, individually designed, and sometimes difficult to define; also, the possible weight of personal influence which may be wielded by the psychiatrist is well known to be great, although it is often overestimated. The concern about the psychiatrist's influence is partly based on facts and opinions about the phenomenon of transference.* In addition, the patient in the psychotherapeutic situation must abandon conventional discretion in the verbalization of his thoughts and ideas; and erroneous notions about the psychiatrist's ability to deal with this situation may alarm certain persons. In addition to these concerns, it must be granted that in the circumstances of human fallibility, perfect technical proficiency is improbable. This improbability is further increased if the psychiatrist does not regularly engage in open discourse with his colleagues about his scientific and clinical work.

To meet these objections and problems, various safeguards

*The tendency of the patient to behave willily toward the therapist as if he were an important and influential figure from the childhood past. This tendency is not to be exploited, but, rather, elucidated.

are necessary. In actual fact, a number are quite explicitly codified, such as those portions of the criminal and civil laws pertaining to medical practice, and the Codes of Ethics of the American Medical Association and of specialty groups or of local organizations. Interestingly enough, although they are bound by them, it is doubtful that the majority of physicians know the specific content of these laws. Their tacit subscription to them is more likely to be based on unspecified systems of ethics, personal or otherwise. Psychiatrists operate under various strictures which they may ordinarily see as "technical" and not ethical considerations, such as: to do no harm; to reject personal aggrandizement at the expense of one's patient; to hold strict confidence; to avoid exploiting the patient to gratify one's own needs or wishes, and so on. These very strictures are, of course, predominantly and basically ethical in nature, and also technical. Although some of these guides have received extensive explication within the framework of particular theories, they may not cover every contingency. A psychiatrist may conceive of some general rule affecting his behavior, such as, "to be a decent human being."

Conceptions like these lead to the second reason or class of reasons why the assertion of a "value-free", technical or scientific proficiency cannot easily be resorted to in an effort to settle the questions of ethics and values as they apply to psychiatric practice. These conceptions carry strong implications of the "good" (and therefore the "not-so-good"). Other ideas, such as "health", "maturity", "normality" (except the purely statistical), no matter how technically stated, seem to some to contain a reference, actual or potential, to the problem of the nature of man and to the transcendental meaning[†] or lack of meaning of his existence. In any case, these implicit values cannot be isolated to everyone's satisfaction from the traditions and ideals which have in our society their most direct statements in religious principles. Although these need not at all be subscribed to by the psychiatrist as "religious" principles, he must recognize that he lives in a world which is pervaded by the influence of religious values. Those who claim to find this state of affairs unrealistic, and who would like perhaps to change it, have a right to their opinion and to their attempts to do so. Properly, however, these attempts should not be made

without genuine self-knowledge and considerable philosophical sophistication.

At the present time, and perhaps for all time, it would be difficult to make a universally acceptable and complete statement of the guiding ethics in psychiatric practice. Such a code would probably contain notions like those "technical guides" mentioned above, and would include some expression of respect for the dignity of the individual and for his inner potential freedom to adapt to and to change his environment, as well as of respect for the communities in which we live.

In this philosophically unsettled condition, the safeguard which most psychiatrists have in mind is the principle of minimal or non-interference. Whatever his own beliefs, the psychiatrist functioning as psychiatrist, strives for "doctrinal neutrality", which means that he will not commit himself judgmentally about his patients' beliefs, nor impose his on them. The psychiatrist most trustworthy of maintaining this position is one who has made, as part of his education, a thorough-going examination of his own systems of values. It should also be stated again that a periodic re-examination is often useful.

B. The Psychiatrist's Attitude Toward His Patient's Religion

The views of psychiatrists regarding the *clinical* significance and *clinical* usefulness of a patient's faith and practice are far from uniform. *Ideally* the psychiatrist takes no position regarding ultimate validity, but nevertheless reserves the right, as a clinician, to concern himself with religion to the extent that it enters into the patient's psychological functioning in general and his illness in particular.

Some psychiatrists take the view that all religious beliefs are based upon illusion. These may assert, for example, that the formation of religion and the concept of a supreme being, however expressed, represent wish fulfillments arising from a sense of helplessness, or an apprehension of death and doom. In the elaboration of the religion, needs for love and approval are gratified; and supervision, to keep one from temptation, is provided. The need for approval is seen as derived from a sense of inability to be

self-sufficient; and the need to be protected against temptation is derived from a feeling of being unable to control instinctual impulses of a destructive or a sexual nature. Psychiatrists of such opinions would hold that ideally the need for such "defenses" is to be obviated by treatment.

Some other psychiatrists assert that psychiatric and psycho-analytic principles are in full agreement with the ethical, therapeutic principles of the sacred scriptures; and find not only that is there no conflict, but that the two—religion and psychiatry—complement each other, and that religious belief plays a part in and is essential to psychotherapy. Some of these psychiatrists would see religious principles as so pertinent to health that they would at least interweave them in therapy. There are those who might even educate their patients and persuade them to these principles as the essence of the therapeutic process.*

Differing from these extreme points of view there is a third, namely, that the patient's religion may or may not enter the psychotherapeutic domain. Thus, the patient may have religious beliefs that are not linked with his neurosis, and a penetrating discussion of his religion may, therefore, enter into the treatment situation minimally or not at all. In such circumstances, the therapeutic activities of the psychiatrist would include considerations involving religious beliefs or practices only as he glimpsed evidence of their connection with neurosis in the individual. Often, in the compromise situations referred to above, the psychiatrist avoids touching upon the patient's religion, and may steer the patient away from examining it. In no case should he deal lightly with serious matters.

Need for Clarification

At another level, religious considerations do enter the treatment situation, but they may or may not fall within the province of the psychotherapy. There may be a need for clarification of the reality: for example, to obtain further information about certain elements of a specifically religious nature that are alluded to in the patient's presentation of his problem. This is properly to

*See remarks on proselytizing on page 330.

be obtained from a clergyman, for when the patient expresses ignorance or doubt about the teachings of his religious community, or when the psychiatrist has reason to think that his patient is entering a misapprehension, consultation, by either patient or therapist, with an authoritative clergyman can serve as a basis of clarification whence the therapy may move.* The information obtained may offer precise and specific prescriptions and prohibitions regarding attitude and conduct, or may, on the other hand, provide enormous latitude. This sort of inquiry is comparable to seeking information about the law from a competent lawyer, or medical information from an internist or other specialist.

