IDENTIFYING THE EFFECTS OF RELIGIOUS PARTICIPATION
ON THE THERAPEUTIC TREATMENT OF
THE MENTALLY ILL

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IDENTIFYING THE EFFECTS OF RELIGIOUS PARTICIPATION ON THE THERAPEUTIC TREATMENT OF THE MENTALLY ILL

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By

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CHAPTER I

INTRODUCTION

The Christian religion has survived the early critical analyses of psychology, which sought to eliminate religion from the area of psychological study. Wundt and Titchener, the founders of the structuralist school in psychology, supported an experimentalist point of view in an effort to establish psychology as a science. A primary goal of these men was to free psychology from both philosophy and metaphysics and establish it firmly as a science (8). Religion, considered part of the area of metaphysics, thus was not a valid area for psychological research (10).

Freud was among the first to consider religion a valid variable for psychological study, as he wrote several books on the topic (6, 7). However, he came to feel that religion was not useful as an adjunct to psychotherapy because, based on his clinical experience, he felt that religion had an essentially negative effect on the development of personality.

Freud frequently wrote about religion, as he did in Totem and Taboo and The Future of an Illusion. However, authors such as Kagan felt that his theories about religion pictured it as an obsessional deterrent or unhealthy retardation of maturity (12). Freud developed the theory that the belief in God evolved out of the childhood father complex.
From this position he wrote that "a personal God is psychologically nothing more than a magnified father (9, p. 354).

Freud compared religion to a childhood neurosis in one book. He wrote that this "infantile prototype (6, p. 29)," as he frequently referred to his concept of religion, was the universal obsessional neurosis of mankind (6, p. 76). Its chief value seemed to him to be that accepting the universal neurosis spared the individual from "the task of forming a personal neurosis (6, p. 77)."

Freud took a clearly defined position with regard to the role of religion in the therapeutic treatment of the mentally ill. He wrote that "religion assuredly has no place in psychoanalysis (9, p. 448)."

Jung began to view religion in a more positive light, and focused his writing on the usefulness of religion in the development of personality. He asserted that a spontaneous religious experience is a normal and meaningful correlate of the individuation process (5). In supporting this positive approach to religion further, Jung made the following observation:

Among all my patients in the second half of life—that is to say, over thirty-five—there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that everyone of them fell ill because he had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook (11, p. 264).
Allport felt that mental health found its roots in the individual's beliefs, or his ability to integrate all conflicts around a central concept or sentiment. He placed religion in the category of a central concept, and felt that a mature religious person could act without the necessity of certainty to strive toward long-distance goals. Allport labeled this action a mature, productive religious sentiment. The religious sentiment, an interest-system within Allport's model of the individual's motivational life, produced conduct consistent with its nature. Allport's religious sentiment differed from other sentiments in that it was more comprehensive, as it aimed to join all experience into a single, meaningful system (1).

Ronaldson attributed to man a spiritual dimension of personality, which was present in the Erikson concepts of the senses of trust, autonomy, and initiative, or their opposites. Ronaldson wrote that this dimension manifested itself during the first five years of life in the parent-child relationship. The author saw two personality processes developing during these first five years of life, the first being developmental in nature, or essentially free, responsible, autonomous, and creative as a process and the second being historical in nature, a process based on the events and physiological changes developing as a result of time. She wrote that the spiritual dimension
emerged from the developmental process to be identified primarily in the person-to-person encounter and also in the person-to-thing encounter. Ronaldson supported Allport's contention that the religious beliefs were the integrating concept of the personality and asserted that the spiritual dimension is the integrative aspect which unifies the personality (18).

Other authors have lent further support to the usefulness of religion as a tool or adjunct in psychotherapy. Walters, writing that "defective reality testing invalidates the religious ideation of the schizophrenic," urged that clinicians should be familiar with "normal religious experience" in order to determine what is pathological religious experience (19). Mann suggested that religious values may be helpful to the patient if they are not imposed on him (15). Boisen, an ordained minister who became a psychotherapist, wrote that he drew heavily from his theological training in his therapy sessions. He felt that the real evil in mental disorder may be found in the sense of estrangement resulting from the presence in a man's life of some fact or event, imagined or real, which he is afraid to admit. He concluded that this evil may best be dealt with by restoring the individual to the fellowship of what one calls God (2, pp. 267-268).

Lowe also felt that religion had a useful therapeutic purpose. He opposed the position of Freud and other psychoanalysts that religiosity among psychiatric patients was an
attempt to substitute the primary process of autistic wish for the secondary process of social reality. He stated:

It now appears, however, that it is more promising conceptually to regard religion as being related to various functional needs than it is to cast it aside as being a symptom of psychopathology or as being a negative prognostic sign for recovery (14, p. 267).

Cortes viewed mental illness as a "frustration or distortion of the inner nature of man." Since he conceived the nature of man as being integrated into a whole, and that distortion of any part distorted the rest of man's nature, he concluded that man's spiritual needs will then always suffer during an emotional disorder, and that proper therapy cannot occur if these needs are ignored (4). Maves supported the Cortes model of the spiritual dimension, or, as he defined it, the spiritual needs of man's nature, in writing that fulfilling these needs is useful in preventing mental illness (16).

Religion, however, has been a concept that cannot be measured scientifically. Williams stated that the most frequently used measurable social index of religious faith or fervor was participation in religious activities, such as church attendance, frequency of prayer, and reading of the Bible (20). For this study religious participation was used as the index of religious behavior.
Statement of the Problem

This study is concerned with identifying the effects of religious participation in the therapeutic treatment of the mentally ill. First, the study attempts to determine if there is a difference in the amount of pathology revealed by tests between hospitalized psychiatric patients who are active religious participants and patients who are not active participants. Second, the study attempts to determine if there is a difference between the ability of psychiatric patients who are active religious participants and those who are not to recover from their mental illness. Third, the study attempts to establish personality correlates for active religious participants.

