Symposium No. 5

Some Considerations of Early Attempts in Cooperation Between Religion and Psychiatry

Group for the Advancement of Psychiatry

Publications Office • 1790 Broadway, New York 19, N. Y.
SOME CONSIDERATIONS OF EARLY ATTEMPTS IN COOPERATION BETWEEN RELIGION AND PSYCHIATRY

The meeting of the Group for the Advancement of Psychiatry, held at the Berkeley-Carteret Hotel, Asbury Park, New Jersey, on Sunday, April 7, 1957

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1790 Broadway, New York 19, N. Y.
This symposium is an attempt to outline some of the opportunities and possible complications of the efforts designed to develop satisfactory methods of collaboration between members of the clergy and members of those professions primarily concerned with mental health. It is not related in any official way to the work of the Committee on Religion and Psychiatry, even though two of the chief contributors are members of that committee. Neither is it a reflection of the views of the Group for the Advancement of Psychiatry. Instead, it is a production of a group of individuals, each one of whom expresses his individual views for the constructive criticism of others who share the opinion that thoughtful attention to such cooperative methods will be helpful to both religion and psychiatry.

Dana L. Farnsworth, M.D., President
Group for the Advancement of Psychiatry

Dr. Farnsworth: Four extensive programs involving the general theme of the relations between religion and mental health are now being developed in some of our leading theological seminaries. These are at Yeshiva University, Loyola University in Chicago, Harvard University, and Union Theological Seminary. It is an appropriate time for our members to look at some of the opportunities, difficulties, and possible hazards before the idealism which brought about their establishment is dimmed by reality factors. We are fortunate in having a representative of three of the projects on our panel.

Our first speaker will be Rabbi I. Fred Hollander, Director of the National Institute of Mental Health Program at Yeshiva University, who will speak on "A Theologian Views the National Problem."

Rabbi I. Fred Hollander: Dr. Farnsworth, Officers of the GAP, Ladies and Gentlemen: It affords me great pleasure to be here with you this morning. In the time allotted to me I should like briefly to discuss with you the question of cooperation between religion and psychiatry, both in reference to the training of theological students and clergymen, and in relation to some of the fundamental problems that have been revealed as the relationship between these two fields of thought has grown and become more complex.

In the past three decades educators in theological seminaries, Catholic, Protestant and Jewish, have come to recognize that the training presently offered to theological students often does not adequately prepare them for the pastoral aspects of their work.
Thus, many students find themselves unable to deal effectively with the problems for which people seek their help and guidance. The educators have come to recognize that this inadequacy may be resolved to a considerable extent by providing the student with a basic knowledge of mental health principles as they relate to his pastoral functions and duties.

In recent years not only theological schools, but also hospitals, government agencies and other institutions through which clergymen, as chaplains or advisors, meet the spiritual needs of individuals, have shown increasing awareness of the need for special mental health training for clergymen. Protestant seminaries have taken the lead in offering varied types of mental health education to their students. Many state hospitals for the mentally ill provide specialized in-service training for clergymen; in New York State, for example, the Department of Mental Hygiene has spent some $20,000 to provide those who will function as chaplains in this Department with an orientation program which will help them work with mental hospital patients. Full-time Protestant chaplains in Federal prisons are required to receive specialized mental health training before they can receive full-time appointments.

The mental health training offered to clergymen and theological students at present may be divided into two broad categories: these are clinical pastoral training and formalized courses of study in an academic setting.

Clinical pastoral training consists largely of giving theological students and clergymen experience in meeting the spiritual needs of people who are physically or mentally ill or who are in correctional institutions. It is a fundamental premise of the advocates of this kind of training that by learning to use the most effective methods of ministering to individuals in these situations, the student acquires a broad fund of knowledge and experience that can help him in all aspects of his future pastoral work. The student may spend anywhere from three months to a year working with patients and taking instruction from expert members of the staff of the institution offering the program. The Council for Clinical Training and The Institute for Pastoral Care are two notable centers for this form of mental health education for the clergy.

Academic mental health training for clergymen includes programs which offer lectures, seminars, and research. There are a number of centers in the United States where a clergymen may study toward an advanced degree in pastoral work. Boston University and Garrett Biblical Institute are among those which offer courses in this field leading to an M.A. or Ph.D. degree. Southern Baptist Seminary, Union Theological Seminary and others present a variety of courses for which seminary and, in some cases graduate credit is given.

In addition to these year-round programs, there are, throughout the country, frequent short-term institutes which provide an intensive course of study or training. One institute of this type is sponsored by Fordham University, where, for a week or two each year, students and clergymen of all denominations study various aspects of the relationship between religion and mental health. Another, which places more emphasis on clinical training, is offered by the New York Board of Rabbis, in cooperation with Bellevue Hospital. Here, rabbinical students participate in a 12-week course that enables them to observe at first hand a wide range of human problems and to learn from experts how best to minister to the spiritual needs of the sick.

As these varied programs of mental health education for theological students and clergymen increase in number and scope, certain problems concerning basic relationships between religion and psychiatry have been revealed. To insure continued cooperation between the two disciplines, it is essential that these questions be recognized and, eventually, answered. They may be divided into two broad categories: The problem of clarifying the unique role of the clergy in the field of mental health and the need to examine some of the differences between psychiatric and religious points of view concerning the factors that contribute to the achievement of mental health.

1. The Role of the Clergyman in the Field of Mental Health

Two features distinguish the role of the clergyman from that of others in the field of mental health. First, we must recognize that people turn to the clergymen for help solely because he is their spiritual leader. They look upon him as the representative of religion, which they believe can help them resolve their problems and evolve a meaningful pattern of everyday living. No other person or group involved in mental health work enjoys such a relationship. Usually, the function of an individual or group in this
area stems directly from the ability to apply not a unique spiritual resource but a technical skill based upon expert knowledge in a particular field of learning related to mental health.

The nature of the clergyman's aid to the achievement of mental health must always reflect this basic relationship. It must, in other words, be derived from religious resources—faith, symbolism, ritual, prayer and philosophical concepts. The clergyman uses his understanding of mental health primarily as an important aid to the performance of his own unique function. This use of scientific knowledge is different from that of others who apply the principles of medicine, psychiatry, psychology and related disciplines directly as their particular instrument of help.

Second, the physically sick, mentally ill and socially maladjusted are not the people whom the clergyman tries primarily to help. Unlike the psychiatrist, whose responsibility is largely to the sick, the clergyman is concerned with the mental health of practically all members of his congregation. Most of these individuals are not sick but need his assistance in developing a meaningful pattern for everyday living and in resolving common problems and crises. The methods the clergyman uses to concretize and convey the moral and spiritual values of his religion must reflect this concern for the needs of the average individual within his congregation.

Education is the principal means the clergyman uses to help people achieve mental health, for he spends more time dealing with groups than with individuals. Through sermons, lectures, classes and discussion meetings he attempts to satisfy the varying needs of the men, women and children who comprise his congregation.

In his direct work with individuals, the clergyman depends primarily on four methods of approach: he offers advice to people who are troubled about making a practical decision concerning a specific moral, ethical or spiritual problem; he recognizes problems which are not within his scope and convinces the individual to accept help from an appropriate source to which he refers them; he ministers to those who are ill and their families by performing religious rites, providing encouragement and dealing with the spiritual stress caused by illness, bereavement or social difficulty; and he undertakes pastoral counseling. Because pastoral counseling is concerned less with mental health than with religious insight, it has been the subject of so much controversy and con-

fusion that it should be differentiated here from other forms of counseling or therapy.

Through pastoral counseling, the clergyman attempts to help the individual resolve conscious problems through the application of religious insights. Problems of daily living, such as those that stem from marriage, parenthood and work, for example, frequently become so difficult that an individual feels he must discuss them with someone. When such problems have a moral, ethical or spiritual aspect that can be dealt with through the application of religious insights, the individual may be helped by a series of discussions with his clergyman. Pastoral counseling usually is not a suitable means of dealing with difficulties which stem from deep-rooted psychological conflicts. These can best be handled by therapeutic techniques that attempt to reach the unconscious.

Although the clergyman may use specific techniques that he has learned from the mental health field, he only employs those which can help him understand and reach the individual with his own pastoral resources, not those which are related to intensive therapy.

Frequently, the clergyman is asked to assume the role of pastoral counselor, not in order to help the individual solve specific moral and ethical problems, but rather to help him achieve through religion a general sense of purpose and motivation in life.

In these four methods of working with his congregation, the clergyman requires a knowledge of mental health principles if he is to obtain an understanding of human behavior which can help him utilize most effectively his own unique religious resources. He needs such understanding, also, to determine to what extent an individual may be helped by the application of religious values and to what extent he may require other forms of aid.