In some instances religion may be used by a patient as a screen behind which he hides for neurotic reasons; he employs it either as an expression of, or as a defense against, neurotic needs. Here the definitive problem is not a religious one, but is, rather, psychopathologic; and therefore his religious views and practices *must* be considered in therapy. As an example, the unmarried patient who continues to put off marriage because his religion does not permit divorce, insisting that he must therefore be completely sure that he has the right partner, soon reveals that his problem is really around a fear of marriage and all it entails, and is not necessarily involved with a religious prohibition. Obviously, many problems are not this clear-cut.† Often the goals of therapy and the degree to which the patient seems treatable will determine how far the psychiatrist can explore a problem that has ramifications in the patient's religious beliefs and behavior.

C. The Psychiatrist and Religion in the Community

Correctly viewed, the position of the psychiatrist in the religious affairs of the community is no different from that of any other responsible citizen, although nowadays there is a tendency to overvalue his opinions. If he enters such affairs he must make it clear in what capacity he is functioning. He may have an interest in religion, and in participating actively in its various functions; but this is a personal choice made equally by all members of our

*Family and ethnic folklore may be confused by the patient with the teaching of his religious group.

†Florida religious delusions may occur, of course, in psychoses.

society. The fact that a psychiatrist chooses as a private person to be a religious observer should not be considered an index of his psychiatric acumen. However, to some people *any* position implies a bias. Psychiatrists find their patients desiring them to be all that the patient thinks himself to be or wishes that he were, and at the same time to have no attitudes or position of their own. It becomes essential for the psychiatrist not only to respect the patient, but to have an identity of his own, and privacy as well, and to help his patients to respect them. The psychiatrist should be quite aware of the significance of his position, and also of its possible effects on himself, his patients, and the community.

If, as a psychiatrist, he presumes to lecture on aspects of religion other than its psychic function and clinical significance, he is out of his province. Training in psychiatry provides no competence in theology. His discipline may make it possible for him to discuss the defensive uses of religion by some patients who use it in their efforts to meet neurotic needs, but here he is actually discussing neurosis rather than religion.

On occasion, the therapist may consider the use of religion as a potential aid to psychotherapy or as a therapeutic resource in itself. It is ironic that while many psychiatrists encourage their patients to participate in other social and cultural activities, they hesitate to do the same in regard to religious groups. Here again, however, the psychiatrist would not be acting as an authority on religious matters any more than he would as an authority on musical matters if he were recommending some musical interest.

The resources that the psychiatrist can offer religious leaders regarding psychiatric matters is discussed in another section.

III. AN OUTLOOK FOR THE CLERGYMAN

The cognomen "clergy" is used here in a very broad sense to denote a person who represents a religious institution and who may be expected to have a relatively intense investment in matters of faith and religious practice. We are using the term to refer to all those who function as clergy within the community. We are aware that there are wide differences in levels of training and in degrees of sophistication.

If, then, a clergyman is to live in a community where inevitably he must meet with and deal with people who are mentally ill, how is he to view them and their disorder?

A. The Nature of Mental Illness

From earliest times mankind has tended to view any form of illness as something imposed from without. This is reflected in the use of the word *attack* to describe an episode of illness: an "attack" of gall bladder trouble, or epilepsy, or heart disease, or hysteria connotes something forced on us as passive victims. In the days of more primitive thinking, as in the days of our own childhood, we were wont to attribute to the things around us personalities similar to our own. The child conceives of furniture, animals, toys, and people as personified in terms of himself; and man in the childhood of civilization saw trees, mountains, wind, rain, rivers—all his world—as having a spirit or demon essential to them. We have learned to recognize this *animistic thinking* as a developmental phase, antecedent to reality testing; and we would view its persistence even into late childhood as a sign of trouble. However, it need not astonish us that, in some degree, adults tend to keep and must struggle against such thinking. For example, we "personify" our countries ("Uncle Sam") and our schools ("The Golden Bears"). Ships are called "she"; and our cars are extensions of ourselves (not "His car skidded into my car", but "He skidded into me").

In such a fashion—by animistic thinking—the pagans constructed their gods as unwitting expressions of their own strong tendencies and wishes. Thence it was a little step to place upon those same gods the responsibility for things, good or ill, that befell the believer. This universal human mechanism for placing the blame (or the blessing) elsewhere is well known. Another step, reflecting the problem of personal responsibility, needs to be pointed out. Even if one blames an outside agency, some aspect of oneself or some good friend (like Job's), is likely to raise a question, if not about responsibility, at least about culpability. The "attack" may come, as it were, from without, but the need for causality must be satisfied: perhaps one is in some way remiss.

The various explanations that have been offered, through the centuries, for mental illnesses have generally been of this kind: either they represented the blessing of some spirit, or the curse; or the mysterious working of some retributive force, exacting pay for unknown evil done; or the visitation upon the children of the sins of the fathers. In general, we can say that a *moralistic* coloration has even to the present tinged our view of mental illness.

This tendency, superimposed upon an instinctive aversion to the strange and distorted, had led by the eighteenth century to a shunning of the sick man, who was both looked down upon and feared. Still today we can hear physicians, who should of all men know better, refer to people suffering from neurosis in most disparaging terms. Although this sad fact is changing for the better, the change is all too slow.

When the symptoms of illness, as in many of those caused by unconscious conflicts, are reflected in the everyday personality and behavior of the sufferer, the clergyman may find himself much taken up with the problem. This fact may manifest itself in two ways. For example, a man who is a pillar of the church, upright, conscientious, uncompromising in his defense of righteousness, may astonish and dismay the clergyman by developing a severe depression. The character he showed at first, and which seemed so estimable, was in this case only a more acceptable reflection of underlying trouble which eventuated so painfully in the depression. This may sorely puzzle the clergyman.

In a second way, the clergyman (by dint of his desire to help

or because of the importunings of a family) may find himself attempting the rehabilitation of an anxious person or an alcoholic. It is well known that some of the practices of religion, or some personal intervention of the clergyman may, on such occasions, relieve the sufferer—either by strengthening his morale or decreasing the pressure on him. However, a well conceived and executed therapeutic program is beyond the capacity of the clergyman, unless, of course, he is one of those who has undertaken specialized training. And where underlying psychological problems are the source of the sufferer's distress, he should be referred to a physician—the psychiatrist—who can assist in their resolution.

In short, his very interest in troubled humanity makes it incumbent upon the clergyman that he have an understanding of the nature of mental disorder. If a clergyman were aware that one of the symptoms of diabetes is overeating, he would wisely refer his parishioner to a physician rather than attempt by religious means to correct his apparent tendency to gluttony. In the same way, hidden psychological (or, perhaps, physiologic) factors need to be understood to lie behind and to be reflected in the illnesses of the mind, *in whatever way they may be manifested*.

One of the serious difficulties that confronts anyone who wishes to awaken in another person a recognition of the nature of mental illness is the tendency of the other to achieve an intellectual awareness of the situation, without feeling any emotional impact. This kind of awareness is better than none, but it does not provide a good basis for fellow-feeling or empathy, which requires an emotional conviction as a take-off point.

