

# Assessing Problems with Religious Content

## A Comparison of Rabbis and Psychologists

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This study measured distinctions made by a sample of clergy and mental health professionals in response to three categories of presenting problems with religious content: mental disorder, religious or spiritual problem, and "pure" religious problem. A national, random sample of rabbis ( $N = 111$ ) and clinical psychologists ( $N = 90$ ) provided evaluations of three vignettes: schizophrenia, mystical experience, and mourning. The participants evaluated the religious etiology, helpfulness of psychiatric medication, and seriousness of the presenting problems. The rabbis and psychologists distinguished between the three diverse categories of presenting problems and concurred in their distinctions. The results provide empirical evidence for the construct validity of the new DSM-IV category religious or spiritual problem (V62.89). Use of the V code allows for more subtle distinctions among the variety of problems that persons bring to clergy and mental health professionals. These distinctions may also provide a foundation for the initiation of co-professional consultation.

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The purpose of this study is to investigate the degree to which a sample of clergy and mental health professionals would be likely to distinguish between diverse presenting problems with religious content as well as to compare these categorical distinctions between the two professions.

A comparative assessment of the ability of clergy to differentiate mental health problems from religious concerns is important because clergy perform both caregiver and gatekeeper roles in the provision of mental health care (Abbott, 1980). In over 30 years of research, people have consistently reported that

when they experience psychological distress, they are most likely to seek help from clergy (Chalfant et al., 1990; Gurin et al., 1960; Veroff et al., 1981). The most recent study found that 41% of individuals would seek help first from clergy, in contrast to 29% who would consult a primary care physician, and 21% who would consult a psychiatrist or a psychologist. Even persons with serious mental illness are as likely to contact clergy as they are to make contact with mental health professionals in times of need (Larson et al., 1988).

Because persons with a range of religious concerns as well as with mental health problems seek out clergy for help, these religious leaders must differentiate between problems that they can respond to alone and those for which they should seek consultation from mental health care professionals. Studies have raised concern about the ability of clergy to make these distinctions. For example, clergy frequently have difficulty recognizing several types of psychiatric difficulties, including suicide lethality (Holmes and Howard, 1980), and severe psychopathology (Domino, 1990).

Mental health care professionals also must distinguish psychiatric dysfunction from religious concerns. The Gallup polls have found that the American public is predominantly religious and churchgoing: 84% view God as a "heavenly father who can be reached by prayer" (Princeton Religious Research Center, 1993, p. 20), and 69% belong to a

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church or synagogue (Princeton Religious Research Center, 1994). As would therefore be expected, the problems people bring to clinicians often present with religious content (Quackenbos et al., 1985). Some of these religious problems, however, do not need to be the focus of clinical attention (Turner et al., 1995).

As with the clergy, studies have questioned the ability of mental health professionals to distinguish between clinical problems and religious concerns. In part, this is because many mental health care professionals are unaware of the multifaceted role of religion in people's lives (Goldfarb et al., 1996; Milstein et al., 1995). In addition, it may be difficult for clinicians to recognize normative religious problems because the previous edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987) confounded the categorical distinctions between psychiatric dysfunction and nonpathological religious problems by disproportionately utilizing religious ideation to illustrate examples of mental disorder diagnoses (Post, 1992). It has therefore been suggested that clinicians would be well-advised to make contact with clergy in order to help them make appropriate categorical distinctions, as well as to become more informed about the role of religion in the lives of the people they serve (Gorsuch and Meylink, 1988).

Recent reviews of a broad range of mental health care literatures have found that there is a great need for empirical research on the possible beneficial or harmful effects of cross-professional interaction between clergy and mental health professionals (Weaver et al., 1997a, 1997b, 1998). For interaction to take place, however, these professionals must first be able to distinguish between psychiatric problems with religious content that would require clinical intervention, and religious problems appropriate for clerical attention.

One way to distinguish between these types of presenting problems is offered by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). This edition introduced the diagnosis religious or spiritual problem (V62.89), which the *DSM-IV Sourcebook* (Lu et al., 1997) describes as a category for clinicians to employ in order to explicitly differentiate psychiatric mental disorders (e.g., schizophrenia, major depression) that require clinical attention, from profound personal religious concerns that are not mental disorders (e.g., mystical experience, near-death experience) but may be a focus of clinical attention because of difficulty integrating these experiences into the individual's social or emotional life. A third distinct category discussed in

the sourcebook is labeled "pure" religious problems. These are described as emotional difficulties that persons have within the context of organized religion and warrant neither clinical attention nor a DSM-IV diagnosis (e.g., mourning rituals, religious doctrine).