In some instances, the present pastoral training of theological students tends to stress the technical principles of psychiatry and other scientific disciplines without relating them sufficiently to the clergyman's function. As a result, students occasionally develop an erroneous view of their pastoral responsibility in the field of mental health. Widespread understanding of the distinguishing features of the clergyman's role in mental health—the primary use of religious resources as his unique contribution to the field of mental health, the major importance of his work with the well, rather than the sick, and the nature of the methods he uses—should lead to new forms of mental health education for the clergy.
An important step in this direction has been the establishment by the National Institute of Mental Health of a five-year project at Harvard, Loyola and Yeshiva Universities to create for the three major religious faiths a standardized curriculum that will integrate the teaching of general principles in the area of mental health with the special functions and educational needs of the clergy. If this approach is adopted by other institutions on a number of levels, the result should be the elimination of many difficulties now created by individuals who do not play their optimum role in mental health or who attempt to assume functions in this field for which they are inadequately trained. Even more important, this orientation can put to fuller use the age-old resources of religion—newly understood, newly applied, and newly significant.

2. Factors that Contribute to Mental Health: Some Differences Between Religious and Psychiatric Thought

There is a second broad area to consider before cooperation between religion and psychiatry can be truly effective. It is necessary to examine the ways in which the religious approach may differ from the psychiatric approach to the achievement of mental health.

Although both the clergyman and the psychiatrist agree upon the importance of mental health to the individual, they often differ about the factors which contribute to mental health. Such disparity stems not from misunderstanding, but from the basic attitudes toward man and his problems which are implicit in their two fields of thought. The following four examples illustrate certain differences revealed by examination of some important elements of the mentally healthy personality:

Integration

Psychiatrists generally agree that integration is one of the primary components of the mentally healthy personality. They have defined it as the ability of the individual to create some form of unity and direction out of his own divergent impulses and aspirations. This ability, according to psychiatric thought, depends largely upon the nature of the individual's early life experiences and his developing relationships to parents and environment. The clergyman, while accepting the importance of human relationships to the development of an integrated personality, believes that the ultimate in integration can be achieved best through man's recognition and acceptance of his relationship to God and universe.

Purpose

Both religion and psychiatry recognize that the life of a mentally healthy person reflects purpose and motivation. The psychiatrist believes that important evidence of possession of these qualities lies in an individual's ability to establish a set of goals that are realistic in terms of his personality, and to attempt to achieve them without being immobilized by temporary failure or easy success. The clergyman feels that in addition to this ability, an individual's capacity to achieve purpose is also contingent upon his power to accept and try to fulfill the spiritual goals and values defined in the precepts of his religion.

Security

Psychiatry recognizes that much of an individual's ability to achieve mental health stems from the feeling of security he gains as a child; that as he moves into adulthood this sense of security forms the basis for mature living; that as he progresses in life the mature individual should be able to add to this heritage of security, both from his own inner resources and from his relationship to others.

The clergyman, although he accepts the importance of developing this kind of personal security, believes that security in its fullest sense can be achieved through man's understanding and acceptance of the concept of cosmic belonging.

Conscience

It is accepted by behavioral scientists that to live in society, an individual must develop the ability to distinguish between right and wrong and to be guided in his actions by this distinction. Such ability is an important aspect of the quality we term conscience.

From earliest childhood the individual learns that certain things he wants to do are not permissible. His ability to evolve from various teachings and prohibitions a meaningful and healthy concept of right and wrong will depend in large part upon his early relationship to his parents. In maturity, the ability to judge one's acts as right or wrong and to feel constructive regret for wrongdoing is a healthy characteristic of a person with a developed conscience.

For the clergyman, the meaning of conscience goes beyond the recognition of right and wrong in relationship to one's fellow man and to society. It assumes a responsibility to
God, and an acceptance of the concept of sin in regard to acts which are in violation of religious values.

There is no doubt that divergences of this type have, in the past, led to misunderstanding and strain. Perhaps some of the difficulty can be overcome if the representatives of both religion and psychiatry accept the idea that there are many concepts of man which, while not identical, are not necessarily mutually exclusive.

When psychiatrists interpret religious concepts, individuals who are religiously minded often become concerned because they assume that this interpretation is offered as the total explanation. Thus, a religious person who concludes that the psychiatric interpretation attempts to represent all there is to say about a certain ritual or concept may feel forced either to reject the psychiatric interpretation or to question his own religious beliefs. It is necessary for the religionist to recognize that the psychiatrist's interpretation of ritual is valid, but valid in the specific context of a scientific explanation of man and his behavior.

Just as it is important for religiously minded individuals to recognize the role of psychiatry in understanding man and helping him to attain a more healthy pattern of living, so, too, it is necessary that psychiatrists give more extensive consideration to the role that religion can play in the life of the individual. Whatever his personal religious conviction, when the psychiatrist deals with a patient on any level, he should realize that religious beliefs can comprise a strong and constant component of the individual's personality.

As the representatives of both religion and psychiatry continue to give careful consideration to these questions, as they begin to recognize more fully that their different concepts can be complementary, those who work on many levels to help people attain mental health have a new opportunity for service and achievement. We earnestly hope that this kind of mutual respect and understanding will continue to develop rapidly and fruitfully, with benefit to all. Thank you.

**Dr. Farnsworth:** Thank you very much, Rabbi Hollander! That was a very clear and concise presentation.

Now we will turn to one of your psychiatric colleagues and GAP member, Dr. Earl Loomis, who is a member of the GAP Committee on Psychiatry and Religion, and Director of the Program in the Inter-relations of Psychiatry and Religion, Union Theological Seminary. Some of us have been on his Advisory Committee, in fact I think that all but one of the Committee are GAP members. When the Committee meets it seems like one of the GAP committees. Dr. Loomis is going to talk on the subject "A Psychiatrist Reflects on his First Year." Dr. Loomis!

**Dr. Earl Loomis:** After reading the title of my topic, I am not quite clear as to what the topic is really about—whose first year and what first year. Since I happen to be interested in the first year of life, I wondered for just a second. I assume it to mean, however, my first year at Union Seminary as a member of the Faculty.

Two years ago, I was invited to teach at Union Theological Seminary. I had many qualms which led me to consider the issue for some time before coming to a decision. Was I being called to be therapist to the student body or to the faculty? Was I supposed to train lay therapists? What would the theologians think of me and do to me, and what would the reactions of my colleagues be? All these questions and a whole lot more coursed through my mind over a period of weeks. One by one they were answered, clarified or simply put on ice as unanswerable prior to experience. Now, I am in a position to begin to review the events and experiences of a very rich seven months on the job.

In order to indicate what sort of work I have been doing, I shall outline our program briefly, describe my role and that of my associate, Dr. Charles Stinnette, in this program, and mention some of our resources, our pitfalls, our future plans, and lessons learned.

It has been customary at Union Seminary to provide students with a part-time parish experience or its equivalent during each of the three years of training, under the aegis of the Department of Field Work. I wondered at first how we could add anything new and different to this. As I examined the existing function of field work, however, it appeared quite clear that there were at least three other dimensions to be introduced—a dimension of content, a dimension of focus, and finally the dimension of intensity.

In terms of content we have attempted to expose the students to a somewhat wider variety of experiences and conceptualizations
of these experiences; to acquaint students with more of the interpersonal dynamics of their work, and to bring into focus some of the techniques of supervision and an understanding of the individual’s own role.

Union Seminary has about 700 students, 220 of whom (the Divinity Students) participate in a three year program which follows graduation from college and leads to the Bachelor of Divinity degree. These students, most of whom live in Seminary dormitories, study Bible, church history, theological and philosophical subjects, and a whole field called “Practical Theology” which attempts to deal with principles and techniques related to the application of theology to life situations in the parish, church school, community, college or wherever else the student may be planning to work. Another 200 students are pursuing Masters and Doctors degrees, and about 100 are in a two-year course for Masters in Religious Education. Still another 150 are studying to be ministers of music or organists and choir masters in churches.

It was determined in advance that our program would not initially cover all possible areas of interest or concern, because we discovered as we looked around, a great number of areas in which our program and our interest might conceivably have relevance. We felt that the greatest danger to our program might lie in premature overextension beyond the time and energy resources of the small staff.

We decided, therefore, to concentrate on two major areas during our first two years. Roughly in order of importance of approach these are: 1) helping pastors to do a better job as pastors; 2) helping to train future seminary teachers in our field and other related fields. We have approached these two goals through: 1) introductory lecture-type courses in personality development and elementary psychopathology as they relate to religious development and to pastoral work; 2) introductory clinical experiences in pastoral care, which are far less intensive than the full-time clinical experiences afforded by hospital training programs, and 3) seminars in the interrelations of psychiatry and theology, in the dynamics of group experience, in special problems of research, and in the preparation of theses and dissertations.

Our introductory lecture course proved to be immensely attractive to the student body and was packed — I suppose because it included something new and mysterious. It was taught jointly in the first semester by the late Lewis Sherrill and myself. It constituted the basic instruction in psychology for all divinity and religious education students.