Statement of Hypotheses

The present study tests the following specific hypotheses:

I. Subjects in a private neuropsychiatric hospital who score high on the Religious Participation Questionnaire will stay a significantly shorter mean period of time than subjects with low religious participation scores.

II. Subjects with high religious participation scores will have significantly higher mean scores on the scales 1, 2, and 3 of the MMPI than subjects who have low religious participation scores.

III. Subjects with high religious participation scores will have significantly lower mean scores on the scales 6,
7, 8, and 9 of the MMPI than subjects with low religious participation scores.

IV. There will be a significant positive relationship between scales 1, 3, 5, and 6 of the MMPI and religious participation scores.

V. There will be a significant negative relationship between scales 2, 7, 8, and 0 of the MMPI and religious participation scores.

Definition of Terms

For this study it is necessary to define three significant terms. The terms are religious participation, pathology, and ability to recover.

Religious participation is defined as scores on the Religious Participation Questionnaire, first devised by Ligon and later used by Williams and Cole (13, 21). The scale is used to separate subjects into active and low participants in religious behavior. Scores above the median score denote more active religious participants, while scores falling below the median score denote less active religious participants.

Pathology is defined as classification of profiles on the Minnesota Multiphasic Personality Inventory into psychoneurotic and psychotic categories, the psychotic profiles indicating a greater amount or degree of pathology than the psychoneurotic profiles.

Defining pathology in the previously stated manner is based
on the theory that holds behavior as ranging along a continuum from normal to pathological, with psychotic behavior falling at the opposite end of the continuum from normality, and neurotic behavior falling in between. Mowrer, a critic of Freud's model of pathology, stated that the neurotic falls somewhere between the sociopath and the normal person (17). Coleman compared psychoneuroses and psychoses and concluded that the two categories overlap, with individuals frequently exhibiting characteristics of both (3, p. 12). Psychologists have frequently referred to clients in test evaluations as having a "psychotic break" or as being "borderline psychotics," thus indicating that the patients were in the process of beginning to exhibit some signs of psychotic episodes without indicating a great loss of reality contact or personality disorientation.

**Ability to recover** is defined as length of stay in the private psychiatric hospital used for this study. The hospital files showed both admission and dismissal dates.

**Limitations of the Study**

This study does not attempt to make generalized statements about the validity of religion's place in the clinical and psychiatric field. There are some limitations which prevent such broad generalizations. These limiting factors are the type and size of population used as subjects, and the use of religious participation as an observable index of religion.
The hospital at which patients served as the subjects of this study was a small private hospital in a large southwestern city. The hospital housed twenty-seven patients in a setting with no security and passes frequently available. The staff consisted of two psychiatrists, three psychologists, four intern psychologists, and an occupational therapist, so that treatment and supervision were daily and almost constant, and help was constantly available. The subjects came from similar family backgrounds. All were from the middle socioeconomic class, with no patients representing either of the remaining two socioeconomic categories. The use of religious participation as an index of religion has several difficulties. Primarily, religious participation is observable behavior phenomena, while religion is a phenomenological or abstract concept, and thus unable to be measured by behavioral observation. Secondly, participation in such "religious" activities as church attendance may be more strongly related to need for status and affiliation than to need for spiritual stimulation (20).
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CHAPTER II

REVIEW OF RELATED RESEARCH

The purpose of this chapter is to provide a brief review of the research related to the study. Articles dealing with the positive relationship between aspects of religion and personal effectiveness have been included in the research. Other research dealt with some negative correlations of these two variables. A third body of research attempted to establish personality correlates for religious affiliation and participation. The research further supported the validity of religion as a variable for clinical psychological research.

A portion of the research dealt with a positive relationship between aspects of religion and personal effectiveness. Bruder presented several case studies in demonstrating that religious faith is related to personal acceptance-rejection feelings by parents and others. He concluded that loss of faith in one's self and others is projected to loss of faith in God (3). Chambers found that students who were not affiliated with a religious group revealed possible conflicts between needs by their scores on the Picture Identification Test of Murray Needs. He concluded from the results of this test that students without religious affiliation
have more adjustment problems than other students. These problems centered around poor goal perception, and around conflicts over desires to be independent and to avoid responsibility for others (4). These findings coincided with those made by Wright, who found positive relationships between religious behavior and some personal adjustment indices. Wright measured the religious attitudes of college freshmen with the McLean Inventory of Social and Religious Concepts, and correlated the results with personal adjustment indices derived from the Heston Personal Adjustment Inventory. He found that women who were more confident were more certain of their religious attitudes. He also found that men who were more orthodox in their religious attitudes scored higher on McLean's Sociability Scale. However, Wright did find a negative relationship between adjustment in the area of personal relations and both religious attitudes and certainty. Those men who were less orthodox in their religious attitudes, and who seemed less certain of their attitudes, tended to score higher on the Personal Relations Scale. To explain this relationship, he referred to Heston's explanation of a high score on his adjustment inventory. According to Wright, Heston described a high score on the Personal Relations Scale as indicating that a person feels others are trustworthy, and is little irritated by others' behavior. With Heston's explanation as background, Wright concluded that religious attitudes and certainty were
negatively related to trust and acceptance of others (24).

Fein supported the positive religion-adjustment relationship in presenting data from a study of mentally ill and normal subjects. The data, based on amount of religious observance during childhood, accurately differentiated between the mentally ill group and the normal group ninety-nine out of one hundred times. Fein suggested that normal adults come from homes where religion was respected and observed, while mentally ill adults are more likely to come from childhood homes where religion was treated lightly or ignored altogether (7).