The sourcebook also reports that the inclusion of the category religious or spiritual problems (V62.89) in the DSM-IV was not based on empirical data, but rather on its face validity.

This study investigates the likelihood that clergy and mental health professionals will distinguish between the three nosological categories of presenting problems with religious content promulgated by the fourth edition of the DSM-IV. As an initial empirical study of these categories, two groups of participants with a theoretically high likelihood of success were chosen: clinical psychologists and rabbis. Clinical psychologists were chosen because, more than any other mental health profession, they belong to a field in which academics and clinicians have studied religion as well as the interaction of religion and psychopathology (Gorsuch, 1988; Larson et al., 1986). Rabbis were chosen for two reasons. First, in previous studies of the consultation practices of several types of clergy, rabbis demonstrated both the greatest frequency of interaction with mental health professionals and the greatest awareness of distinct psychiatric categories (Cumming and Harrington, 1963; Ingram and Lowe, 1989). Second, Lyles (1992) has shown that the ethnicity of the clergy has a significant effect on consultation willingness. By choosing rabbis, the results of this initial study were less likely to be confounded by the effects of ethnicity, as might happen with a random sample of Christian clergy.

The participants' categorical evaluations were investigated by measuring their responses to three unlabeled vignettes representing each of the diagnostic categories (Table 1). Vignettes were used because they offer the opportunity to evaluate responses to a uniform set of situations, rather than elicit participants' answers based on their own varied and indeterminate circumstances.

The participants answered three questions in response to each vignette. These questions measured the rabbis' and psychologists' assessments of the religious etiology of the presenting problems, the utility of pharmacological intervention, and the seriousness of the problems. Categorical distinctions were evaluated by measuring the probability that the rabbis' and psychologists' responses significantly differentiated between the vignettes. Concurrence between the two professions was also evaluated.

TABLE 1  
*The Vignettes Presented by Category*  
 Mental Disorder: *Schizophrenia*

Mr. Green, a 19-year-old college sophomore, has come to you because for the last six months he has lost his drive to participate in his usual school activities. He left school and came home—eventually spending most of his day in his room. At night, when everyone else is sleeping, he is thinking, pacing back and forth in his room. He gets so preoccupied with what he is thinking that he skips meals and has stopped bathing regularly. Mr. Green says that he has seen and heard God talking with His angels. He repeatedly hears a strange voice telling him what to do and how to behave. Mr. Green wants to know whether he should obey the voice.

Religious or Spiritual Problem-V62.89: *Mystical Experience*

Mr. Lowell has had a very powerful experience which he wishes to discuss with you: "I remember the night, and almost the very spot on the hilltop, where it seemed that my soul opened up into the Infinite, and there was a rushing together of the two worlds, the inner and the outer. I stood alone with God who made me, and all the beauty of the world, and love, and sorrow, and even temptation. The ordinary sense of things around me faded. For the moment nothing but joy remained. It is impossible to fully describe the experience. The darkness held a presence that was all the more felt because it was not seen. I could not any more have doubted that God was there than that I was. I felt myself to be, if possible, the less real of the two. I have never experienced the same feelings since then."

"Pure" Religious Problem: *Mourning*

Mr. Simon's father recently drowned in a sailing accident in the Caribbean. Mr. Simon followed his father's wishes and had his remains cremated, even though this was against his own religious beliefs. He now wishes to mourn his father's passing but does not know what rituals he should follow. He would like more information from you.

### Hypotheses

1. The "pure" religious problem will be identified as most likely to have a religious etiology, followed by religious or spiritual problem (V62.89), followed by mental disorder.

2. Medication will be designated as more helpful to the mental disorder than to the presenting problems from the other two categories.

3. The mental disorder will be evaluated as more serious than the religious or spiritual problem (V62.89) that may be a focus of clinical attention, and both of the above will be evaluated as more serious than the "pure" religious problem that does not warrant clinical attention.