The psychiatrist is well aware of this problem, which he has had to work against in himself as a part of his training, and he knows that great personal effort, used with honesty and integrity, must be called forth if one is to glimpse and experience the psychological reality of unconscious motives in oneself and in others. It is easy to deny the significance of one's own utterances and "mistakes" (slips of speech or writing, mis-hearings that may suit convenience or wishes, forgettings that have a purpose); to turn away from the inference that repetitive failures and errors have a meaningful pattern; to see a scrupulosity as a virtue rather than as a mask for impulses that might be deemed wanton. As a matter

of fact this shunning of certain significances as they pertain to oneself offers us a glimpse of the sick man's frequent urgent evasion of the truth about himself.

From motives of pride, or of fear of injury or loss of love, all humans resist knowing themselves, and defend against it. This is true not only in terms of painful aspects of ourselves of which we may be partially or even well aware while attempting to evade or deny them; but it is even more true of aspects that, while others may perceive them, are out of our ken—unconscious. In the first instance, it may be possible by authoritative direction, suggestion, and persuasion to help the individual to a broader and more realistic view of himself; but in the second, no quantity of such tactics will or can prevail. Specialized psychological techniques are required. Definitive psychotherapy may be described as an exercise in the recognition and undoing of self-deception.

The clergyman who is able to recognize—really *know*—that the sources of the behavior that characterize mental illness are not only unknown to the patient, but also, without specialized psychologic therapeutic intervention, unknowable, is in a better position to be of maximal help to the sick person. It is often said that, as is true for the physically ill, the mentally sick cannot be held responsible in the usual sense of the word for their trouble; and what has been said immediately above would bear out the assertion.

In physical illnesses, with current medical knowledge as a measuring rod, we can usually predict a course. To be sure, there may be complications, but for the most part these can be anticipated and dealt with. In mental illness, on the other hand, the form of the disorder (or its content) may change radically. A man who develops alcoholism may be persuaded to abandon the symptom, only to develop a physical disorder. The latter may be well treated by his physician, but as it clears an episode of depression may supervene—and so on. Unconscious conflict, in other words, may remain dormant (latent), or, may find expression in a number of different ways in the same person. Those who mistake the symptom for the source may believe that a cure has occurred, when actually it is only that one expression of illness has been relinquished and another has taken its place.

This is not the place for any detailed exposition of the nature of mental illness, but it may be useful to summarize current thinking about it. The child's experiences are felt intensely, and his responsiveness and reactivity are urgent and strong, in every area. He lacks, however, the self-control, wisdom, judgment, and skill to cope with his own impulses and to direct his behavior appropriately and effectively, so that for safety, love, growth, and survival he requires parental aid. The necessary family situation, on the other hand, in itself provides problems for him—rivalries, jealousies, over-weenings, rebellings—all the varied forms that childhood loves and hates and selfishnesses and sacrifices can take. Around the handling of these his ability to deal with life evolves, his conscience is structured, his aspirations take form, and his feeling about himself as a person, and about others, develops.

When some aspect of his impulses or thoughts is too distressing to him (perhaps because of parental condemnation, real or fantasied), in his discomfort and anxiety he may "forget it"—the psychiatrist says *repress*—rendering the fear-laden impulse or thought unconscious. This is the setting for the unconscious conflict; the conflict between an impulse or idea seeking expression in behavior (including words), and the repressing forces, which, out of fear of injury or of loss of love, holds the impulse back.

Repression, like blood pressure, is a necessary thing; but, also like blood pressure, there may be too much or too little. If there is too much, the child is crippled and restricted in his mental and emotional development; if there is too little, he lacks the constraints to make him a respected and self-respecting person. Most often, however, it is the repressed impulses, seeking an outlet, that cause trouble, for after being latent for years they may be awakened by the stimuli of puberty or adolescence, or the strain and stress of adult life, and, eluding the repressive forces, find a compromise outlet in a symptom or group of symptoms. An example may be seen in the case of a soldier who developed an hysterical paralysis of his right arm. Investigation revealed that this was, in part at least, a defense against his unconscious aggressive impulses toward his superior officer—impulses that were found to be derivatives of his childhood anger toward the father whom he admired, hated, and feared.

The simplicity of our description may be misleading, for the complexities of symptom-formation are enormous. The clergyman's understanding of the matter can be greatly enhanced if he has an opportunity not only to read books, but also to look at children with open eyes, and to listen with open ears to adults who are ill. In these latter endeavors an experienced guide—psychiatrist, psychologist, social worker, well trained nursery school teacher or child care worker—can be of immense help. Formal courses, or time spent in training in a hospital, may be extremely valuable.

Perhaps most cogently the clergyman, to help the sick person effectively, must develop a sense of conviction that illness is *just that*, and must avoid the error of viewing it as an unaccountable mishap, a retributive calamity, or simply the reflection of a moral issue.

B. The Attitude of the Clergyman Toward the Psychiatrist

There are many ways in which the clergyman has been understandably at odds with the psychiatrist in recent years. For one thing, the most influential psychiatrist of our era, Freud, was an avowed atheist, a fact which led many religious people to assume that his work was somehow tainted, or his findings in psychology tinctured by some necessity for, or seduction toward, doublings of religion. Actually the case here is no different from that in which any scientist works as honestly as he is able, and then publishes his findings for others to check in their own ways. It does not occur to us to wonder whether anti-Catholic feeling should keep us from learning from a Galileo, or anti-Semitism from an Einstein, or anti-Negro from a Carver, or anti-Protestant from a Millikan; nor should anti-atheism block our learning from Freud. In other words, while Freud had a personal point of view regarding religion and religious belief, his scientific work must stand or fall on its own merits, as others test its validity. Men of diverse backgrounds have applied his methods and critically tested his hypotheses: a Swiss Protestant who remained a pastor and a staunch Freudian; gentle psychiatrists who are active Protestant or Catholic laymen; Jewish psychiatrists who have retained their position in Judaism; and others who are agnostics and atheists. If any aspect of Freud's

psychology is to be questioned, it cannot be on the basis of his personal irreligion.

There has been a tendency to suppose that all modern psychiatrists are atheistic, and this is simply not so. As a matter of fact, as has been said, it shouldn't make any difference *in treatment* if it were, for the psychiatrist's task is to deal with illness and strive for its cure, and not otherwise to interfere with his patient's outlook or belief or behavior. Let it be emphasized once more: if a patient's religious belief be tied up with his illness, it will be affected (changed, strengthened or weakened) by treatment, no matter what the psychiatrist believes; if it has no connection with his illness, it will remain the same.