Brown and Lowe found a significant positive correlation between religious belief and adjustment among college students. Students who scored higher on the Religious Beliefs Inventory were found to have more optimism, greater social inclinations, and better family relations than low scoring students. The low scorers were found to be more pessimistic, more introverted, more anxious, and have interests more like those of the opposite sex than the high scorers (2).

A second body of research articles deals with some negative correlations between religion and personal adjustment. An article by Rosenberg suggests the probability of maladjustment when the individual's religious characteristics differ markedly from those of persons in his immediate environment. Such a "dissonant context," as Rosenberg referred to it, led to low self esteem, psychosomatic anxiety symptoms,
and depressive affect as indicated by scores on a ten-item Guttman scale measuring self-esteem and a six-item Guttman scale measuring depressive affect. Rosenberg used ten of the fifteen items appearing in the Neuropsychiatric Screening Adjunct used by the United States Army Reserve during World War II to measure psychosomatic symptoms (17). King found that religious participation gave college students a supportive sense of belongingness and direction. This positive sense of belongingness, according to King, had a detrimental or negative effect on students needing psychiatric help, as he felt that the students who were religious participants would be hindered from seeking psychiatric help until their emotional disorder was more severe than that of non-active students seeking psychiatric help (10).

Khanna conducted a study which also yielded a negative correlation between religion and personal adjustment. He attempted to relate religiosity, which he defined as consisting of faith in God, immortality, and the church, and rigidity in college students. Khanna used the Kirkpatrick and Stone's Scale to measure religiosity and several tests, including two subscales of the California Psychological Inventory, the Barron and Welsh Test, Cattell's Motor Perseveration Test, and the Anagrams Test to measure rigidity in beliefs, perception, motor abilities, and intellect. His study concluded that high religiosity was characterized by authoritarianism, ethnocentric orientation, inflexibility
in thinking, a preference for simplicity and symmetry in perception, and a tendency to have a stereotyped approach to problem-solving (9).

Other research found more negative correlations between aspects of religion and personal effectiveness. Kleiner and others divided subjects into high and low status groups on the basis of religious affiliation, Protestants being classified as members of the high status group and Catholics as being classified as members of the low status group. Results of a statistical analysis of the psychiatric diagnoses of Protestant and Catholic patients in Pennsylvania state mental hospitals over a five-year period indicated the presence of aggression and withdrawal symptoms and earlier onset of mental illness for the Catholic or lower status group. The researchers then concluded that the effect of religion on mental disorder was related to status (11). Riffel used a panel of priests to divide college students into a religiously scrupulous group, each of whom was characterized by the priests as having a chronic, excessive concern about the moral responsibility of his past, present, and future behavior; and a religiously non-scrupulous group, who did not show this chronic concern. The religiously scrupulous students scored significantly higher on the Religious Behavior Inventory. Their scores on the MMPI revealed general maladjustment, with most of the T-scores over seventy falling on the Pt, Sc, D. and Pd scales. Thus the non-scrupulous group was better
adjusted than the other group, which exhibited behavior that was compulsive in nature in the area of religion (15). A study by Broen that also used the MMPI as a criterion found that college students categorized as religious by scores on a religiosity index scored significantly higher than non-religious students on the MMPI Pa scale (1).

The author of one article used clergymen as subjects and found a negative correlation between personal effectiveness and religion as manifested by occupational choice. Rooney reviewed MMPI studies of clergymen and found T-scores above the seventy mark on several maladjustment scales; specifically, the Hs, Hy, Pa, MF, Pt, and Sc scales. Rooney attempted to dispel the conclusion that clergymen are poor in emotional adjustment by criticizing customary interpretations of the MMPI, especially that of high scores on the K scale indicating defensiveness. He referred to Kania's study as he pointed out that high K scores were positively correlated to such desirable measures as ego-strength on other inventories (16).

The majority of the articles reviewed deal with establishing personality correlates for religious affiliation and participation. Slusser divided Christian denominations into four groups: ecclesiastical, denominational, sect, and Roman Catholic. He then designated the Presbyterian, Disciples of Christ, Church of Christ, and Roman Catholic churches respectively, as representatives of each category. The
Presbyterian and Disciples groups scored significantly higher on the Abasement scale of the Edwards Personal Preference Schedule than the other two samples, and the Presbyterian and Church of Christ groups scored higher on the Edwards Affiliation scale. Because the results did not significantly differentiate the four groups, Slusser suggested that the importance of socialization practices varying by groups may be less than previously assumed (18).

Vaughan also conducted research on religious affiliation. He investigated the influence of religious affiliation on MMPI scores, administering the test to an equal group of Catholic and Protestant freshman college students. The Protestants scored significantly higher than the Catholics on the D, F, and MF scales. Vaughan applied a Chi-square test to the frequency distributions of twenty-four items with religious and moral conduct content that were a part of the scales where significant differences were obtained. He wrote that three items on the D scale particularly reflected a divergence between the two essential elements of Catholic belief, but which many Protestants believe may be accepted or rejected. The third involved religious practice. He stated that the Catholic experiences a moral obligation to attend weekly services while the Protestant is given more latitude. An affirmative response on the three scores lowered the D scale scores. He also wrote that differentiation due to items with religious belief content on the F and MF scales
was not as pronounced, but did warrant further research (23).