4. There will be significant group differences between the rabbis' and the psychologists' evaluations.

### Methods

#### Participants

A random, nationwide sample of psychologists and rabbis was identified and sent questionnaires.

Psychologists were chosen from a national listing of experienced professionals in clinical practice (Council for the National Register of Health Service Providers in Psychology, 1994); rabbis were chosen from comprehensive listings that represent the total national membership of the four major denominations' rabbinical organizations: Orthodox (Rabbinical Council of America, Inc, 1995), Conservative (The Rabbinical Assembly, 1995), Reform (Union of American Hebrew Congregations, 1994), and Reconstructionist (Jewish Reconstructionist Federation, 1995).

There were 15,461 eligible psychologists listed; the rabbis totaled 2,059: 407 Orthodox, 662 Conservative, 944 Reform, and 46 Reconstructionist.

We randomly chose 210 psychologists and 210 rabbis. To have rabbis from each denomination equally represented in the study, 55 Orthodox rabbis, 55 Conservative rabbis, 54 Reform rabbis, and all 46 Reconstructionist rabbis were chosen. For subsequent analyses, the rabbis' variables were weighted to account for the different rates of sampling.

Participants returned surveys from 44 states and the District of Columbia. The mean age of the psychologists was 54 (SD = 9.08); the mean age of the rabbis was 48 (SD = 12.92). Rabbis were significantly younger than psychologists ( $t = 3.86, p < .001$ ). There was a significant gender difference between professions  $\chi^2[1] = 6.30, p = < .02$ : among the psychologists, 67% were men and 33% were women; among the rabbis, 83% were men and 17% were women.

The survey was accompanied by a cover letter explaining the purpose of the questionnaire. After a description of the study to the participants, implicit informed consent was obtained by the following wording of the letter, "The return of this questionnaire represents your anonymous consent to participate in the study."

#### Mailing Schedule

The mailing schedule followed the recommendations of Dillman (1978). There was an initial mailing of 420 questionnaires. After 3 weeks, a postcard was mailed out. At 6 weeks, a replacement questionnaire was mailed to all nonrespondents, and at 9 weeks, a letter was mailed. During the 12th week after the first mailing, all nonrespondents were telephoned and encouraged to complete the questionnaire.

#### Rate of Return

A total of 201 surveys were returned, representing a 54% rate of return of the 373 deliverable questionnaires. Psychologists returned 90 (48%), and rabbis

TABLE 2  
 Summary of Participants' Responses to the Categorical Vignettes: Means, Standard Deviations, ANOVAs

Questions	Mean Values and Standard Deviations <sup>a</sup>								Repeated Measures ANOVAs		
	Schizophrenia		Mystical Experience		Mourning		Profession	Category	Interaction		
	Psych	Rabbi	Psych	Rabbi	Psych	Rabbi					
Religious etiology	Mean	1.71	2.37	2.81	3.05	3.63	3.75	<i>F</i>	20.69***	179.94***	4.78*
	(SD)	(.74)	(.91)	(1.06)	(.97)	(.57)	(.56)	Partial <i>R</i> <sup>2</sup>	.10	.49	.03
	<i>N</i>	84	109	85	108	90	111	( <i>df</i> )	(1,184)	(1.73, 318.60)	(1.73, 318.60)
Medication helpfulness	Mean	3.89	3.66	1.42	1.50	1.40	1.35	<i>F</i>	.59	1140.73***	4.43***
	(SD)	(.35)	(.53)	(.67)	(.67)	(.58)	(.62)	Partial <i>R</i> <sup>2</sup>	.001	.86	.02
	<i>N</i>	85	109	82	108	89	110	( <i>DF</i> )	(1,181)	(1.95, 353.48)	(1.95, 353.48)
Seriousness	Mean	3.99	3.99	1.96	2.06	2.89	3.28	<i>F</i>	9.25**	420.14***	6.09**
	(SD)	(.11)	(.11)	(1.01)	(1.01)	(.63)	(.68)	Partial <i>R</i> <sup>2</sup>	.05	.70	.03
	<i>N</i>	85	109	84	108	88	111	( <i>df</i> )	(1,183)	(1.57, 287.35)	(1.57, 287.35)

<sup>a</sup>Response codes: 4 = Very, 3 = Somewhat, 2 = Not Very, 1 = Not At All.