A second source of the clergyman's doubts about the psychiatrist lies in a concern about his point of view regarding morality. For example, if a given bit of behavior is considered by the clergyman to be sinful, wicked, or bad, and the psychiatrist, seeing its source in illness, views it only as a *symptom*,* the clergyman may look askance at the psychiatrist. He should remember, though, that the psychiatrist is concerned only with treating illness, and not with making moral judgments or imposing moral corrections. The psychiatrist's actions do not preclude the clergyman's function of making such judgments and offering appropriate recommendations.

Perhaps more difficult is the question of the reasons for morality in general. The psychiatrist as psychiatrist is usually a relativist, seeing morality as arising in the psychology of family and social life, while the clergyman as clergyman usually values morality as something revealed, or referable to a transcendental power. This may be a point of honest divergence, the levels of discourse become different, and communication may then be extremely difficult. It will be of some help if both look at the *content* of the moral codes involved, and realize that the differences there may not be so very great. The psychiatrist is interested in truth and honesty as expressions of healthy living, and is constantly attempting to pursue both more effectively, and to help his patients to get at the

*The psychiatrist frequently deplores the effect of the symptom because it is self-destructive or causes pain to others; but this is quite different from viewing it as bad, sinful, wicked, or evil.

truth about themselves, and to face and evaluate honestly the facts of the universe around them and of the persons they encounter. In many cases the clergyman will be content with this knowledge of what the psychiatrist's orientation is toward morals; in other instances the clergyman can only regretfully, or angrily, feel that so humanistic an approach to morals, namely one without reference to divine authority, can only be in error and lead to error. In the latter case communication will, again, be extremely difficult.

It would be remiss to write about attitudes of the clergy toward psychiatrists without specifically mentioning the topics of sexuality and aggression (destructiveness, hostility).

The word sexuality denotes for the psychiatrist the premium of pleasure, over and above its sheer usefulness, that a person may derive from any behavior. He does not see sexuality as confined to sex in the genital sense, but thinks of the latter as a particular expression of a general pleasure-seeking urge, which, even as early as the first year, begins to be expressed, primitively to be sure, in terms of gratifications with another person.

In short, sexuality is the basis, biologically derived, for the human experience of all enjoying and loving, and for all loving relationships. It is a constructive, supportive, enhancing force in life, and finds its most intimate expression in the mutual heterosexual love of adults, and its most useful social expression in the loving of one's fellow men. While the psychiatrist may have various opinions of one moral code or another, he has no truck with the devaluation, misuse, or prostitution of a drive that he sees as responsible for all that is best in mankind. Call it love, *caritas*, *agape*—it is still our most valuable commodity in human interchange, highly to be cherished, and wisely and honestly to be used.

Aggression (destructiveness, hostility), on the other hand, is to sexuality as hate is to love. There is no agreement as to its ultimate sources in man; but its usefulness (as well as its awful potentials for harm) is apparent. If a man attacks his own problems—greed, selfishness, or childishness; if he attacks social evils—prejudice, crime, bad housing; if he attacks ignorance, disease,

or man's inhumanity to man; then his hatred of these things, and his energetic efforts to be rid of them, are in the service of love.

Indeed, without such energy, no tree would be felled to build a cabin, nor any threatening animal killed to protect a child. It takes the human being a long time, even at best, to learn to use his aggressiveness appropriately and constructively. Many an illness reflects the results, annoying to exasperating to terrifying, of an unsuccessful effort to cope with it. The psychiatrist, even when he really understands a problem in which destructiveness plays some major role in the patient's unconscious, has all too often a very difficult task to treat the patient successfully; but he knows that condemnation, vengefulness, and retributive action have no place in the therapeutic program.

With these really major considerations—attitudes toward religion, morality, sexuality and aggression—at issue, the clergyman is, as has been said, understandably wary of the psychiatrist's orientation toward life and toward behavior, and he may be very mistrustful. His qualms are not diminished by two further considerations: treatment is often long, anxiety-laden, and likely to be marked by variations of all sorts in the patient's attitude and behavior; and the psychiatrist speaks a jargon of his own, and is often too uncommunicative—sometimes rude, as must be confessed—with interested third parties. Thus, an anxious and overwrought patient, whose situation is well understood by his competent psychiatrist (who sees him as in pain but progressing satisfactorily) may appeal to the clergyman, perhaps more than once. The latter is bound to feel somewhat exercised, and if he cannot get from the psychiatrist enough clarification to quiet his own anxieties, he may begin to doubt the correctness or the efficacy of the treatment. It is even worse if the patient's behavior takes a turn that is at odds with good or useful standards. The psychiatrist may have no cause for dismay, but the clergyman may not have an analogous basis for serenity.

It is probable that most psychiatrists would welcome an opportunity to find the clergyman an ally in the effort to deal with the illness of a patient, or for that matter with illness in general. At the outset, they must be aware that each is an authority in his

own field, and that their fields somewhat overlap. Each tends to see problems of character, or of marital relations, for example, to be in his own domain; consequently, feelings of possessiveness and rivalry may arise, consciously or unconsciously, to interfere with collaboration. We think it is reasonable to assert, however, that in the diagnosis and treatment of illness, the doctor must be the authority.

The clergyman, when he talks with the psychiatrist about a case, should regard himself as an informed and influential layman, with no more authority or competence in the field of psychiatry than the psychiatrist has in the field of theology. Even when he has a legitimate interest in a parishioner who is a patient, and knows clearly what the interest is and whence it derives, he should be sure that he is not being possessive, manipulative, or competitive in connection with the patient, or being exploited by the patient or the family. He may, of course, be genuinely puzzled about what his role should be, and wishing not to interfere with treatment, be concerned only to use his own calling advantageously for patient and family. Often he can be immensely helpful as a strong person, allied with the psychiatrist to combat the illness, who deals with the anxieties of family and friends with serenity and warm support in the face of their emotional storm. He can often explain and clarify, especially if he has had training and experience in understanding and dealing with people who are mentally ill.

When the illness is quite overt, the clergyman may have no difficulty in leaving matters in the hands of the psychiatrist; but it is especially when the problem involves the character of the patient that there may arise subtleties and difficult distinctions that make for vexatious debates between the two professionals. For example, the clergyman may recognize that the prodigal tendencies of a parishioner requires attention, and may seek to deal with the situation by assuming that he is dealing with a moral or spiritual problem. At the same time, the psychiatrist, seeing the problem as a symptom of illness requiring treatment, would prescribe from the experience and practice of his scientific discipline. In such situations the two approaches need not collide

or conflict, but on occasion they do. Often what may seem to be a grave difference may actually prove to be based on a misunderstanding of professional interpretations and instructions. Such difficulties can then be easily resolved by mutual consultation. However, it may happen that the positions remain mutually antagonistic.