This course is followed in the second semester by “Psychology and the Pastoral Office,” which is designed to introduce the future pastor to some of the psychological situations in which he is likely to find himself in parish work. It deals with the psychological significance of some life-cycle ceremonies, typical life crises and stress situations, and with the more common psychiatric problems and symptoms he is likely to encounter in his work. Finally it outlines sources of reference and consultative help in the community. Emphasis is placed upon the help that comes naturally to the pastor and minister, in order to strengthen the confidence of the minister-to-be in using the modalities at hand and thus diminish any tendency to lean too heavily upon other disciplines. To some extent we try to help the minister rediscover what his resources are. These may or may not have been overlooked, both historically and in the burst of enthusiasm for this new and young science, psychiatry. We also familiarize the minister with the contrasting and over-lapping functions of related professions so that he can have an orientation to and a better understanding of their operation. It is in this second course that we are now attempting to play a clarifying role: this is indeed a difficult and perhaps treacherous, undertaking. Pitfalls lie both on the side of too little and too much knowledge — so-called — especially when the minister fails to perceive his own limitations as he steps into the psychiatrist’s shoes and tries to walk in them, and when he fails to appreciate his own prerogatives and sources of assistance. Through a variety of approaches we are attempting to surmount and avoid as many of these difficulties as possible.

In a course entitled “Introduction to Clinical Pastoral Care” we place students in hospital or prison settings for ten hours a week. We hope eventually also to have laboratory parishes in which they can work under the supervision of trained resident chaplains who will be adjunct members of our faculty and meet periodically with us. This first year we have selected 16 advanced students who have had the beginning courses or their equivalent, for this opportunity actually to perform pastoral functions with persons in need, and to come to recognize their own feelings and those of their parishioners. On the average, these students undertake three pastoral
calls or interviews per week. The balance of the ten hours is spent in attending seminars in other departments of the Seminary, receiving individual and group instruction, and attending seminars which deal with the needs of their parishioners. The student reviews with his instructors verbatim reports of his calls on parishioners, so that he may develop insight and increase his professional competence. Emphasis is placed upon the role of the pastor, as distinct from that of other disciplines. Opportunity is provided for group conferences and collaboration with doctors, nurses, psychologists, social workers and others who may have an interest in the patient or inmate. This furthers understanding of the functions of other related disciplines. The eight or ten students who gather in each seminar, discuss together the problems which arise weekly in field work. This group experience is both a means and an end. Students see themselves and their fellow students in action and study their own responses to group processes. The insight thus gained can then be applied to their work with church groups of all types from youth fellowship gatherings to Board meetings. Some notion of the psychodynamics of groups, of the difficulties of group communication, and of working with a congregation is gained from these experiences. In some seminars more emphasis is placed on content than on process. These deal largely with theological and philosophical issues as they intersect with the concept of psychiatry and the social sciences.

We have had the avowed and active cooperation of the whole faculty of Union Seminary; the support of the Old Dominion Foundation, and its special consultant to our project, Miss Mary Schweitzer; and the active collaboration of the Psychiatric Advisory Committee consisting of Drs. Kenneth Appel, Binger, Blain, Booth, Farnsworth, Ginsburg, and Karl Menninger. I should do a major disservice to omit special emphasis on the contribution and function of my colleague the Reverend Dr. Charles R. Stinnette, Jr. who is Associate Director of our program and formerly Associate Warden of the College of Preachers and Canon of the Cathedral in Washington, D.C. Without him I am sure our program would not be a very safe undertaking. Dr. Stinnette comes from a background of advanced study in philosophy, psychology, religion, Army chaplaincy, personal psychoanalysis, and extensive experience in applying the principles of group dynamics and group life within the church. He is the author of the book “Anxiety and

Faith.” He has shared in the instruction of our second course, “Psychology and the Pastoral Office,” and leads the Seminary students in the course on “The Psychodynamics of Groups.” He has also supervised approximately half of our graduate students in the research for their theses.

In our first year, we have naturally held our work with graduate students to a minimum. Certain students who were already in the Seminary before our arrival were found, however, to have special interests relating to our field. During the first semester, these students asked for and received our assistance in the preparation of their theses. Next year, we plan to begin the training of 9 graduate students in our field. Half of these plans to go on to seminary teaching; the other half to return to the parish for institutional ministry.

I must say that the problems actually encountered have turned out to be fewer than I dared hope. I had really anticipated some repercussions, and perhaps the axe is yet to fall. The problems that have arisen have not tended to force me into the role of therapist for the student body. Obviously it had been feared that if a psychiatrist were on the faculty he would become therapist to the student body, if not to the faculty. Therefore assistance was built into the program. Foresight led to the creation of a moderate but still inadequate fund to partially subsidize the treatment of students who became disturbed during the course of their Seminary life. Assistance was thus built into the program, if for no other reason than to protect my time. The plan has worked out very well this year, and I have managed to protect my time from this type of incursion. This is of particular importance, since my family and I live in the Seminary community, in a faculty apartment within the grounds of and in a building belonging to the Seminary. It seems to me that it would have been most undesirable to become therapist to the faculty or student body.

I have not found the faculty to be either narrow-minded or intolerant toward our courses, nor have I found them to be simply pushovers who accept blindly the notions of psychiatry and psychology. On the contrary, they are open, fair and critical, in a scholarly manner. I think I have learned a great deal from them about both theology and the ministry.

For me personally, a major problem has been the need to teach a larger number of students than before. The pressure for personal conferences with students about theses, term papers, etc., is far
greater than that which I have previously encountered in teaching child psychiatry to residents and medical students. Another problem, whose ugly head has not yet really appeared is the serious need for clarification of roles, both for the students and for myself. The problem of defining the areas common to psychiatry and religion and those in which the two fields are distinct has been discussed at length. Chary of oversimplifications, we have tried a variety of approaches, assuming calculated risks in proposing new undertakings. We hope to add a social scientist to our teaching team next year in order to increase the breadth of instruction and to build additional, valuative skills for the Seminary, the ministry as a whole, and for our program in particular. Meanwhile our initial explorations have begun, but are not yet reported.

All in all, this experience has proved subjectively satisfying and seems to be leading toward a better understanding of the role of the clergyman in relation to the psychiatrist and also to a better understanding of the position of psychiatry in the world of ideas, persons, and institutions. Thank you.

Dr. Farnsworth: Thank you very much, Dr. Loomis. I can testify to the enjoyment you have been getting out of your work at Union Seminary. . . . Your talk reflects it.

Now we are going further back in one sense of the word and will ask our next speaker for some comments about a job on which he has not yet even reported for duty. Professor Hans Hofmann, Associate Professor of Theology at Princeton Theological Seminary, is Director-Elect of the National Institute of Mental Health Program at Harvard University. I shall ask him to reflect for us on some considerations that have been running through his mind during the period since he took the job and before he officially starts to work on it.

Professor Hans Hofmann: As you have been told, I have not yet had the traumatic experience of working in this field; and I therefore take the assigned topic quite literally, namely: to speak as a theologian about a future opportunity. Furthermore, I am not going to deal with a field which is indeed very exciting and promising, which pertains to the possible relevance of theological insights to the training and practice of a psychiatrist. I hope that one of your coming sessions will take up this topic.

At the moment, we merely state the fact that the ever-growing importance of psychotherapy has meant a real challenge to the ministry, to which I am not sure the theologians and pastors have responded quite adequately.

One reaction resembles very suspiciously the theological attitude toward the scientific and technological evolution in the last century. Partly they decry scientific findings as devilish when they did not fit into the theological or religious assumptions about this world. On the other hand, they leaned over backwards to prove that theology could be understood as an almost equally scientific system, only much deeper and by far more encompassing than science could ever be.

Another questionable approach on the part of the pastors toward the growing outreach and success of psychiatry consists of a "dilettantish" imitation of psychotherapeutic skill and practice in the realm of pastoral counseling in order to dress this up and channel some of the water passing to the psychiatrists back over their dams.

It is obvious to me that all such strategies, because of their utter defensiveness, are doomed to end in harmful confusion and a further lowering of the pastoral prestige in our time. I deplore this since it barricades an honest and constructive teamwork between theologians and psychiatrists.

This surprisingly insecure attitude of the clergy is most revealing. It seems that the psychiatric approach to the human personality and life has hit its religious counterpart between the eyes. The traditional and embarrassing weakness of the theological understanding of man lies in its inability to dovetail its doctrinal statements concerning the God-man relationship with its ethical and moral admonitions.

A two-fold predicament constantly threatens the doctrinal attempts. The absolute entity which we presume to be prior to everything else and whom we name God is in its very nature beyond the reach of our knowledge and rational concepts. Even less can we predict its intentions or actions. The natural result is that all theology can only testify retrospectively to what God has done in the past and speculatively to conclude from this His reality and consequent implication for the human understanding of the self and its place in this world. The persistent theological temptation is to cover the inevitable uncertainty and limitation of all religious
knowledge concerning God with insistence upon dogmatic infallibility and authoritarian demands.