\**p* < .05; \*\**p* < .01; \*\*\**p* < .001.

returned 111 (60%). Among rabbis, the Orthodox returned 29 (59%), the Conservative returned 31 (67%), the Reform returned 28 (60%), and the Reconstructionist returned 23 (52%).

### Survey Instrument

The categories were presented in three vignettes (Table 1). The category of mental disorders was represented by a young man exhibiting DSM-IV (American Psychiatric Association, 1994) symptoms of schizophrenia. This vignette was written with additional reference to pastoral care literature (Beals, 1982). The category of religious or spiritual problem (V62.89) was represented by the description of a mystical experience excerpted from William James' *Varieties of Religious Experience* (James, 1990/1902, p. 67) and edited to conform to more recent research findings on contemporary reports of mystical experience (Spilka et al., 1985). The category of "pure" religious problems consisted of a case history from the authors' clinical experience and conformed to the guidelines recommended by the *DSM-IV Sourcebook* (Lu et al., 1997). After reading each of the three vignettes, the participants were asked to rate the following three evaluation questions on a 4-point scale (4 = very, 3 = somewhat, 2 = not very, 1 = not at all):

1. How likely is it that the situation might be caused by a religious or spiritual problem?
2. How helpful would psychiatric medication be?
3. How serious would you consider the problem to be?

Throughout the questionnaire participants were encouraged to add comments in the margins.

### Statistical Analysis

For each question a repeated measures analysis of variance (ANOVA) was conducted to determine

whether there were significant differences among the two professions' overall pattern of responses based on a main effect of category, of profession, or as an interaction of category and profession. Within subject results were adjusted for nonphericity of the dependent variables with the Greenhouse-Geisser procedure recommended by Keselman and Keselman (1984). Partial squared correlations were computed to determine how much variance each part of the ANOVA equation explained. Paired sample *t*-tests were calculated to compare the rabbis' and the psychologists' evaluations across the three categories. Independent sample *t*-tests were calculated to test for group differences between the rabbis and psychologists within each category.

### Results

The means, standard deviations, and repeated measures ANOVA results are reported in Table 2 and summarized below. The independent sample *t*-tests and paired sample *t*-test results are reported below.

#### Religious or Spiritual Etiology

Participants answered the question, "How likely is it that the situation might be caused by a religious or spiritual problem?" In a repeated measures ANOVA with this response as the dependent variable, there was a significant main effect of profession, a significant main effect of category, and a significant interaction. In paired sample *t*-tests, rabbis evaluated the etiology of the schizophrenia vignette as significantly less religious than the mystical experience ( $t[105] = 4.72, p < .001$ ), which they reported as significantly less religious than mourning a parent ( $t[107] = 6.82, p < .001$ ). Psychologists also evaluated the etiology of the schizophrenia vignette as significantly less religious than the mysti-

cal experience ( $t[79] = 7.75, p < .001$ ), which they also reported to be significantly less religious than mourning a parent ( $t[84] = 7.14, p < .001$ ). Independent sample  $t$ -tests demonstrated that rabbis considered the etiology of the schizophrenia vignette as significantly more religious than did psychologists ( $t[191] = 5.45, p < .001$ ), but there were no significant differences between the rabbis' and psychologists' evaluations of either the mystical experience or mourning a parent.

#### *Helpfulness of Psychiatric Medication*

Participants answered the question, "How helpful would psychiatric medication be?" In a repeated measures ANOVA with this response as the dependent variable, the results indicated that the main effect of profession was not significant. There was a significant main effect of category, and a significant interaction. In paired sample  $t$ -tests, rabbis evaluated psychiatric medication as significantly more helpful for the schizophrenia than for the mystical experience ( $t[105] = 25.23, p < .001$ ) and significantly more helpful for the mystical experience than for mourning a parent ( $t[106] = 2.17, p < .05$ ). Psychologists evaluated medication as significantly more helpful for schizophrenia than both the mystical experience ( $t[77] = 30.53, p < .001$ ), and mourning a parent ( $t[83] = 40.37, p < .001$ ), with no significant difference between the mystical experience and mourning a parent. Independent sample  $t$ -tests demonstrated that psychologists considered schizophrenia as significantly more helped by psychiatric medication than did rabbis ( $t[192] = 3.59, p < .001$ ), but there were no significant differences between the rabbis' and psychologists' evaluations of the helpfulness of medication for either the mystical experience or mourning a parent.