Another group of articles attempted to establish personality correlates for active religious participants. Ligon and Penrod wrote that the maturing adolescent who receives a religious education through participation in church activities and programs is provided with "catalyzers" useful in achieving his maximum potential destiny. They defined this maximum potential destiny in terms of developing a mature, well-integrated personality. The authors listed among the catalyzers the following: providing a climate for peer group thinking and developing skills for a dynamic tolerance of others (12).

Cooke attempted to relate religious behavior to perception of parents. Using Protestant college students as subjects, he found that groups of students scoring significantly high on a Protestant Manifest Religious Behavior Scale perceived their mother as being devout. The study also indicated that these same students tended to perceive themselves as more similar to both parents than non-religious students, and tended also to like both parents better (5).

Ranck developed and administered a fifty-item measurement inventory that included the Levinson-Lichtenberg and McLean religious attitude scales, authoritarianism scales, the Bernreuter dominance-submission scales, and several MMPI subscales. He found that these results indicated that religiously liberal subjects were more impulsive and had
more feminine interests than religiously conservative subjects. Ranck also found a significant relationship between authoritarianism and religious conservatism. He found that traditional family ideology had the highest correlation with religious conservatism as well as the greatest predictive power for religious attitude and belief. Among the sociological variables that Ranck studied, he found significant correlations between religious conservatism and rural residence, between religious liberalism and higher education, and between religious liberalism and great difference between parent and child in religious and familial attitudes (14).

Dreger conducted a similar study. He first administered the Salvation Questionnaire to persons from several churches, selecting thirty subjects from the conservative and thirty from the liberal class groups. He then administered the Rosenzweig, Rorschach, and Thematic Apperception tests to both groups. His test results indicated that religious conservatives scored higher on measures of ego-defensiveness, conformity, and dependency. Liberals scored higher than religious conservatives on total response to the Rorschach and T.A.T., form perception, and negativism-independency. The test results were not generally statistically significant, and Dreger was not able to support the hypothesis that religious liberals were more mature, and less rigid and guilt-ridden than the religious conservatives. However, he was able to accept the hypothesis that religious conservatives
have a greater need for dependence than do religious liberals (16).

Kania used Protestant theological students as subjects in his study and administered the MMPI, the IPAT Anxiety Scale, and Bills Index of Adjustment, the Rokeach Dogmatism Scale, and the Heilbrun scales of defensiveness to them. He used high MMPI K scale scores which he defined as falling between T-scores of 55 and 74, as an index of high defensiveness in normal subjects. He found that high K scorers had higher adjustment scores, higher ego strength, and higher self acceptance scores on the Bills Index than low K scorers. Kania also found that high K scorers had lower values on Heilbrun's defensiveness scales, and on Rokeach's Dogmatism Scale. From the results he concluded that the high K students tended to be more open, better adjusted, less dogmatic, and have higher ego strength than low scoring students (8).

Murray and Conolly used Catholic theological students as subjects in their articles. They administered the MMPI to the students, then re-administered it seven years later. Using the Ma and Sc scales as criterion measures, the authors found a negative correlation between high scale scores and perseverance in vocational choice, that of the priesthood (13).

Stanley presented two studies that investigated personality correlates for theological students. The first article used two scales on the Maudsley Personality Inventory as a measure of neuroticism, the Rokeach Dogmatism Scale
and conversion, fundamentalism, and parental religious belief items in a questionnaire administered to the students. Stanley found a negative correlation between religious conversion and amount of parental religious belief, and between religious conversion and neuroticism. Stanley also found that religious conversion correlated positively with fundamentalism, dogmatism, and extraversion (20). Stanley also administered the questionnaire to groups of students who were then classified as fundamentalist or non-fundamentalist on the basis of their response to a belief item on the questionnaire. He found that the fundamentalist students scored higher on the lie scale, were more conservative, more certain, and more dogmatic than the non-fundamentalist students. He suggested that fundamentalism represented the religious manifestation of the "closed mind (19)."

Two other studies investigated the relationship of religion to personality development. Tennison and Snyder used college students as subjects. They administered the Thurstone and Chave Scale for Measuring Attitudes, the Kirkpatrick Religiosity Scale to them to assess varying degrees of favorable attitudes toward the church. The authors used the Edwards Personal Preference Schedule to delineate the psychological needs of the students. The authors then described the Freudian, or psychoanalytic, position on the effects of religion on personality. They stated that psychoanalysts felt that religious beliefs caused the highly
religious person to be dependent, submissive, and self-abasive. They found a negative relationship between the mean religiosity index and the Edwards Dominance, Achievement, and Succorance scales. Other findings included a positive relationship between the mean religiosity index and the Edwards Abasement, Affiliation, and Deference scales. These results led the authors to conclude that there is some support for the Freudian conceptualization of religion (21). Tisdale gave college freshmen Wilson's Extrinsic Religious Values Scale, the Edwards schedule, and a brief questionnaire concerning the individual's religious practices. He found that the Affiliation and Abasement scales of the Edwards test were positively related to the Extrinsic Religious Values Scale for males in the sample, as were the Abasement, Order, and Succorance scales for women. He also found that the Autonomy and Aggression scales were negatively related to the Extrinsic Religious Values Scale for men, and that the women had a negative relationship between the religious values test and the Edwards Intraception and Dominance scales. Tisdale agreed with Allport on the basis of these results that the extrinsically oriented person is characterized by a childhood marked with suspicion, distrust, insecurity, and inferiority (22).