This excludes, by definition, the flexibility necessary for taking into account the ever-changing self-awareness of man in different periods and places. For this reason, theology always fears the challenge coming from any secular understanding of man and nature, for this would mean “an agonizing reappraisal” of the religious concepts of God and man even where God Himself may be sovereignly untouched by any such changes.

The other aspect of the very same predicament, which in itself could be challenging and renewing, is the fact that any religious organization seeks to overcome its obvious vulnerability as a subject of worldly change through exempting its institutional character from any outside challenge. The church becomes the only and unquestionable source of any true knowledge of God and the salvation of man. Its tenets and liturgical forms are regarded as an “end all,” subject to belief without further inquiry or doubt.

It is self-evident that such an understanding of religion is unwilling to consider any understanding of man which does not begin with such a premise. But even more consequential is it that the moral and ethical regulations born out of authoritarian religious conclusions do not solicit the natural, vital incentive of human nature, but confront man solely with demands as conditions for his eternal salvation. Ironically enough, the advice for human conduct given by the church does not reflect true human concern but is suspended between theological speculations on one hand and an illegitimate abuse of human fear and pride on the other.

One cannot insist enough on the radical opposition to this which the ethos of the biblical writers voice, even where this calls for their fanatic and cruel persecution by the strange but powerful alliance between ecclesiastical leaders and moralistic perfectionists.

The unique characteristic of the biblical religious outlook is to subdue unconditionally religious insights and moral conduct to a life-awareness caused by an unshakeable confidence, independent of any personal self-evaluation or conditioning through the environment. Its rational and verbal expression as well as its impact on moral behavior and ethical actions are clearly secondary and fully subject to interpersonal re-evaluation in the community of human living together and do not claim any absolute or infallible qualities.

Surprising as it may sound, the God of which the Christian faith speaks is said to express His being different from any human “knowledge of God,” precisely by being more human than we would expect anybody to be or allow ourselves to be. We simply cannot afford to cast off our wishful and defensive images of ourselves and run the risk of being merely human. As C. G. Jung expressed it rather polemically in his Answer to Job, God reveals His divinity by becoming extremely human. As a matter of fact, the drama of God’s self-revelation in Jesus Christ receives its dimensions through its uncompromising collision with human religious self-glory at its complacent and rigid height. On such a level, man’s religious concepts excluded the possibility that God may be and appear contrary to our expectations.

The record of the New Testament persistently points out that it takes God’s own breath of life, otherwise known as the Holy Spirit, in order that any human being may conceive his existence as related to and renewed by God’s lively dwelling in him.

The permanent religious temptation of man arises where he perceives such a God-related self-awareness either as a constitutionally integral part of his own personality or the magical and sacramental gift of a religious institution. Or then, we pervert the God-given confidence in life into a goal and achievement toward which we have to strive in order to be “good” and acceptable before God and man.

Hence, the task of theology lies clearly before us. It is not to produce religion or petrify religious beliefs in thought systems and moral rules. On the contrary, its constructively negative assignment calls for the constant razing of religious superstructures to their still vital foundations, the realistic self-expression of man in his awareness of the working of God in and through man.

Its constructive duty consists in assisting and guiding the human attempt to clarify and express man’s creative God-awareness without permitting him to use this as an escape from honestly facing his human situation and predicament.

From here, it does not take too much to realize the tremendous relevance of psychiatry for the work of theologian and pastor alike. Not only does it point out the neurotic tendency to use religion as a substitute for free and courageous living, thus facing appropriate responsibility for one’s own existence, it also lays bare
the destructive attempt to abuse "mother church" for the sake of avoiding mature adulthood.

Far beyond this, psychiatry seems to become gropingly aware of the fact that life has its own precise birthplace, structure, meaning and goal. The exciting discovery of such indications and their implications may sometimes tempt psychiatry to see itself almost as another or pseudo-religion.

You may have the problem of the identification of scientific findings with truth, unable to see that truth is much rather an event where I am set free to become true to another person and allow another person to become true to me. If you have the problem of confusing experiment with experience, surely we have this problem, too, as theologians. We confuse theological concepts with truth and our own life awareness with absolute reality.

The challenge between a vital and realistic theology and an honestly searching and flexible psychiatry might well be a mutual one. I only dare to point out to you how much psychiatry, with its keen insights into what constitutes the causes for the deterioration of appropriate human self-awareness, as well as in its ability to use such psychopathological findings for reconstruction of the human personality, is extremely relevant for the theological understanding of man. Needless to say, the theologian who listens sympathetically to the psychiatrist's conclusions about human nature will be less tempted to fabricate an understanding of man in the vacuum of his own speculations. He may even discover that the human self-revelation of God may use psychiatric findings to reform our theological ideas of the God-man relationship.

A minister who again finds his natural place and decisive function in human living together, where the genuine pastor will be respected and can never be replaced, can base his self-respect on a realistic consciousness of his unique task. Then, he will welcome teamwork and sharing with his psychiatric colleague.

At Harvard, we hope to further a basic and sensitive concern for the true nature of man before God in our time. We shall welcome the possibility of creating a forum where any inquiry into human self-awareness and its implication for this world can be approached from many different facets in mutual respect for their uniqueness. Ours is not to smear over necessary differences nor to synthesize abstract systems. We must bear together the challenge which comes to us from others wherever we overstep our due limitations and lose ourselves uncritically in our own thoughts.

Dr. Farnsworth: In this change of pace from the theologians to psychiatrists we will now go back to the psychiatric point of view. Our own Dr. Roy Astley will talk on "A Psychiatrist Balances Objections, Needs and Possibilities."

Dr. Royden C. Astley:

I. Introduction

It seems to me important to emphasize at the outset that I am speaking primarily as a medical psychologist; for actually it has been the development of the psychologic aspects of psychiatry, worked out first in the ill, and then applied to personality development in the healthy, that has brought about the phenomena of attraction and repulsion between psychiatry and religion that we are here to consider today.

Some basic assumptions in my point of view should be made clear:

A. The first of these is that psychic phenomena—motivation, ideas, affects, attitudes, behaviour—can be elucidated in terms of an unconscious. This is not to say that they can be completely elucidated, for just as research into the nature of the universe, microscopic or astronomic, finds an ever receding frontier, so does research into the psyche. It does mean, however, that what a few decades ago might have been considered a cause of behaviour can no longer be assigned that role as it used to be understood. To anticipate a bit, this would imply that if some transcendental influence were brought yesterday to have prompted a piece of behaviour or an attitude, it would today seem clear that the given behaviour or attitude was prompted by unconscious motives—although it still would remain possible that transcendental influence played a part as far as these unconscious motives are concerned. At the very least, if transcendental influence is not obviated, it has become more remote.

B. Other basic assumptions are that man is capable of increasing his understanding of himself as well as of others; of resolving unconscious conflict; and accepting conscious conflict, uncertainty, or renunciation. Such assumptions imply that suf-
Suffering due to unconscious conflict can be diminished by psychiatric treatment, and that, generally, when it is thus diminished, the capacity to find gratification is enhanced. Reality factors will dictate how and where this amplified capacity may be utilized; but, in any case, the number of possible alternatives is increased and the individual has become less blind to his own wishes and needs, and to ways of satisfying them. When he is in this condition, we say he has insight.

C. Implicit, I think is another assumption; namely, that suffering which I mentioned first in connection with unconscious conflict, has three sources:

1. Reality.—Mankind has always had to contend with an apparently modifiable but basically inescapable quantity of suffering imposed by reality. This includes suffering caused by such intensely personal realities as unavoidable illness and death; and also that occasioned by earthquakes, cyclones and other natural disasters, accidents, etc. In the western world, the ravages of illness can be diminished, and the dangers of the environment remarkably lessened, but an inescapable remnant will always remain. Death can sometimes be postponed, but is eventually inevitable.

2. Civilization.—There is nothing at all new in the concept that socialization involves privation, frustration, and suffering. Marcuse’s “Eros and Civilization” attempts to suggest that the quantity of pain from this source may perhaps be diminished more than has heretofore been thought; in any case, however, it is inevitable that a minimal quantity will remain. If it actually does occur this process of diminution must be so slow that none of us sitting here now could hope to live to see an appreciable change.

3. Emotional Illness.—Neuroses and psychoses, based upon unconscious conflict during the relative weakness of childhood, cause great suffering. Psychiatry asserts that this variety of suffering can, in a fair number of individuals, be all but completely done away with—that is, people can be “cured” of such illnesses. It seems possible that as knowledge and skills increase, more kinds of emotional illness will become curable. Moreover, we are beginning to know some useful things about prevention, and there is hope of greater knowledge to come.