#### *Seriousness*

Participants answered the question, "How serious would you consider the problem to be?" In a repeated measures ANOVA with this response as the dependent variable, there was a significant main effect of profession, a significant main effect of category, and a significant interaction. In paired sample  $t$ -tests, rabbis evaluated the schizophrenia vignette as significantly more serious than mourning a parent ( $t[108] = 10.91, p < .001$ ), which they reported as significantly more serious than the mystical experience ( $t[107] = 11.32, p < .001$ ). Psychologists also evaluated the schizophrenia vignette as significantly more serious than mourning a parent ( $t[82] = 16.14, p < .001$ ), which they reported to be significantly more serious than the mystical experience

( $t[82] = 7.97, p < .001$ ). Independent sample  $t$ -tests demonstrated no significant difference between the evaluations of the psychologists and rabbis as to the seriousness of the schizophrenia or mystical experience. Rabbis did consider mourning a parent to be significantly more serious than did psychologists ( $t[197] = 4.18, p < .001$ ).

#### **Discussion**

The sample of clergy and mental health professionals surveyed for this study distinguished between the three categories of presenting problems with religious content: mental disorder, religious or spiritual problem (V62.89), and "pure" religious problem. These rabbis and psychologists also demonstrated an overall pattern of nosological agreement.

The rabbis and psychologists never differed significantly in their three evaluations of the religious or spiritual problem (mystical experience). Although the rabbis did, on average, consider the mental disorder vignette (schizophrenia) to be attributed to a religious etiology significantly ( $p < .001$ ) more than did psychologists, neither group considered it a likely explanation. Similarly, although psychologists considered psychiatric medication to be significantly ( $p < .001$ ) more helpful for the schizophrenia than did rabbis, both groups recognized medication as very helpful. This pattern again proved true for the "pure" religious problem (mourning) where rabbis considered the vignette as significantly ( $p < .001$ ) more serious than did the psychologists, but both affirmed it as a serious problem.

Across all three evaluation questions, the repeated measures ANOVAs consistently demonstrated that the significant main effect of the participants' evaluations of the diagnostic categories—rather than the main effect of profession or the interaction of profession and category—explained the greatest amount of the variance: 49% (religious etiology), 86% (psychiatric medication), and 70% (seriousness).

As hypothesized, the psychologists and rabbis distinguished between the disparate religious etiology of the schizophrenia and mystical experience vignettes, even though both vignettes present persons describing contact with God. In addition, both the rabbis and psychologists evaluated the religious etiology of the mystical experience as intermediate between the schizophrenia and mourning vignettes. These results reflect the expectations of the authors of the new DSM-IV category religious or spiritual problems (V62.89; Lu et al., 1997).

The participants' comments elucidated these distinctions. About the schizophrenia vignette one psy-

chologist wrote, "I consider this a problem of mental illness. The delusions just happen to have a religious content." One rabbi was deductive: "The no-sleeping and hearing voices are very serious symptoms! He needs immediate psychiatric intervention." Another rabbi was more emphatic: "We go right to the emergency room!"

In contrast, the mystical experience was not evaluated to be as perilous as the schizophrenia. One psychologist wrote, "He sounds fine. Unless he is experiencing other issues, this is a religious/mystical experience." Another psychologist succinctly identified the mystical description as a "peak experience." One rabbi perceived only a positive encounter in the mystical narrative, "Mr. Lowell is sharing a moment of personal spiritual connection. . . . We should all be so lucky." Another rabbi considered the possibility of psychotic thinking when commenting on the mystical experience vignette, but this was rejected: "This experience, in and of itself, does not seem delusional but spiritual (if it was part of some larger pattern of hallucinatory experiences . . . the issue of medication might be worthy of consideration)."

In fact, as hypothesized, both rabbis and psychologists confirmed the need for medication only in response to the schizophrenia vignette.