Perhaps a resolution of such difficulties lies in thinking of the following kind. Over the centuries the mastery of more and more of mankind's problems has been the achievement of science, although no *ultimate* answers are forthcoming from that source. In medicine, including psychiatry, this has meant an increasing potential for recognizing and dealing with illness, but has not meant providing answers to such ultimate questions as derive from concerns with the meaning of life and of death. These are left to theology and to philosophy. The clergyman can safely leave medical diagnosis to the physician, and in the case of illness of the mind, to the psychiatrist. If the psychiatrist sees illness, he should be permitted a free hand in its management. The clergyman should yield to science what it is competent to deal with, retaining to himself the responsibility for those areas in which religion has special competence, and psychiatry none. In occasional instances the division may not be clear and collaborative effort is called for.

The clergyman in his parish is very frequently confronted with or consulted about problems that arise from illness, often long before the psychiatrist is consulted. It is therefore important indeed that he be able to do two things: to differentiate between the theological and the psychiatric difficulties of his parishioners; and to serve effectively as a first consultant, which means that he should know when referral is necessary, and when not, and how and where to refer. When his major endeavor is in the pastoral field, he is often in a position to recognize the earliest manifestations of illness and to see that proper measures are taken. To develop the requisite skills he must acquire, in addition to his theological knowledge, sufficient information from the science of human behavior to give him broader qualifications than those of the pure theologian; and this information is best obtained from the psychiatrist.

IV. RECOMMENDATIONS

A. To Psychiatrists

Religion as a Source of Research Data

The discussion so far has dealt primarily with the problems arising from the contact of psychiatry and religion as two social institutions with overlapping interests, much as psychiatry shares interests with law, social work, other branches of medicine, and so on. Although the psychiatrist, in his *professional role*, has no special right to make assumptions about values and meanings of religion and other social institutions in their own terms, he is interested in all of them; for, whatever else they do, they also function to satisfy human biologic needs, as these needs are expressed in human psychology. Therefore their structure and manner of operation may enlighten us about human needs and how these can be satisfied. Yet religion differs from other social institutions in a way that is of interest to the psychiatrist. We have been presenting the view that human needs are determined by the biologic nature of man, and we conceptualize these needs in terms of instincts and their derivatives. Their operation, their origins, development, inter-relations, and modes of expression are determined by a mode of thought which is peculiar to the instinctual life,—a calculus which is quite different from the kind of thinking we call rational, logical or scientific.

The instinctual calculus is called *primary* process. The entire sequence of images and ideas which constitute a primary process operation is seldom, if ever, conscious. Only one or a few of these may reach awareness, as for example in dreams, fantasies, and myths. On the other hand, the scientific mathematicological calculus which has been so successful, for example, in comprehending and

influencing the world of objective reality, is the paradigm of what we call *secondary* process. This is the mode of thought which corresponds to the events of the objective real world, which serves but does not prevail in the inner world of the instincts. With the beginning of the Age of Reason, men expected human institutions to cloak themselves in the outer wrappings of logic and science, even though these were seldom more than rationalizations which were irrelevant to the actual function of the institution. Non-rational thinking and ideas, that is, primary process, is acceptable in few aspects of even contemporary life (sophisticated as it may think itself)—it is in art, for example, by virtue of a special artistic license. The non-rationality of the products of previous ages is condescendingly regarded as a pre-scientific contaminant.

Religion has withstood the assault of the application of "reason" as a sole criterion of validity. The phenomena of religion have a special interest for psychiatrists because we have learned that the religious view is indeed a faithful one. In its ritualistic, sacramental, and mystical content it does not correspond in all ways to secondary process, "realistic" thinking. In psychological terms these contents commonly correspond rather to primary process regularities which govern perception and motivation, if not execution, in human behavior. This correspondence with primary process contributes to the powerful appeal to the worshiper, and to the character of intensity and of immediacy of religious experience. Hence, we may expect to find, in religion, representations and indications of the instinctual forces and of efforts to control them, with relatively little revision by rationalization.

Some Parallels

Because some elements of his patients' religious behavior became transparent to the psychoanalyst, early in his work Freud began to observe with interest, and to comment upon, the numerous parallels between neurotic derivatives of the unconscious forces, and pre-religious and religious derivatives. From his work and the work of others, it has been possible to build up a fairly consistent and probably reliable account of some of the psychodynamics of religious teachings, interests and performances. It

is supposed principally that the mental image of the god or gods of any religion is a projected and idealized image of one or of both parents,—an image which had previously been taken in by the child at the time when he had to terminate or attenuate his infantile desires for sensual, loving contact with the parents.

Upon this central core is applied a complex set of teachings and practices which deal with methods by which the individual can influence and be influenced by the deities. Family morality thus automatically forms a central component of religion, and social ethics become an essential requirement of the religious life subsequently. Because most religions developed before the age of science, they acquired cosmologies and pictures of the universe which on sophisticated scrutiny turn out to be comprehensible as projections of intrapsychic entities. These cosmologies, in many religions peripheral rather than central, attracted criticism because of their non-scientific nature. Although the dynamic studies are most interesting, we shall not attempt to present them here. The interested reader may consult Freud's own writings^{4,5,6,7,9,10,11,12,13,14}, those of his contemporaries, e.g., Flugel³, Reik^{22,23}, Jung^{16,17}, and of more recent authors.

Opportunities for Research

We should like, however, to call attention to another, less generally recognized facet of the psychiatrist's interest in religion. Because religion is concerned with the gratification of human needs, because it is expressed *via* a social institution with centuries of history, and because there have been relatively few attempts to comprehend the pattern of its contents in psychological terms, it is reasonable to expect that the history, the literature, the doctrines and the practices of religion will be found to contain a wealth of source data on psychodynamics. This mine of information has not yet been worked; in fact, it has been scarcely recognized. We should like to draw attention to some of the opportunities for the study of psychodynamics from a study of religion.

At this point perhaps we should make explicit the purpose of our use of psychoanalytic concepts in this discussion. To understand neurosis, Freud developed a psychology of unconscious psy-

chie processes, that is, a system of psychodynamics. With this tool he was able to initiate a new kind of study of the psychology of religious forces, experiences and acts—a study which quickly surpassed previous phenomenologic and philosophic approaches in its profundity and scope, since it enabled the observer to discern features common to diverse religions, and common to the determination of normal behavior. It is only as a result of psychodynamic studies that the psychologic effects of many religious teachings and practices become comprehensible.

Therefore, until recently it was primarily the psychoanalysis among the psychiatrists, the students of Freud, and also the students of Jung, who were interested in pursuing a psychologic study of religion. Since our subject is the relation between religion and psychiatry as a whole, we have no intention in this report of urging one system of psychology in preference to others. We are willing to grant that any sophisticated and profound system of human psychology has much to learn from an examination of religious forms and history. However, we feel that we can illustrate most clearly and fully the point that human psychology has much to learn from religion by referring to the system of classical psychoanalytic psychodynamics.