The articles reviewed in this chapter have covered three major areas. The first group of articles dealt with some positive correlations of religion and personal effectiveness.
The second group dealt with some negative correlations between religion and personal effectiveness. The third group of articles attempted to establish personality correlates of religious participants. It is apparent from the number of articles reviewed in this chapter that the various aspects of religion have been considered by many authors as a possible aid in the development of the individual's personal effectiveness, or mental health. Many of the articles reviewed supported a positive relationship between religion and personal effectiveness. The articles reviewed in this chapter also illustrated extensive use of religious participation as an index of religiosity. The amount of background research pointing to this use of religious participation lends considerable support to the use of religious participation in a similar manner in this study. The amount of evidence given in this chapter supporting the positive relationship between religion and mental health lends further justification to hypothesizing that a background or history of religious participation will be useful in the therapeutic treatment of the mentally ill.
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CHAPTER III

METHOD

This chapter presents the method used to obtain the data for the study. A description of the subjects of the study, patients at a private neuropsychiatric hospital, is provided. The instruments used in the study are also described in this chapter. Finally, the procedure by which the data were collected is presented, and the method of statistical testing of the hypotheses is outlined briefly.

Subjects

The subjects for this study were forty-two patients in a small private hospital. The ages of the subjects varied greatly, with the youngest being sixteen and the oldest being fifty-two. The subjects did not vary so much with regard to socioeconomic status, however, as all patients listed their occupation or the occupation of spouse or parents on information records as one of the occupations that Rohrer and Edmonson classified as denoting middle-class status (4, p. 26).

The chief criteria for selection of subjects were that the patient was hospitalized and that the attending psychiatrist had requested that the patient be given the MMPI upon admission to the hospital. No outpatients were used. Not all patients admitted to the hospital were given the MMPI,
as the psychiatrists admitting patients did not rely on psychological testing of his patients by the affiliated psychologists and psychology interns in such instances as re-admission of patients or treatment of severely disoriented patients.

The subjects were differentially diagnosed by the hospital psychiatrists. Because the hospital had minimum security requirements, the patients typically did not exhibit extreme pathological symptoms, and all had some contact with reality. Most of the subjects were diagnosed as having either a depressive or schizophrenic reaction.

All of the subjects received basically the same treatment as the other hospital patients. Each subject saw his psychiatrist once a week for a therapy session. Each was assigned a psychology intern who gave the subject an individual psychotherapy session every other day. The subjects were encouraged daily to use the occupational therapy center in a house adjoining the hospital. The subjects also participated daily in a group session directed by the intern psychologists under the direction of the psychologists. The group sessions involved the use of different therapeutic approaches, including group psychotherapy, film therapy, role therapy, and educational therapy. One day weekly the occupational therapist conducted a ward meeting. The subjects were not required to be at each meeting, but were encouraged to do so.
Instruments

Two instruments were used in this study. The Religious Participation Questionnaire was used as a criterion for dividing psychiatric patients into active and less active religious groups. The scores of each group of patients on the Minnesota Multiphasic Personality Inventory were used to test the hypotheses.

The Religious Participation Questionnaire was designed by Ligon in 1961 to quantify participation in religious activities. Ligon constructed the questionnaire to yield a numerical score based on responses of the subjects to questions indicating minimum to maximum time spent in various activities of worship, devotion, and Bible study. It also gained information on the religious activity of the subject's parents. Ligon first developed the scale for an unpublished master's thesis in 1961. She used the same questionnaire to gather research for an unpublished dissertation in 1963. The questionnaire was described in a paper presented at the Southeastern Psychological Association Convention in Atlanta in 1965 (2). Williams and Cole later used the Religious Participation Questionnaire as a criterion measure for dividing subjects into high, intermediate, and low religiosity groups (6).

The Minnesota Multiphasic Personality Inventory, designed as a diagnostic tool for use with the psychiatric patient, has frequently been used in diagnosing patient
differentially along the neurotic-psychotic continuum discussed in Chapter I. Meehl and Dahlstrom, using 988 psychiatric patients as subjects in eight cross-validation samples, found that profile curves accurately diagnosed neurotic patients and psychotic patients at a hit-miss ratio of 3.2:1 (3). Goldberg, who worked with 861 MMPI profiles from seven hospitals and clinics around the country, found that MMPI indices prove more accurate than the best diagnosticians (1).

A third article deals with the use of the MMPI to differentiate neurotic and psychotic patterns. Taulbe administered the MMPI to a group of seventy patients diagnosed as neurotic, and to a group of forty-three patients diagnosed as schizophrenic. He found that the MMPI accurately differentiated between the neurotics and the schizophrenics (5).

Procedure

All patients admitted to a small private neuropsychiatric hospital from July, 1969, to February, 1970, were considered as potential subjects for this study. The hospital was located in a large, north Texas city. All patients were given the Religious Participation Questionnaire during the weekly ward meeting which they attended. This particular group session was selected as the administration time for several reasons. First, it was used for the administration of the questionnaire because of the qualifications of the
therapist in charge. The hospital occupational therapist conducted the ward meeting because this worker supervised such activities as outings, social events, and recreational therapy in addition to conducting occupational therapy. This was felt to be the person who saw the patients most frequently and who thus would be much less threatening a figure than an interviewer or administrator with whom the patients had had no previous contact. The therapist was also a trained psychologist with experience in psychotherapy with psychiatric patients. The therapist, then, was adequately trained to handle any possible adverse reaction by a patient to the contents of the questionnaire.

A second reason the ward meeting was used to administer the Religious Participation Questionnaire was that the meeting was designed as an opportunity for the patients to have some participation in developing and strengthening the therapeutic situation. They were encouraged by the therapist in charge to air complaints about the therapeutic community and make such suggestions as they felt would improve or facilitate their treatment. Because the ward meeting was not used to discuss personal problems or to release feelings long repressed, it was felt that administering the questionnaire would not significantly detract from the therapeutic treatment of the patients.