At present our attempts to alleviate suffering by adjustment of reality factors often ricochet or boomerang: cars, which improve transport, kill children; idiots, thanks to good pediatrics, survive; and dams burst. Social change is very slow. Even if psychiatry should remove all neurotic suffering, we would be left with what Freud referred to as “the unhappiness common to mankind.” Man must accept this as inevitable; but he can seek relief from various sources—work, art, drugs, or religion.

These, I think, are the basic assumptions of psychiatry.

II. Objections

I come now to objections to some early attempts at cooperation between psychiatry and religion. Some of these are general and some quite specific.

I wish first to contrast the modes of approach to suffering of, on the one hand, psychiatry and, on the other, religion. The basic assumptions that I have already mentioned are not derived from introspection, but from research done in the spirit of scientific inquiry which has always served to forward the practical effectiveness of medicine. The approach of religion is different. It assumes not only rational, but also irrational, undemonstrable causes for suffering, deduced and held to be faith, or derived from authority. It offers explanations of things that are beyond the frontiers of science. It entertains and defends ideas and beliefs about existence before or after this life and about ultimate causes, and absolutes. It strikes me that in matters of faith, or belief based upon faith, religion attempts to obviate skepticism—to be rid of it; while science thrives on skepticism and would die without it. This basic difference has not always been clearly mentioned and is one reason for difficulty in early attempts at cooperation, for parties in each group have misunderstood both their own position and that of the other fellow and have misused their own data and the data of the other fellow. You can no more prove or disprove a theologic argument based on faith, by one science than by another. Psychiatry can no more be used to support or destroy a theologic argument than can astronomy or chemistry or physiology. The levels of discourse are different. In mentioning this contrast, I have of course in mind the disparate uses that the psychiatrist and the clergyman (who here symbolizes the person with the religious approach) might make of psychiatric data.
To begin with, both are interested in helping suffering man, but they see different causes for the suffering. The clergyman, often poorly trained in the scientific approach, is likely to pick up the new data eagerly. He may attempt to incorporate them into his system of belief in a fashion damaging to both; for example, by assuming something demonic about the concept of the death instinct and something divine about Eros, with no good way to account for the necessity of their fusion. Or, avoiding that error in attempting to ally himself with the psychiatrist, he may prematurely exploit the new data only to get into semantic difficulties with words like love, superego, conscience, etc. Worse still, the clergyman may attempt to use ideas or techniques in his work with parishioners before he has acquired an adequate understanding of them or of their significance. This makes for an over-facile and superficial approach which tends to by-pass more difficult, but not less important, concepts. Further problems arise when scientific data or techniques are used without adequate comprehension of their applicability or probable results.

Now of course one reason for the clergyman’s interest in psychiatry lies in the fact that the psychiatrist, in finding psychologic means for curing certain types of suffering, has seemingly stolen a quantity of the clergyman’s thunder. I repeat seemingly stolen. If I were a good medical historian, I could be sure; but in any case, I suspect that there have been times in the past when members of the clergy have felt bereft by virtue of medical progress in other areas. It is certainly true that character disorder, when it becomes a psychiatric “entity” and problem, moves somewhat away from its previous position in the orbit of theology. The clergyman remains interested in the man, however, and therefore tends to be interested in character disorder and its management. The same can be said of hysteria or schizophrenia. Consequently, the clergyman may well say to the psychiatrist, “Let me help, too.”

This attempt at cooperation can make for trouble. Not only does the clergyman carry his theologic concepts with him; he is likely also to be satisfied with relief of distress that is short of cure. The psychiatrist sees this as a dilution of psychiatry, and reacts with anger and criticism. This “dilution” may be increased by the adduction of specifically religious techniques, such as prayer, admonitions and exhortation. If the clergyman were to disavow such usages entirely, the psychiatrist would see in him only a layman attempting to be something of a psychiatrist.

More realistic and more cautious clergymen have avoided unwise attempts to work after the fashion of psychiatrists; but even these individuals may injure or betray the cause of religion by over-enthusiasm for psychiatric theory or by overestimation of the promise of psychiatry. Psychiatrists must share the blame for the fact that their specialty has been oversold; but the clergy need to be surer than they now are of the ways in which psychiatry can probably be effective. In this regard, they are certainly not different from other nonpsychiatrists, but their desire to help sufferers may lead them to expect more from psychiatry, both qualitatively and quantitatively, than it can give. The psychiatrist finds this exasperating.

In addition to the sober, but courageous spirits who are willing to try to work in conjunction with the clergy, the ranks of psychiatry contain individuals who, with little wisdom and less judgment, have tended to move into the churches, as it were, and to encourage the clergy toward psychiatric work without suitable preparation. When this happens, good psychiatrists can only deplore the fact that lack of adequate training and supervision permits anyone to offer to sick people the quality of care that results. Sometimes we feel it would be better to throw the baby out with the bathwater than to risk repetition of the fiascos which have followed this practice.

I have implied throughout that, in terms of a risky generality, the clergyman is concerned with the relationship of the soul to God, while the psychiatrist is concerned with working out the relationship of his patient to himself. The clergyman has always been taken up with the whole man, for he sees the body as the temple of the soul, and the mind as something of a reflector of the soul. When the clergyman steps away from his primary concern about the soul, however, he denigrates his own calling. There are, of course, people who for one reason or another doubt the existence of a soul or of God; but not the clergyman. If concern about the soul be his main business, he lessens his dignity and his efficacy if he removes himself from it. Although the objections I have mentioned touch frequently on this problem, the fact that the clergyman is legitimately interested by inference in the whole man leaves room for true cooperation.
After this sketchy outline of objections, I would like to move on to an equally sketchy listing of where the needs seem to lie, and of the possibilities I glimpse.

III. Needs.

The first need is for better communication. Scientists who have worked in interdisciplinary seminars know that a couple of years of talk are necessary for mutual understanding. When discourse is on different levels as it is in religion and psychiatry, communication is particularly difficult. The differences between religion and psychiatry seem to me to be very real, and therefore to require clarification and not devaluation. A clergyman who was primarily interested in counseling, once agreeably told me that he couldn’t see that anything he could do was different from what I could do. My private reaction was that then he had no business to be a clergyman, that he was, at best, a clinical psychologist. Some psychiatrists might say that, since he did good work as a counselor, it would be well if others of the cloth followed his example, because then religion would have disappeared from the clergy and no problem would exist. I cannot agree. Other religious leaders would arise, so it is better for us all to see, as precisely as possible, where we stand.

Another real need is for psychiatrists to acquaint themselves with the devices, techniques and literature of religion. These constitute a rich social and historical storehouse of ways of dealing with human feelings and behavior, however much one may question their supernatural basis. By this, I do not at all mean that psychiatrists would necessarily profit from learning or from “getting” religion. I am sure, however, that they can learn much from what religion has advised or done. The usefulness of mourning rituals will serve as one example of what I mean.

As Earl Loomis has already pointed out, the psychiatrist and the clergyman need to be able to talk intelligently together about the human mind. This requires education in terms of personality development, psychopathology, and techniques of interviewing. It is necessary that enough knowledge be imparted, in one way or another, to make the clergyman thoroughly competent in his legitimate spheres of counseling; knowledgeable about seeking consultation; and unwilling to attempt what he is not qualified to do.

There is need for psychiatrists to learn more about the religious aspects of their patients’ beliefs and attitudes, and whence they arise. Whether one views them as symptomatic or not, the psychiatrist should treat them with reasonable respect. I suspect, also, that there are certain aspects of theological thinking with which the psychiatrist would do well to become acquainted. If these are regarded, when he encounters them, as poetry and nothing more, at least the psychiatrist has made the acquaintance of another art form.

There is need for adequate clarification of the clergyman’s area of competence as counselor. Unless responsible psychiatrists assist, this can never be accomplished. Pastoral psychology is here to stay, and we may as well help make it useful.

There is need for the clergyman to become satisfied with his own role. I suspect that the psychiatrist can help him do this by insisting that he remain in his own domain, behaving as a well-informed clergyman, not like a half-informed psychiatrist.

There is need for the psychiatrist to learn to avoid theologic pronouncements. Nothing in his science fits him for theological discussion. As a private person he may hold opinions; as a psychiatrist he must not. This is a hard dictum that is hard to follow. The psychiatrist has every right, however, to look at and study religion from a psychiatric viewpoint, just as he might regard and study art, surgery, politics or communism. To do this, he should have some acquaintance with his subject matter.

IV. Possibilities

I see possibilities in four senses:

1. There is much to be gained from continuation of such ambitious pilot programs as those at Harvard, Loyola, Union, and Yeshiva, with reports in psychiatric journals to meet the needs described. It is to be hoped that other comparable studies will follow.

2. I glimpse a rich source, for psychiatry, of able, willing people who are in an excellent position to do not only the job of religious work which psychiatry cannot do, but also to deal with certain psychiatric problems so well that they need never reach the psychiatrist.