Psychodynamics and Religion

First, we may seek in religion greater knowledge of the contents of the *id*; that is, of the instinctual forces which are expressed mentally as unconscious wishes. These may appear in the explicit or implicit goals of religious worship. What, for example, are the instinctual goals of mystical contemplation, which is so important a part of a number of religions?

The rules of symbolic equivalence, learned in clinical practice, have been adduced by psychoanalysis to illuminate religious phenomena. For example, Freud, taking a clue from the fact that the threatening animal of childhood phobias was a symbol for the father, suggested⁸ that the totem animal of totem religions was also a representation of the father. Conversely, we can probably acquire information about symbols *from* religion, as Jung^{16,17} especially has tried to show.

Ritual performances, individual and group, prescribed by religion, may be derivatives of instinctual operations, that is, they may be acts that are part of the inherited repertoire of movements which are provided for the purpose of achieving instinctual goals. Thus, they may appear as stereotyped movements in schizophrenics, or in a compulsive neurosis, or a tic. Lorenz,¹⁸ for example, suggests that baring the head, which is a widespread, religious gesture, might be an inherited instinctual sign of surrender, and that "turning the other cheek" might be an exaggerated form of the same movement, having the effect of deterring an aggressor.

Primary process, we noted above, refers to the manner in which instinctual drives transfer their impetus from one impulse to the other, —for example, to a second when the first is frustrated. The principles by virtue of which one can substitute for the other are non-rational, but, on the other hand, probably not indeterminate. We do not by any means yet know all there is to be known about primary process. Among other things religion is concerned, to a considerable extent, with frustrated impulses. Some frustration it imposes, as in the case of behavior regulation; other frustration it presides over, as in the case of bereavement. Is there any regularity in the way the various religions attempt to manage strivings which must not or cannot be gratified?

In attempting to devise an ultimate classification of instincts, Freud was led, after considering some preliminary hypotheses, to suggest that there were two general groups of instincts, the erotic instincts and the death (aggressive) instincts; that is, instincts concerned with synthesis and construction (they were alluded to in the discussion of sexuality), and instincts concerned with disintegration and destruction (alluded to above as aggressiveness, destructiveness or hostility). While this classification has moral overtones, it is not addressed primarily to morality. Apart and aside from the moral aspects of a good and evil dichotomy, do the various religions also recognize two opposing vital forces? How are they described and what recommendations are made for dealing with them?

We may find answers to some of these questions in the litera-

ture, the history, the doctrines, the cosmology and the art of religion; we may find answers in the commendations and prohibitions of religion, in the techniques of prayer, sacrifice and ritual; we may find answers in the similarities and dissimilarities among the many religions of the people of the earth, and in the study of religious experiences of individuals. Certainly the material available has not been properly developed.

The Structural Hypothesis and Religion

A study of the data of religion may help us with a second kind of problem, namely, the problem of the structure of the psychic apparatus. By assuming the existence of active unconscious mentation, Freud was able to discern the operation of hitherto unrecognized, potent forces in neurosis and in normal behavior. In his earliest writings, he considered those to be traumatic memories and ideas. Later he found that the unsettling forces were expressed in childhood fantasies, which need not derive from actual experience.

Finally, he realized that these fantasies were themselves expressions and derivations of instinctual needs, that is, biologic needs required by the biologic nature of man, for example, nutritional needs, filial needs and reproductive needs. The distinction between the quality of being conscious and of being unconscious, which had served so well in elucidating these basic psychoanalytic concepts of instinct and derivative, proved to be inadequate, taken alone, to account for all of the phenomena of neurosis and psychosis. In every neurosis, one can find a conflict between two sets of forces, both of which are usually unconscious. These forces express themselves in certain behavioral tendencies or aversions. Since it is difficult to conceive of forces except in a spatial frame of reference, Freud proposed a structural hypothesis. He spoke of "structures" or "entities" within the psyche ("psychic apparatus"), each of which had its own characteristic set of functions and set of contents.

These structures are hypothetical constructs, not designed to correspond to any known or suspected anatomic structures within the central nervous system, but to simplify and organize the hypo-

theses about mental function that clinical data required. The psychic "structure" in which the instinctual needs are generated, and their priority established, is the *id*. While the *id* is the source of the instinctual demands upon mental life, another "structure," the *ego*, is concerned with satisfying some of these demands, but, also, with ensuring the frustration of others which would tend to create intolerably dangerous situations. The *ego* must not permit any of this second group of wishes to gain expression in behavior, or even in consciousness. In psychosis, one portion of the *ego*, the part that is concerned with self-observation and conscience, alters its relation to the rest of the *ego*. That is, it is projected outward so that it seems to reside in another individual (in schizophrenia); or it is drawn closer to the center of consciousness, occupying the whole of awareness (in melancholia). If the position of this part of the *ego* can change with respect to the rest of the *ego*, it deserves to be considered a separate "structure," and it is called *superego*—roughly, the conscience.

What has all this to do with religion? Projection, which is a defense against disturbing irritants, whether they be unwelcome *id* impulses, external threats, or physical or mental distress from any other source, is also a means of relating to a loved individual. In our striving towards others, we tend to project ourselves into them and to superimpose portions of our personalities upon the images of those we love. We can detect behind many elements of religious figures, projections of fragments of the personalities of the worshippers. Because they are typical or are sufficiently vague, these super-natural figures appeal to large numbers of individuals as appropriate targets for projection. From these considerations it follows that in the gallery of religious personalities, figures, and forces, we shall probably find personifications that have been elements of human personality.

Those investigations that have been conducted hitherto, and that form the basis for these statements, have been concerned chiefly with identifying, in religious material, psychic elements that are already known. We are suggesting that a further step can be taken: we may be able not only to confirm knowledge we already possess, but as Freud suggested, we may be able to obtain new knowledge from investigations based on these principles.

It would be interesting, for example, to catalogue the various images in which the instinctual sources of the id are represented.

While we know a good deal about the functions of the ego, its internal structure, if it has one, is still obscure. Doing and thinking, self-control and self-indulgence, awareness and consciousness, resisting the pressures of the id or finding environmental opportunities, perception and action, fantasy and reality testing, are all activities of the ego. To what extent are these activities represented in religion; how are they represented; are they represented independently or in clusters; are the personifications different in the different religions; why are they different and with what can the differences be correlated? Magic and superstition are modes of ego function characteristic of the primitive ego, that is, the ego of the child and of the unsophisticated adult. These appear overtly in primitive religions, and more subtly in modern religion. It is likely therefore that much can be learned about primitive ego function in religion. Under what circumstance is the ego of the sophisticated adult permitted to regress to more primitive function?