Finally, the ward meeting was used for administering the questionnaire because this was the only time during the week
when all the patients were together. During the rest of the week, the patients were in therapy sessions, either individual or group. Therefore, it would have been very difficult to administer the questionnaire to all of the patients during any other part of the week.

After the Religious Participation Questionnaire was obtained for all patients, the file for each patient was checked to find MMPI profile sheets for each. Those patients who had not been administered the MMPI upon admission to the hospital were eliminated from the study. For the forty-two patients for whom MMPI profiles were available, admission and dismissal dates were obtained from hospital records. The patients were then separated into high and low religious participation groups. Patients who scored above the median score on the Religious Participation Questionnaire were included in the low or less active religious participant group. Twenty-one patients were included in the active religious participant group on the basis of their religious participation scores, and twenty-one were included in the less active religious participant group.

The first, second, and third hypotheses were tested by applying the t-test of group means to them. The Pearson product-moment correlation coefficient was used to test the fourth and fifth hypotheses.

2. Ligon, LaVeta, Based on a paper read at the Southeastern Psychological Association Convention, 1965.


CHAPTER IV

ANALYSIS AND DISCUSSION OF RESULTS

This chapter presents an analysis of the results of the study described in Chapter III and a discussion of the results. An account of the statistical treatment of the data is included in the chapter, and is presented first. The next section of the chapter presents the hypotheses stated in Chapter I and is concerned with testing their significance. The third section is a discussion of the findings.

Treatment of the Data

As described in Chapter III, the subjects were divided into high and low religious participation groups as their scores fell either above or below the median score of 14 on the Religious Participation Questionnaire. To analyze the data, t-ratios of significance of difference between group means were computed. The two groups were measured on length of stay in the hospital, and on all of the MMPI scales. Table I presents the group means and t-ratios of difference between mean stay in the hospital for both groups. Table II presents the group means, t-ratio of difference between means, and the degrees of freedom for the high and low religious participation groups on each of the MMPI validity and diagnostic scales.
The data were then analyzed by computing Pearson correlation coefficients. Table III presents the correlations between high religious participation scores and each of the MMPI scores.

There were 40 degrees of freedom, so the .05 level of significance was 2.021 for the t-ratios, and the .05 level of significance was .32 for the correlation coefficients. It was on the basis of the .05 level of significance that the hypotheses were accepted or rejected.

Analysis of the Hypotheses

The section will consider each hypothesis stated in Chapter I. The groups compared were identified in Chapter III.

Hypothesis I states that subjects in a private neuropsychiatric hospital who score high on the Religious Participation Questionnaire would stay a significantly shorter mean period of time than subjects with low religious participation scores.

The data in Table I indicates that the t-ratio of -1.11 was not significant at the .05 level. Therefore, the hypothesis was rejected. It was of interest to note that the T-score was in the opposite direction from that predicted by the hypothesis.
TABLE I

LENGTHS OF HOSPITALIZATION FOR HIGH LOW RELIGIOUS PARTICIPATION SCORERS,
DIFFERENCE BETWEEN GROUP MEANS

<table>
<thead>
<tr>
<th></th>
<th>High Group</th>
<th>Low Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Hospitalization</td>
<td>$\bar{x}$ (N=21)</td>
<td>$\bar{x}$ (N=21)</td>
</tr>
<tr>
<td>Number of days</td>
<td>22.43</td>
<td>17.05</td>
</tr>
<tr>
<td></td>
<td>17.73</td>
<td>7.32</td>
</tr>
<tr>
<td>t-value</td>
<td>-1.11</td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis II stated that subjects with high religious participation scores would have significantly higher mean scores on the scales 1, 2, and 3 of the MMPI than subjects who have low religious participation scores.

This hypothesis was also rejected since, as may be seen in Table II, the group means for the low religious participation scorers were 6.26, 5.57, and 4.05 points higher, respectively, than the group means for the high scorers. The t-values of -3.20 for scale 1, -2.80 for scale 2, and -2.60 for scale 3 were thus in the opposite direction predicted by the hypothesis.
The third hypothesis was that subjects with high religious participation scores would have significantly lower mean scores on the scales 6, 7, 8, and 9 of the MMPI than subjects with low religious participation scores.

The hypothesis was accepted for MMPI scale 6, as the t-value of -2.35 exceeded the 2.021 ratio needed at the .05 significance level, as illustrated in Table II above. However, the hypothesis was rejected for the other three MMPI scales, as the t-values of -1.82, -0.84, and 1.08 were not significant at the .05 level.

Hypothesis IV, which stated that there would be a significant positive relationship between scales 1, 3, 5, and 6
of the MMPI and religious participation scores, and Hypothesis V, which stated that there would be a significant negative relationship between scales 2, 7, 8, and 0 of the MMPI and religious participation scores, were both rejected. From Table III it may be seen that all four coefficients indicated a negative relationship, rather than the positive one stated in Hypothesis IV. The first scale coefficient of -.42 was significant in a negative direction at the .05 level but the remaining coefficients of -.28, -.16, and -.28 did not exceed the significance level. Table III also indicates that Hypothesis V was rejected for all four scales, as none of the coefficients—-.28, -.14, -.01, and -.19—was significant at the .05 level.