3. I envision a scholarly and acceptable definition of roles, not without skepticism on the part of psychiatry, which must be
skeptical, but without rancor or pussyfooting on either side, and with lessening of prejudice on both sides.

4. Finally, I see the possibility that serious psychiatrists and clergymen, each in his own role, may experience with increasing richness the pleasures of cooperation as they work to diminish the suffering of mankind.

**Dr. Farnsworth:** The discussion will be started by Father William C. Bier, S.J., of Fordham University, who is on the Advisory Council, National Academy of Religion and Mental Health, Associate Professor of Psychology, Fordham University, and Executive Secretary of the American Catholic Psychological Association.

**Father William C. Bier:** I should like, initially, to express my appreciation of being invited to inaugurate this morning’s discussion. I have had some anxiety about this assignment, mainly because I could have no opportunity to see, beforehand, the papers to be given. I am enough of a psychologist to face rather than repress such anxiety. When I verbalized my concern to Dr. Ginsburg and Dr. Farnsworth, they both attempted to reassure me. Now, I find myself less anxious because of the obviously friendly atmosphere in which the discussion is being conducted, and because of the opportunity for subsequent editing. You will understand, however, that my remarks are necessarily rather informal. I know that you will accept them in such a spirit.

First of all, I wish to say how sincerely impressed I am by the fact that GAP would plan a panel discussion of this kind. I have been aware for a considerable time of the interest of some clergymen in psychiatry, but the formal interest of psychiatrists in religion, at least to the extent of considering it at a professional meeting such as this, seems to me to be a more recent development. I have therefore been more interested in the remarks of the psychiatrists on the panel than in those of my fellow clergymen. I had some concept of what the clergymen were likely to say, but I felt much less able to predict the attitude of the psychiatrists.

As an approach to a mutual problem, I find the remarks of both Dr. Astley and Dr. Loomis tremendously encouraging, especially those of Dr. Astley, because they represent the viewpoint of a number of psychiatrists.

In looking over my sketchy notes on the papers presented, I discern two common threads. I will mention each in turn.

The first thing that strikes me in the remarks of all of our panelists is the great promise for forward progress in cooperation when clergymen and psychiatrists actually work together. As I see it, this progress is evident in the various programs mentioned. Dr. Loomis remarked that he was initially a little uncertain of what the theologians were going to do to him. I can reciprocate, and assure you that many clergymen are more than a little uncertain of what psychiatrists might do to them. Consequently, it is a tremendous forward step to get the two groups working together—a step which in practical value is second to none. This step has been taken in Dr. Loomis’ work at the Union Theological Seminary. I think it is also one of the important features of the three N.I.M.H. programs currently being conducted for theological students at Yeshiva, Harvard and Loyola. The fact that these programs are scheduled to run for a five-year period, means that these groups will be working actively together over this relatively extended length of time.

My own experience has been sufficient to indicate to me the tremendous value derived from the active cooperation of clergymen and psychiatrists. Rabbi Hollander made passing reference in his paper to one project with which I have been intimately associated, namely, the Institute for the Clergy on Pastoral Psychology conducted at Fordham University. This Institute was held for the first time in 1955, and will be repeated again in June of this year, with subsequent repetitions in alternate years.

I have had a more limited connection with the Pastoral Psychology Workshops conducted each summer since 1954 at St. John’s University, Collegeville, Minnesota. These Collegeville Workshops are open to Clergymen of all faiths (as is the Fordham Institute) and have a faculty composed almost entirely of psychiatrists. I am happy to note the presence here today of several psychiatrists associated with these workshops—Dr. Appel and Dr. Bartemeier, who have participated at Collegeville in the past, and Dr. Loomis and Dr. Farnsworth, who are scheduled to appear at Collegeville this coming summer.

Those who participate in this sort of undertaking find that it is a tremendous learning experience, and that it is, moreover, a two-way learning situation. Psychiatrists have acknowledged to me
that they learned as much from the experience as did the clergy-
men who were presumably the students. This is a very solid kind
of learning; it is education in fundamental human understanding
and cooperation. In terms of the problem in which both groups are
interested, nothing is more valuable than such an experience with
a frank interchange of views. All the programs mentioned by the
speakers this morning have had this element of cooperation in
common, as does, indeed, our current discussion. When everything
else is said and done, this is the kind of experience which we need
so much, and which holds such fruitful promise.

I suppose I may refer here to the 1956 Presidential Address
of the APA by Dr. R. Finley Gayle entitled, "Conflict and Coopera-
tion Between Psychiatry and Religion." You may recall that Dr.
Gayle described the present status of the relationship between
psychiatry and religion as one of "peaceful co-existence." He fur-
ther characterized it as a kind of live-and-let-live situation, in which
we occasionally get together to express our mutual admiration, and
then go our separate and distinct ways. Dr. Gayle suggested that
we should be ready now to move gradually from this state of
peaceful co-existence to one of active cooperation. I discern, in a
meeting such as we have this morning, an indication that we are,
indeed, beginning to move into a phase of more active cooperation.
I wonder whether ten or fifteen years ago a group of psychiatrists
would have sponsored the kind of a discussion we are having
today?

The second point to which I should like to draw your attention
has been touched upon in one way or another by each of the
panelists this morning. It is the question of differentiating and
clarifying the role of the clergyman, of the psychiatrist. It is evi-
dent enough why each speaker in his own way felt drawn to say
something about this matter, because it intrudes itself into any
discussion of the cooperation between psychiatry and religion.
If we are to work together, we must specify what our roles shall be.

It seems to me that our discussion of this point can begin on
common ground. I assume that we can all agree that the roles of
psychiatrists and clergymen differ, and that any obscuring of the
difference would be disadvantageous. The role of the psychiatrist
should not be confused with that of the clergyman or vice versa.
Even though our speakers this morning would agree with me on
this point, it would be a mistake to assume that this is an attitude
universally acknowledged among clergymen and psychiatrists. The
history of the interrelationship between these two disciplines indi-
cates with sufficient clarity that differentiation of the roles has
not always been recognized. Part of the difficulty that we are
trying to work out and to move beyond arises from the fact that
certain psychiatrists and certain clergymen have not observed
the legitimate limits of their respective roles. It is these role-
jumping representatives from both sides who have held back, for
more than a generation, the cooperation between religion and
psychiatry. Separateness of role, then, seems to me to be a neces-
sary premise for any genuine cooperation between the two disci-
plines — but something more is needed.

Attempting to define the next step in the collaborative process,
I am inclined to suggest that it be a recognition of the fact that
differentiation of role is not to be understood as exclusive. In very
general terms, it would seem to me that we want clergymen to
have at least an understanding of and respect for psychiatry and
psychiatrists. More than this cannot be realistically expected of
the average clergyman. The Institutes we have mentioned aim to
develop in clergymen such attitudes toward psychiatry. Distinctly,
they give no comfort to the clergyman who would think of himself
as an amateur psychiatrist. There is just as great a need to develop
in psychiatrists an attitude of sympathy for religion, and an under-
standing of its role in the lives of their patients. Only when we
have in both camps a sizable group which has this tolerance, if
we may call it that, this basic understanding and willingness to
work with the other group, only then, I think, are we going to
achieve a substantial degree of collaboration between religion and
psychiatry.

In a meeting such as we have this morning, I think it is possible
to make a further point without fear of being misunderstood. It
has seemed to me for some time that clergymen are considerably
more willing to learn about psychiatry than psychiatrists are to
learn about religion. There are undoubtedly many reasons for this
state of affairs, some of which would occur to you as well as to me.
Since it is impossible for us to attempt to probe these reasons at
the present time, I must content myself with a mere reference to
what I believe to be an unquestionable fact. I want, however, to
ask this group whether anything can be done by those who
wish to improve this state of affairs. I have been so tremendously
impressed by the value of various Institutes in promoting an understanding of psychiatry by the clergy, that I wonder whether something comparable cannot be done to give to psychiatrists a better understanding of religion. I think that the corporate expression of concern for religion by a representative body of psychiatrists would be very valuable, quite apart from the personal significance it would have for the participants themselves. The NIMH program, aimed at bringing psychiatric concepts into the theological training of clergymen, suggests the possibility of a parallel program aimed at bringing religious concepts into the training of psychiatrists. Would it be altogether impossible for some psychiatric training centers to pioneer in teaching psychiatrists about religion? You can answer this question better than I can, and I am content merely to propose it as a possibility.