Religion can probably tell us more about the superego than about the other psychic agencies; for, as Freud presumed, religion appears itself to be transmitted by and carried in the superego. Hence, not only projected images and personifications are relevant; the forms of religious teachings and the techniques of instruction and prohibition will doubtless be found to contain implicit information about the structure and function of the superego.

We may look for further knowledge of the function of self-observation, not only as it is projected onto omniscient supernatural figures, but also as an aspect of prescribed methods of self control. The nature of codes of conduct, their sources, their persistence and tendency to transmit themselves, all require study. How does the learning of a preferred profile of behavior compare with the acquisition of academic information? At what developmental phase does the superego start to appear, and when does it begin to function? What are its precursors? How universal are codes of behavior, and are some elements more widely distributed than others? Whence does the superego derive its power, that is,

how can it enforce compliance? How flexibly does it respond to individual needs and to social pressures? Which agency of the human psyche is responsible for ascertaining what is real?

At one time Freud^{10,p.114} stated that it was the superego, for the child accepts as real what his parents tell him is real. Later Freud^{11,p.34} was led to conclude that it was the ego rather than the superego which was concerned with reality testing, for the former was in direct contact with the real world and had to distinguish between those images which were conveyed to it by the organs of perception, and those that rose to consciousness from within the psyche. But is the issue resolved? The first argument is still true and obviously pertains to the problems of religious belief. What influence will persuade an individual to believe in the reality of an idea or image? Here is an area for study which is central to religion and important in psychological theory.

Sublimation is the maturational process whereby instinctual drives that must be denied direct gratifications are nevertheless led to partial (and acceptable) discharge by being deflected to non-sensual goals. Religion seems to make a deliberate effort to exploit the power of repressed drives to motivate religious behavior. It would be interesting, then, to examine and catalogue the different ways in which the various religions deal with the problem of aggression; for example, human sacrifice, animal sacrifice, masochistic self-punishment, self-criticism and self-denial, and deflection of aggression against non-believers or against other religious groups.

Methods of Influencing Behavior

A third area of psychologic concern which would benefit from a study of religion is in the application of psychologic principles to the influencing of behavior. We can probably learn more about the organization of groups and their maintenance from religion than from any other single source. In his monograph on Group Psychology,¹⁰ for example, Freud compared the organization of the Catholic Church with the organization of an army. Religion contains techniques for influencing the behavior of groups of people, in the directions both of encouragement and prohibition.

These may include, for example, the exploitation of instinctual tendencies to respond to threats and promises, to obey authority, to protect the vulnerable, and to imitate. Methods of transmitting and enforcing moral codes have been worked out and applied by religious institutions, even though they are not able to make explicit the psychodynamics of their methods.

The differences between the goals and methods of Eastern and Western religions must have some important psychological meaning. How is religion able to induce groups of people to renounce some modes of gratification of their instinctual needs? Why does it succeed in some cases and fail in others? The psychology of leadership will profit from a study of religion. For example, with what qualities must an individual be endowed in order to command the obedience of others? What can the leader expect of this group, and what should he be prepared to give? Under what circumstances does allegiance to the person supersede allegiance to the organization? What can we learn from and about prejudice?

Methods of Investigation

These are some of the many psychological questions which can probably be answered, at least in part, from an investigation of religion. How can such investigation be undertaken? It was clinical experience that led Freud to see the dynamic relation between neurotic and religious phenomena. Clinical experience can still teach us much about the psychology of religion. What is required is merely a careful analysis and colligation of the religious and pseudo-religious experiences of our patients. It may be true that relatively few patients are seriously concerned with religion; yet even in those who are not, some aspect or another of religion probably becomes meaningful from time to time, even if only in a negative way.

One Jewish patient, though otherwise indifferent to religion, is interested in and credits the story of the Resurrection. Analysis discloses that behind this interest there lie his own rebirth fantasies. Another patient actively repudiates religion and resents religious people. Yet he is scrupulous to a fault in his personal and profes-

sional conduct, and he listens to radio sermons—but only to laugh at them. Some patients are too taken up with themselves to be interested in any group organization, religious or otherwise. That is, their instinctual strivings towards others are so fraught with danger or guilt, that they have foregone all of these strivings and seek gratification only within themselves. Other self-centered individuals retain religion as their sole or chief channel of contact with society.

Among these we may, perhaps, study which elements of religion tend to encourage narcissism (self-love), and which tend to discourage it. In a number of patients one can see a close and direct correlation between fluctuations in attitude toward religion on the one hand, and to the father on the other. One finds patients who resent religious institutions because they feel that their parents place their religious obligations ahead of their love for their children. It is interesting to see how a parent's ambivalence toward religion, which he himself may not discern, is nevertheless apprehended by the child.

In compulsive patients one often finds pseudo-religious prayers used as magical gestures to undo the consequences of hostile wishes. Among clergymen, one encounters not only problems of faith and ambivalence (feelings in opposite directions), but also problems associated with leadership, such as the need to project a portion of oneself onto congregants, acquisition of a feeling of omnipotence by identification with God, and exhibitionistic needs and fears. Though such clinical studies are especially valuable for elucidating the psychodynamic meaning of religious phenomena, they can also be used for the purpose of learning about psychodynamics from religion.

Comparative religion is a second important source from which one may extract new psychological information. While beginnings have been made, much remains to be done. One may compare myths, symbols and practices. How much universality can one find? Is there any regularity or system in the variations? What is it that all cultures put into and demand of religion? What part do morality and ethics play in the different religions? Are they essential to religion? Can one find sexual elements in all religions

or only in some? How central are such elements? How are they disguised and what roles do they play?

A study of the history of each of the religions, as well as of religion as a part of civilization, is a third source of the information we are seeking. Has religion played a consistent role in the development of all civilizations? What are the features which strengthen a religion and what features weaken it? Has religion contributed to the rise of peoples? To their fall? Under what circumstances has one religion been superseded by another? How have religions come to be subverted and exploited?

B. Recommendations to the Clergyman

This report has been prepared by psychiatrists, and much has already been said that it is hoped will be of interest to the clergyman. Pertinent data has been sketched in concerning the psychiatrist's view of the development of human nature, and of the ways in which man comes to attitudes, feelings, thinking and behavior. An effort has been made to present the concepts of the unconscious, of primary and secondary process, of motivation and drive, and of the repressed. The structural hypothesis has been touched upon; and id, ego, and superego functions and dynamic interaction briefly described, including the phenomenon of defense. The source of mental disorder in unconscious conflict has been pointed out, and, in simple terms, the way in which the illness occurs, symptoms are formed, and treatment done.