**TABLE III**

**CORRELATIONS BETWEEN RELIGIOUS PARTICIPATION SCORES AND MMPI SCALES**

<table>
<thead>
<tr>
<th>Scale</th>
<th>$\bar{X}$</th>
<th>SD</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>49.20</td>
<td>6.72</td>
<td>.10</td>
</tr>
<tr>
<td>F</td>
<td>71.61</td>
<td>12.87</td>
<td>- .23</td>
</tr>
<tr>
<td>K</td>
<td>46.23</td>
<td>7.85</td>
<td>- .10</td>
</tr>
<tr>
<td>1</td>
<td>71.01</td>
<td>14.54</td>
<td>-.42*</td>
</tr>
<tr>
<td>2</td>
<td>72.79</td>
<td>12.63</td>
<td>- .28</td>
</tr>
<tr>
<td>3</td>
<td>68.59</td>
<td>11.04</td>
<td>- .28</td>
</tr>
<tr>
<td>4</td>
<td>78.24</td>
<td>11.64</td>
<td>- .43*</td>
</tr>
<tr>
<td>5</td>
<td>57.18</td>
<td>13.55</td>
<td>- .16</td>
</tr>
<tr>
<td>6</td>
<td>72.66</td>
<td>11.44</td>
<td>- .28</td>
</tr>
<tr>
<td>7</td>
<td>73.52</td>
<td>13.55</td>
<td>- .14</td>
</tr>
<tr>
<td>8</td>
<td>76.23</td>
<td>18.37</td>
<td>- .01</td>
</tr>
<tr>
<td>9</td>
<td>66.27</td>
<td>11.14</td>
<td>- .18</td>
</tr>
<tr>
<td>0</td>
<td>61.02</td>
<td>10.54</td>
<td>- .19</td>
</tr>
</tbody>
</table>
Discussion

The hypotheses, with the exceptions of the application of Hypothesis III to MMPI scale 6, were all rejected at the .05 level of significance. Analysis of Hypothesis II yielded a significant t-ratio in the opposite direction from that predicted. When the significantly lower value of MMPI scale 2 for the high participant group is viewed in the light of a negative correlation between scale 2 and religious participation scores that approaches significance at the .05 level, it becomes possible to interpret these results as indicating that the high group was significantly less depressed than the low scoring group. Significant t-values for MMPI scales 1 and 3 were also in the opposite direction from that predicted by Hypothesis II. A significant negative correlation was also obtained between scale 1 and high religious participation scores. These findings may be interpreted as indicating that the high religious participation group tended to be more conventional, more cheerful, and freer from the neurotic inhibitions of over-evaluation of self and one's own problems than the low scoring group. The results indicated that the high scoring group was less prone to worry, less narcissistic and cynical, and less likely to be defeatist and reject therapy attempts than the low scoring group.

Both statistical treatments of the data yielded significant negative values between MMPI scale 4 and high religious participation scores. These results also indicated a tendency
for high religious participation scorers to be more conventional and conservative, more accepting and cheerful, and have better self control than low scoring subjects. The previously mentioned results point to the presence of significantly greater ego strength for active religious participants.

The results tended to support Kania's conclusions that religiously active subjects have higher ego strength than less active subjects (5). The results also coincided with Wright's finding that subjects more certain of their religious attitudes were more confident (8).

The results also tended to support the conclusions of Brown and Lowe, who stated that religious students were more optimistic than less religious students. These results also pointed to the presence of significantly greater ego strength for active religious participants than for less active religious participants (2).

Hypothesis III, as previously stated, was accepted for scale 6. High religious participation scorers were significantly less suspicious of others than were low scorers. This interpretation directly conflicted with the results of both the reviews of Rooney and Broen's results, which indicated high scores on this scale for religiously active subjects (1, 7). The results also conflicted with Khanna's study, which found that active religious participants were more authoritarian than less active participants. Authoritarianism
is characterized by inflexibility, suspicion, and distrust of others; therefore authoritarian subjects tend to score higher on the Pa scale than subjects who are not as suspicious (6).

A more difficult result to explain was the finding that no statistical difference existed for high and low religious participation scorers on MMPI scales 7 and 8. The MMPI Handbook was consulted in an effort to interpret these results (3). The handbook described subjects who score significantly high on these two scales as being rather equally divided between neurotic and psychotic cases, with chief clinical features being depression, introversion, irritability, nervousness, and social isolation (3). However, MMPI scales are considered by many clinicians to be of diagnostic value only when significantly high scale scores are reviewed in pairs. The handbook also deals at length with the clinical features exhibited by patients scoring high on individual pairs of scales. Therefore both scales 7 and 8 were paired individually with each of the scales on which the low religious participant group scored significantly higher: scales 1, 2, 3, 4, and 6. Since the mean scores for the low religious participant group were significantly higher than the means for the high group, and were also above a T-score of 70 on all scales, it was believed that the low religious participant group would exhibit more of the clinical features described by the handbook for each of the scale pairs than the high participant group, that they would exhibit these
characteristics to a greater degree than the high group.

The most frequently mentioned characteristics were taken from the handbook descriptions of each of the scale pairs to form a composite clinical picture. The common clinical characteristics were depression, nervousness, schizoid personality featuring paranoid or suspicious tendencies, irritability, and social withdrawal. The high religious participant group, because of the reasons discussed in the preceding paragraph, was felt to be much less likely to evidence these symptoms. The results displayed further support for the findings previously stated.

The presence of higher ego strength and lower paranoid tendencies lead to another interpretation worthy of discussion. This interpretation is that the high religious participation scorers have either felt less guilt, or have dealt more successfully with the guilt they felt. Since religious activity has traditionally been a center of super-ego development, the first possibility seemed unlikely. Therefore, the probability has increased that the high scorers dealt with any guilt they felt over their condition in such a way that it did not have as great an ego-lowering or self-debilitating effect upon them. That these high scorers had significantly lower paranoid tendencies seemed to be an indication that the method of dealing with guilt was also realistic enough to include accepting self faults without projecting them on others.
Analysis of Hypothesis I yielded an insignificant t-value in the opposite direction predicted. The direction of the t-value suggests the possibility that patients who are active religious participants might be found in later research to take a longer time to recover.