I have a final consideration in this connection. I have been emphasizing the importance of differentiating between the roles of the clergyman and the psychiatrist. It has always seemed to me that clergymen turn to psychiatry basically because they think that psychiatry may help them achieve their religious goals. When the clergyman turns to psychiatry, either in search of insight into his own work, or to obtain skilled help for his parishioners, he does so within the framework of his religious goals. Psychiatry becomes an additional resource which the clergyman can enlist, as need dictates, in his attempt to provide religious ministration for his people. It seems clear to me that the psychiatrist who would resent this clerical attitude toward psychiatry, this “use” of it in the service of over-all religious goals, would not be able to enter into fruitful collaboration with the clergyman for the benefit of a third party whom both would be anxious to help. It is the fear of not finding this kind of over-all sympathetic treatment of religion which has prevented many a clergyman from making a psychiatric referral even when he thought that psychiatric help was needed.

It is unquestionably true that for many people religion gives life a purpose and a meaning. To this extent it can be a substantial contribution to mental health. Consequently, the psychiatrist too can “use” religion in his therapeutic work, as many have done. To my mind, it is just as unreasonable for the clergyman to object to this use of religion by a psychiatrist, as it is for the psychiatrist to object to the use of psychiatry by the clergyman. The psychological value of religion is genuine, but it is not the exclusive value nor the chief value of religion.

As all of us have come to realize in recent years, mental health is a problem too big for the psychiatrist alone and too big for the clergyman alone. It may even be too big for both combined. There seems little doubt that the only really effective approach to the problem of mental health is through collaboration which will draw ultimately upon all pertinent community resources. We have been concerned this morning only with the contribution of religion and psychiatry, and have said that these two disciplines should make a collaborative and as far as possible a coordinated approach to this problem. The contribution of the clergyman will be largely in the realm of prevention of mental disorder, where he can make a substantial and frequently a unique contribution. The chief contribution of psychiatry will always remain in the realm of treatment and cure. These are strictly medical in character, and are necessary, once preventive forces have proved ineffectual. A meeting such as we have had this morning gives promise that we are working toward such a collaborative goal.

In conclusion, I wish to congratulate the panel members on their substantial and valued contributions, and thank CAP for bringing all of us together.

Dr. Farnsworth: We are now ready for discussion from the floor.

Dr. Clemens E. Benda: Listening to this symposium, I am somewhat surprised at how cautiously the psychiatrists justified their relationship to religion, and how defensive most theologians seem to feel when confronted with psychiatry. From my long and close association with theologians, I am convinced that psychiatry has much to offer the student of religion and theology. Never in the history of man has the knowledge of human drives and motivations been on surer scientific ground. In the dynamics of the psyche, we see a progress similar to that which occurred in the physical sciences as physical laws came to be understood. We have learned to what extent human actions and reactions are determined by emotional factors which, in turn, are determined by the life history of each individual. Man lives primarily in the cage of his emotional experiences, and is not able to break the bars of this cage
except through the guidance of other individuals who provide a new viewpoint and help change unconscious reaction patterns.

The education and spiritual development of man was entirely in the hands of the Church in the earlier part of European civilization, and the clergy was, therefore, in a central position. In the centuries following the Reformation, personality development became increasingly a matter of education. Humanistic ideas of development superseded the older religious ideas. With the decline of religion and humanism at the turn of the century, the psychiatrist has moved into a unique position. He is now the recognized, scientifically trained expert on personality development and is expected to fulfill all functions previously divided among clergymen, educators, parents, and other agencies. If we now attempt to re-establish a relationship between psychiatry and religion, it must be recognized that long-range planning is necessary. At this moment of history, many patients cannot accept what religion has to offer. These individuals consider the psychiatrist to be the only firm reliance in the ocean of emotional currents. Therefore, the present role of the psychiatrist seems to be to make it possible for the patient to interact with his social and cultural environment.

The message of religion is love, but the message of love, whether it comes from the Church or from the psychiatrist, sounds empty and often ironic to those who have never experienced love. It is therefore extremely important that the clergyman understand the dynamics of personality development; why even his best intentions may be so completely rejected; and why he needs to know so much about human beings before he can break through the wall that separates him from many of his parishioners.

Psychiatry can learn a great deal from theology, not only in the sense mentioned by Dr. Astley that psychiatrists may adopt some of the healing techniques with which religion has had such long experience. Psychiatrists have consistently confused religion and the ontology of religious values with the psychology of religious persons, or rather with the pseudo-religion of psychiatric patients who use religion as a crutch in their psychological make-up. Practically all psychiatric literature on religion goes back to Freud's work. He depended almost exclusively on the rationalistic ideas of the nineteenth century as expressed by Feuerbach, Renan, Nietzsche, and others. These ideas are by no means the outcome of "scientific" research, but are rather the uncritical application of rationalistic thinking to unsuitable subjects. The whole idea of the genesis of religious values as derivatives of social conveniences, taboos, and projections is a mistake. We are gradually coming to understand that the system of values in any culture is deeply rooted in the religious thinking of the time. This religious framework is an autonomous creation which transcends the particular sciences and can never be understood through one single science like biology or psychology.

Modern psychiatry has much to say about natural needs, drives and biological motivations. By considering all human values to be sublimated biological needs, it deprives the world of understanding of cultural and religious systems. Cultural anthropology has recently called attention to the autonomy of cultural values and has shown how civilizations revolve around a central theme which is not derived from biological needs but is created by the specific culture. Cultural anthropology has, however, failed to realize that the central cultural theme of a given civilization is rooted in the specific religious concepts of that civilization. Religion is not an afterthought or after-phenomenon of a culture, nor does it merely serve to satisfy some emotional needs that cannot be gratified by scientific endeavors. Religion deals with the frontiers of human existence which border on death, illness and destiny. As long as human beings question the meaning of life and are confronted with the reality of illness and death they will try to comprehend those realms of existence in which human life transcends rational understanding. It is easy to show that human morality and ethical laws are not the outcome of some rational regulations but rest upon religious beliefs. As far as it is concerned with psychosomatic illnesses, psychoses and emotional disturbances, psychiatry can proceed without touching upon religion. As soon as psychiatry is confronted with problems of character, personality, maturity and the meaning of life, it becomes clear that these questions can only be understood within a framework of values which has developed from religious beliefs.

The concepts which the nineteenth century bequeathed to our generation evaluate psychological function as a device for staying out of trouble, avoiding frustration, finding pleasure and happiness, and avoiding collisions with the environment. Those who consider this a poor framework for living and see in life some meaningful
deployment toward a final goal must realize that these life values are rooted in ideas and beliefs that deal with man as a creature confronted with a cosmos beyond his own power. Only when psychiatry is aware of the fact that the realm of human relations organized in religion is as real as the interpersonal relationships studied in psychology, will psychiatrists and clergy be able to build together a sounder framework of human understanding.

**Dr. Matthew Brody:** As a clinician I should like to express a protest against a widely held misconception, namely that psychiatry is atheistic and that psychotherapy makes atheists of many patients. I think that patients who enter treatment take certain calculated risks as far as their religious beliefs are concerned. Some become more and some less religious than before treatment. The psychiatrists’ objective is to help this patient achieve mental health and normality, whatever that may be.

In my contacts with members of the clergy I have often encountered an unconscious or pre-conscious concept of demonology as a cause of mental disorders— a feeling that if a person really had faith, if he really prayed, he would never become mentally ill and that if such a person did become ill it was the devil’s work and he should have prayed harder instead of visiting a psychiatrist.

I firmly believe in the usefulness of workshops for the clergy with psychiatrists in attendance. I think the best way we can learn about each other’s work and get help from each other is through mutual consultation.

**Dr. Grete L. Bibring:** I would like to return to questions of a less general nature, such as those raised by Rabbi Hollander about the practicalities of future cooperation and to say a few words as to his request that psychiatrists should help to delineate what theologians might use in their work.

I do not think that the psychiatrist, who is not a theologian, could delineate this material for the clergyman. But he can avoid doing certain things which Dr. Astley pointed out so clearly, namely, to go into the field of theology and, without really having this as his explicit goal, trying to teach what is quite specifically psychiatric knowledge or technique. Not to do this demands a lot of careful and new thinking on the part of psychiatrists. There is an area of teaching which perhaps Rabbi Hollander will find helpful. It is a growing area which has not been adequately named yet, which is sometimes called limited psychotherapy, superficial psychotherapy, short term psychotherapy and sometimes counseling. It is a matter of skill and knowledge based on insight into deeper psychological processes but it is not in any way restricted to the function of the psychiatrist. The field is not yet clearly delineated, it is growing and changing and much more has to be known about it for anybody including the psychiatrists.

The psychiatrist’s activities today cover a broad spectrum from treatment of the psychotic patient to these procedures which I just enumerated, consisting of advising, or directing, or helping an individual to find his way amidst inner and outer difficulties. It is this area which we will have to delineate: an area which is not restricted to the theologian, but is shared by the social worker, by the doctor whom we try to teach, he he surgeon or he an internist. It is a common area for all these professions and to a certain extent for the psychiatrist.