For information that will help the clergyman to recognize illness and to learn how to deal with it appropriately, we feel he should avail himself of the many excellent resources in the general community. Seminars offer courses and recommend experience in mental hospitals; courses and seminars are offered by departments of psychiatry, by social agencies, and by some psychoanalytic training facilities; and mental health organizations offer programs and seminars. Good reading lists are available from all these sources and agencies. Once again, an intellectual grasp of the ideas presented is of value; but we cannot overstress the fact that it cannot compare with the sort of learning and growth that comes from experiencing the impact of one's own hitherto unrecognized feelings and attitudes, — from achieving a piece of insight.

The counselling that the clergyman undertakes should be limited by a keen sense of responsibility and a most honest appraisal of his qualifications and competence. Psychiatry, because of its necessary preoccupation with the scientific study of techniques of interviewing and counselling, has much to teach. We think it of salient importance that the clergyman continue to be just that—a clergyman; and if he desires to improve his counselling techniques, within the context of his pastoral work, then he may consult such resources as are mentioned above.

Among the basic aims of his counselling should be the ability to suspect and to recognize illness; and to make a referral, when it is indicated, to an appropriate physician, clinic, hospital, or social agency.

C. Recommendations for Further Collaboration

Regarding Moral Issues in Psychiatry and Medicine in General

Finally, it might be well to conclude our report with some recommendations for cooperative work in which psychiatrists and the clergy can participate. From a practical point of view, there is still much work to be done in the area of elucidating the ethics of psychiatric practice. The psychiatrist need not look beyond his daily work to see that he is often called upon to make moral decisions, and it would be well for him to acknowledge them for what they are. Would it be helpful if the profession as a whole, or in component groups, consulted with religious experts on morals and ethics in establishing and maintaining specific principles?

We have indeed seen that many of the patients who might have been considered candidates for lobotomy are now responding to drug therapy. Some think the decision to operate may have been too hasty. Furthermore, is it proper to assume that consent of a responsible relative is acceptable as a substitute for the patient's consent? We know that relatives are frequently influenced by unconscious hostility toward the patient.

There are other vexing questions which cannot be quickly answered, but which should be pondered. Is it morally defensible to perform brain operations solely or principally for investigative

purposes? Should the implantation of brain electrodes for periods of days, weeks or months be condoned? Who should make such decisions: the responsible psychiatrist, the neurosurgeon, the responsible relatives? Should clergymen be asked to participate? Should a professional organization draw up a code and keep it abreast of current requirements? There are also other areas in which the psychiatrist finds himself, willy-nilly, facing and making moral decisions.

For example, what are the psychiatrist's privileges and obligations with respect to marriage? Should he attempt to preserve all marriages, or if the marriage is clearly a bad one for one or both partners, should he, even by his silence, condone divorce? Should a psychiatrist ever recommend divorce; should he recommend extramarital sexual activity? What are a psychiatrist's obligations when he sees a patient acting out fantasies which are likely to be destructive to himself or others? There is of course also the difficult moral and legal problem of criminal responsibility.

It is generally acknowledged that if a man is grossly psychotic so that he is no longer able to test reality and to be guided by his own conscience, he is not to be treated as a criminal. But where can one draw the line between such an individual and one who commits a crime while acting out a neurotic impulse, or one intent on bringing punishment upon himself, or one driven by perverse sexual need or craving for drugs? In each of these cases the reality principle is overridden by powerful derivatives of instinctual forces; but if such individuals are not held responsible for their acts, then who can be? Moreover, if exemption is granted to them, will we not be removing a powerful deterring factor?

Outside the special area of psychiatric practice, the psychiatrist may also have something to contribute to the clarification of current moral problems. There are moral problems in the practice of medicine and surgery which the psychiatrist may illuminate. For example, with increasing surgical resources and skill, more and more radical, mutilating operations for the extirpation of cancer are being performed. Where should the surgeon stop? Is he to be guided only by the principle that all measures are justified if they may be lifesaving? If not, who is to help him draw the line? Abortion and contraception are troublesome problem areas in which

medicine, religion and law are recurrently involved. In these controversies, and in the problems of radical surgery among many others, the psychiatrist can provide information or informed guesses about the psychic implications of current practice and about the implications of any proposed changes. Such information may help to guide the principals in the discussion.

Regarding Problems of Public Policy

In essentially the same way the psychiatrist may contribute, as clergymen have often already done, to deliberations on current non-medical, moral issues by providing expert information on the implications of current practice and proposed changes. For example, the Group for the Advancement of Psychiatry has already examined the psychological issues involved in desegregation in the schools, and its Report* was considered in judicial debate. Many other problems can probably be to some extent elucidated, and possibly even simplified by psychiatric insight: matters, on the international level, such as nuclear testing, disarmament, foreign economic and military aid; such as civil rights and non-conforming behavior, on the national level; and as employment and residential discrimination, on the local level, are all essentially matters of government policy with strong moral overtones and implications. It is conceivable that where they are available, psychiatric insights, not only into consequences, but also with regard to motivation and defensive rationalizations, may add a valuable dimension to discussions of public policy, and provide significant data to those who have the responsibility for making decisions.

Regarding Issues in Religion

The principle that psychiatric insights into motivations, rationalizations, and consequences will be found useful in all areas in which decisions are made affecting human behavior may apply to religion too. Though religion may tend to be conservative, it is constantly confronted with new problems and must make important policy decisions. While in all of these, theological considerations are paramount, still, those who are responsible may wish to be guided by expert psychological knowledge of the nature of the con-

*"Psychiatric Aspects of School Desegregation," *GAP Report* #37, May, 1957.

tending forces, and by the psychologic implications of the possible outcomes. For example, in some religious groups women are asking for more responsibility and participation. A few Protestant women have been ordained to the ministry. It may not be clear to many clergymen that considerably more is involved here than simply democracy in the religious community. The sex of the leader or participant in a religious ritual has important psychologic overtones, and not all of these may be known to, or desired by, the responsible authorities or the members of the religious group. Unconscious, often irrational, attitudes regarding the sexes and their functions influence the responses of both male and female congregants toward the leader in religious rites. The differences in response can be detected in clinical practice where they are articulated by patients; and probably also in comparative studies of religions with female deities, male deities, and both. This example we mention merely as an illustration of a problem in religious policy where the psychiatrist's contributions are relevant and might be welcomed as useful.

For the purpose of facilitating cooperative work along the lines we have described, among others, we should like to encourage existing trends toward the establishment of continuing or *ad hoc* groups composed of religious scholars, clergymen, and psychiatrists. Such groups could pursue collaborative study into the psychology of religion for the purpose of elucidating psychologic or religious problems, or both; and they could work toward a whole-some and sophisticated resolution of current moral and ethical issues in psychiatry, in medicine, in international, national, and local community life, and in religion.

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Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

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- (1) To collect and appraise significant data in the field of psychiatry, mental health and human relations;
- (2) To re-evaluate old concepts and to develop and test new ones;
- (3) To apply the knowledge thus obtained for the promotion of mental health in good human relations.

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