This possibility may be due to the religiously active patients' taking a more realistic approach to their therapy than the less active patients. That is, they may have been more willing to spend the necessary therapy time to effect a real "cure" than the low group. Jung supported this position by stating that no patient of his over thirty-five was effectively or really healed unless he regained his religious outlook (4). In considering the significant number of psychiatric patients who have been hospitalized more than once over a period of time for a recurring disorder, it would be of great value to learn whether religiously active patients are hospitalized more than once over a period of time.


CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This research was designed to identify the effects of religious participation in the therapeutic treatment of the mentally ill. The two instruments used to gather data for the study were the Minnesota Multiphasic Personality Inventory and the Religious Participation Questionnaire. Scales 1, 2, and 3 of the MMPI were used to measure subjects' neurosis, and scales 6, 7, 8, and 9 of the MMPI were used to measure subjects' psychosis. The Religious Participation Questionnaire was used to assess the amount of participation in religious activity for each subject.

Forty-two patients in a small, private neuropsychiatric hospital located in a large north Texas city were used as subjects for the study. All of the patients had to fill two requirements; they had to have been hospitalized for some period of time, and they had to have been administered the MMPI the day they were admitted to the hospital. There were both males and females in the study, and the age range varied from sixteen to fifty-two. All of the subjects came from the middle socioeconomic class.

The subjects were given the Religious Participation
Questionnaire by the staff occupational therapist at their weekly ward meeting. The occupational therapist was also a trained master's level psychologist. The religious participation scores were then used to divide the subjects into two groups; one group scoring high on the questionnaire, and the other group, low. The MMPI scores of these groups were then compared.

Five hypotheses were tested. Hypothesis I stated that psychiatric patients who score high on the Religious Participation Questionnaire stay a significantly shorter mean period of time than low-scoring patients. Hypothesis II stated that patients with high religious participation scores have significantly higher mean scores on MMPI scales 1, 2, and 3 than low-scoring patients. Hypothesis III stated that patients with high religious participation scores have significantly lower mean scores on MMPI scales 6, 7, 8, and 9 than low-scoring patients. Hypothesis IV stated that a significant positive relationship exists between religious participation and scales 1, 3, 5, and 6. Hypothesis V stated that a significant negative relationship exists between religious participation and scales 2, 7, 8, and 0.

Hypotheses I, II, IV, and V were all rejected. The first hypothesis was rejected because of an insignificant t-value. The other three rejected hypotheses were not accepted because of t-values in the opposite direction of that predicted by the hypothesis. Hypothesis II was
accepted for MMPI scale 6, the Pa scale. The low religious participation scorers had significantly higher scores on MMPI scales 1, 2, 3, 4, 5, and 6. There was also a generally higher elevation of all MMPI scales for the low-scoring group, with the exception of the K and Ma scales, than for the high religious participation group. The analysis of the data thus indicated that there was a negative relationship between religious participation and depression, suspiciousness, and irritability.

Conclusions

In view of the analysis of the results in Chapter IV, it is possible to draw some conclusions. First, it is possible to conclude that being an active religious participant has a buoying or supporting effect on the emotional outlook of the psychiatric patient. That is, he tends to be significantly less depressed than do relatively non-active participants. This conclusion has several implications. First, it is possible that active religious participants who become psychiatric patients are less likely to have suicidal tendencies. The fact that they are not as depressed as the non-active religious participants would tend to support their self view and help to keep them from deciding that life is not worth living. Secondly, it is possible that active religious participants have a greater reservoir of ego strength from which to draw, which may have its sources
in the religious behavior.

A second conclusion may be drawn from the analysis of the results. That conclusion is that religious participation does not significantly decrease the hospitalization time required for treating the patient. The conclusion does not support the purpose of the study in Chapter I. However, the stronger strength and decreased suspiciousness may make treatment of the active religious participant initially easier, as he not only has more health in the form of ego at the onset of therapy, but also tends to be more trusting. Therefore the therapeutic treatment is likely to be more successful for the active religious participant than for the less active participant.

Recommendations for Future Research

The results of this study suggest several possibilities for future research. The generally higher elevation of all the MMPI diagnostic scales except for scale 9 suggests that the same study performed on a much larger subject population might yield other significant results. It is suggested that the same study be performed with patients in state-supported hospitals, as these patients may exhibit a difference in the differential diagnostic pattern expressed by the subjects of this study. The subject population in a public hospital will also include patients who may be classified as falling into the lower socioeconomic class.
The study should also be repeated for populations which are largely Catholic or Jewish in religious affiliation. Owing to the geographical location of the city in which the hospital used for this study was situated, the religious affiliation of the patients fell almost entirely into the Protestant denominations. This information was gathered on the Religious Participation Questionnaire. It is possible that altering the group religious affiliation will significantly alter the results. It is also possible that with a population that is largely Jewish in nature, the Religious Participation Questionnaire will not be applicable.

Future research should also contain a measure that tests the accuracy of the subjects' responses on the Religious Participation Questionnaire. Since the questionnaire is a self-report device and is used on psychiatric patients, the accuracy with which they report their religious activity may be questioned. For example, a patient may wish to make himself appear more acceptable to the researcher or to any therapist that he hopes may see the questionnaire. He may therefore try to present himself as either a more or less active religious participant according to his interpretation of the preference of the researcher or therapist. Another possibility would be that the depressed patient would tend to score lower on the questionnaire in order to perpetuate his self-defeating or ego-lowering perception of himself. As psychiatric patients suffer from an inaccurate perception
of both self and others, it may be quite reasonable to assume that their perception of their religious activity will also be inaccurate.
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