Psychiatrists still have a tendency, ever so often, to apply a kind of therapy which may be too extensive for the case thus treated. To find different methods appropriate for the different situations in which the individual has to solve his problems is the responsibility of those of us who are engaged in teaching not only psychiatrists but also other professional personnel to whom people turn in distress. A great deal of background knowledge is necessary in such situations in order to be able to recognize certain personality structures, in order to understand the specific need and the specific difficulty of each individual and in order to offer adequate help towards overcoming these problems. This counseling should result in directing a person towards self-recognition and towards his own solutions.

This is the area where the clergyman can gain from us though he will have to blend what he has gained with his own skills, just as the surgeon does who has learned from the psychiatrist to observe and diagnose what is going on in his patient before an operation, what kind of reactions one may have to expect from him in the postoperative period, and how one may offer the best possible solution to him.

**Dr. Leo Berman:** In a friendly and frank atmosphere such as we find ourselves this morning, I think it would perhaps be
valuable to have a few observations and comments directed by professionals toward their own professions. It is not fair that the psychiatrist should make observations only on the religionist and that the religionist should offer observations or impressions only on the psychiatrist. As has already been done a little by two psychiatrists today, they should offer observations on themselves.

I should like to pick up only one point, where I think some further thought might be useful. I am sure all of us would agree with Dr. Asløy’s point that in psychotherapeutic situations it is not proper, it is not good psychiatry or good analytic practice, to offer one’s own personal religious beliefs or philosophies to the patient. I think we would all agree upon that and upon Dr. Asløy’s point that whatever personal or private beliefs we have certainly deserve observation and expression in us as private individuals. If you look at this question a little more thoroughly, it gets to be more complicated than it sounds at first. I believe that each one of us, psychiatrist, religionist or whatever, inevitably has to have some system, some private ideology, let us say, to use a kind of neutral term, or system of beliefs, through which or by which we live. It seems to me that even if we try our darndest not to let this leak out during the psychotherapeutic session with the patient, it is going to manifest itself somehow or other, despite our best efforts, because it is built in as part of our personality. If one accepts this kind of observation as having some validity, perhaps one practical consequence might result. Would it be worthwhile to attempt to study the ideologies, or private beliefs, or Weltanschauung of the psychiatrists and analysts? Would then, the information learned from such an inquiry constitute another bridge of understanding with the religionists?

**Dr. Kenneth Appel:** I can’t help but see the contrast between the remarks today and the pronouncement made by GAP in 1947, which I think was a timid pronouncement: that psychiatry and religion could have a contact, and that they need not have any great antagonism; that we were for freedom and for the dignity of the human individual and for science and psychiatry and religion. The meeting today is entirely different. It attacks this problem from the point of view of exploration and study and experiment.

I believe there has been great progress in ten years. Someone has said that one of the diseases of our society is isolation, over-

specialization. I think that is so. We get involved in our ivory towers and do not have contact and communication with other disciplines, and we meet these communications and contacts with trepidation.

Here there is a path laid, a program outlined for communication, for contact, for exploration, for study. There is no dogmatism. There is effort at exploration. That is terribly important. It is terribly important for our American community. It is terribly important for our psychiatry. We have 100 million people who are said to be related to churches, related to religion. They somehow or other officially say they are interested in religion and have religious affiliations.

Psychiatrists have been timid in meeting and trying to help these people. I think it is awfully important for us to develop some sort of leadership in helping 100 million people.

I cannot help but think of another thing; namely, the figure that has just come to hand in the last two weeks really, of 400,000 divorces a year in this country. That means that in the course of the life expectancy of the American population, say 65 years at the present time, 70 million people are going through this experience. Seventy million of our friends, our relatives are going through such a stress. If that is so, and if there are 100 million people that have religious affiliations, I don’t know what the conclusion is, but I am sure it is a problem for those interested in theology and those interested in the process of helping people with their stresses and strains, which we call psychiatry.

**Dr. Hofmann:** I think I am still a theologian, but I would like to clarify just one point which may have been confusing. I am not against rituals or dogmas or anything like that, as such, but I do think that they must be life expressions; otherwise I do firmly believe that they are only stumbling blocks to real and vital faith. You may have your own ideas on that too. Furthermore, I do believe our whole discussion of it looked a little static to me, what we think our concept of faith to be, our concept, or, if I may use your word, "ideology." I don’t think that it is such a set thing. I think it must be a growing experience. As a matter of fact, I believe you have to get rid of the faith of your father and your mother, and your home church before it can come alive to you. In theological terms, you have to die to it and then it has to come
alive in you, and then it still has constantly to go through change. This I would call a living faith. Therefore don't look at religion as something that is there as a static thing. Thank you very much.

**Dr. Astley:** I suppose that I have one need to add to my list, and that is patience. The test seems to me to be easily talked about but enormous in its scope and in the quantity of energy involved. I think this is particularly necessary when it comes to the field of education. Here we deal with relatively young people, relatively immature people, who may have extremely strong feelings, or who may be very weak and timid and be very easily pushed around. The educational job for this reason becomes ever so much more difficult. Therefore patience has to be added to the list of necessities.

**Rabbi Hollander:** As Dr. Appel mentioned, there are 100 million people in our country who affiliate themselves with religion in one way or another. It is one of the functions of these three programs to develop the kind of orientation which will help clergymen help their people to live a better life. I sincerely hope, speaking for myself, that you will continue interest in this project that is going on now and will go on for the next five years. Thank you.

**Dr. Farnsworth:** If lack of time has prevented any of you from expressing thoughts that should be considered in a balanced presentation of these problems, I would suggest that you send them to me in writing.

*In response to Dr. Farnsworth's request, the following comments were received:*

**Dr. Florence Powdemaker:** The widespread interest and effort to effect collaboration between clergymen and psychiatrists is surely an indication of a need felt by both groups. This discussion, however, like others in which I have participated, has left me with a certain uneasiness which I have tried to understand in terms of the methods, aims, motivation and meaning of the collaborative efforts of psychiatrists and clergy.

It occurs to me that two diverse motivations and goals are involved here. As Dr. Hofmann described the plan for the Semi-
be that the psychiatrist and the clergyman, each unhappy and dissatisfied with the difficulty and failures inevitable in the task of changing lives, and lacking the sense of vocation which makes failure endurable and even acceptable, find themselves turning to the other for help in fulfilling their needs. Possibly I have made too much of the use of the word role. It may only be an evidence that we live in an age of hysteria as well as in an age of anxiety.

Religion gives a way of life; psychiatry is a branch of medicine which, it would appear from observation and reading, has been accepted by some as a way of life, or at least as a Weltanschauung, and this in spite of the disavowal by Freud of the possibility.

As an example of the former I might mention a young analyst who once said to me, “How can I be a good husband and father and an analyst at the same time?” The question has haunted me as possible evidence of something askew in the training of a psychiatrist that could be truly tragic. I surmise he was saying “How can I understand the dynamics of what is going on between my wife and child and me and still maintain a close relationship with them?” The inference, I take it, is that he, as an analyst, cannot live intimately with the understanding and empathy that comes from close relationships and that makes perception, understanding and response, spontaneous and “right”; rather, he relates through an intellectual process in which he observes, studies and applies what he has learned. The very process of training in which the trainees are expected by word and example not to experience any relatedness or any feeling (though it is being recognized that this is impossible) removes the possibility of an I-thou relationship in Buber’s terms, and makes for an I-it relationship. A lonely time indeed during all the long office hours! And if this is carried over perhaps unwittingly into intimate and social life, it is not to be wondered at if the analyst seeks to find out if religion has anything to offer that will give him what analysis either does not give, at all, or may make difficult to achieve. One wonders if at least some physicians, and possibly others whose profession and vocation is to help people do not seek to become related to people through their work, and thus without true intimacy which they may wish to avoid. It will never, of course, help the psychiatrist to bridge the gap in relatedness that he may feel by association with clergymen in committees, departments etc. but only through a personal religious experience.

On the other side, I recall a prominent clergyman saying to me, “I am seeing a lady five times a week for an hour each time. That makes me an analyst, doesn’t it? And you know, X (a clergyman on the staff of his church) is getting a Ph.D. in clinical psychology this June, and then he will start a clinic and be as well-trained and just as competent as any psychiatrist or psychologist.” The obvious question is why did either one of them become or stay clergymen if they so obviously wanted to function in another vocation, or what were the unrealized needs that were not being met in their own profession.

Perhaps because we know more we expect more of ourselves and others—perhaps too much—even the impossible of man in this age of physical wonders. But we also know that knowing cannot substitute for perception and experience but is part of them. Insofar as the association between the psychiatrist and clergyman is truly one of exchange of knowledge, it is valid and valuable; but insofar as each seeks through the association an emotional satisfaction (or a way out of a dissatisfaction, perhaps unconscious) apart from that given by added knowledge itself, the validity and usefulness might be questioned.
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The Group for the Advancement of Psychiatry has a membership of approximately 60 psychologists, 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 attempts to present the composite findings and opinions of its members only, guided by its many consultants.

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