The one exception to the hypothesized distinctions of the diagnostic categories was that the DSM-IV code religious or spiritual problem (V62.89), which may be a focus of clinical attention, would be evaluated as more serious than the "pure" religious problem, which does not warrant clinical attention. Instead, both rabbis and psychologists judged the mystical experience to be significantly less serious than the search for mourning rituals described in the "pure" religious vignette.

It may be that because the protagonist of the mystical experience vignette does not report specific emotional or interpersonal distress, this incident was not evaluated as serious, would not require further professional help, and would therefore not receive the diagnosis of religious or spiritual problem (V62.89; Lukoff et al., 1998). However some participants' comments did indicate that clinical attention might be necessary to help maintain appropriate reality testing in the face of this powerful, emotional episode. One rabbi described a differential diagnostic approach, "I'm not sure he has a problem. He's not hearing voices, or being told to perform dangerous acts." A psychologist wrote, "I heard this as a sharing and possible looking for external validation or reality testing—not a problem." In sum, the comments appear to agree with the *DSM-IV Sourcebook* (Lu et al., 1997) that

in order to rule out a diagnosis of religious or spiritual problems (V62.89), persons who present with concerns about a mystical experience would need careful evaluation and reassurance, and in the words of one psychologist, "either discipline could do it."

In response to the "pure" religious vignette the participants' comments consistently indicated that, although serious, it would not require clinical attention or evaluation. One psychologist wrote emphatically, "I don't see this as a problem, but as a life issue!" A rabbi commented, "Mr. Simon needs an answer to the question, 'How do I mourn?' Anything that leads to that is helpful—anything else is not." Another rabbi wrote, "I take this to be a serious issue, but not necessarily a serious health issue." These responses support the suggestion that a religious problem can be serious and best responded to by clergy rather than clinicians (Gorsuch and Meylink, 1988).

Finally, although the opposite was predicted by the fourth hypothesis, professional disparity did not interfere with categorical distinctions of cross-professional salience. Rabbis recognized the clinical seriousness of the schizophrenia vignette; psychologists were able to transcend professional boundaries and recognize the nonclinical seriousness of the mourning vignette. Concurrence was also found in the participants' evaluations of the helpfulness of psychiatric medication for, and the religious etiology of, the presenting problems.

These empirically demonstrated categorical distinctions show that clergy and mental health professionals can distinguish psychiatric dysfunction (*e.g.*, schizophrenia) from emotionally profound religious episodes (*e.g.*, mystical experience) and both from doctrinal religious concerns (*e.g.*, mourning rituals). The parallel patterns of evaluation by the rabbis and psychologists also provide evidence for the utility and construct validity of the three diagnostic categories (Messick, 1995). Comments written by the rabbis and psychologists indicate a willingness to seek co-professional consultation when they encounter presenting problems with cross-professional salience. Further research is now necessary to investigate the relationship between symptom categorization and subsequent co-professional consultation by clergy and mental health professionals.

One limitation of this study is that only rabbis and clinical psychologists were studied. It is recommended that future studies seek a multi-faith and multi-ethnic sample of clergy, as well as additional types of mental health professionals to further evaluate the generalizability of these results.



Another limitation of this study was the overall 54% rate of return. The return rate ranged from 48% for psychologists to 67% for Conservative rabbis. These response rates, however, are consistent with a review of 14 surveys of clergy and mental health professionals where the rates of return ranged from 27% to 73%, and averaged 54% (Meylink and Gorsuch 1988).

### Conclusions

People bring a variety of presenting problems with religious content to both clergy and mental health professionals (Abbott, 1980; Chalfant, et al., 1990). This study has empirically demonstrated that a sample of rabbis and psychologists could distinguish between three diagnostic categories of presenting problems with religious content: mental disorder, religious or spiritual problem (V62.89), and "pure" religious problem. The specific distinctions made by these participants—as well as their cross-professional concurrence—provide evidence for the utility and construct validity of these categories. Use of the categories allows for more subtle differential diagnosis than was available with previous editions of the DSM. Comments written by the participants indicated a willingness to seek consultation for presenting problems with cross-professional salience. The results of this study support the need for future research to evaluate the relationship between the categorical distinctions of diverse presenting problems with religious content and the subsequent initiation of co-professional consultation by mental health professionals and clergy.

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TABLE 2

Summary of Participants' Responses to the Categorical Vignettes: Means, Standard Deviations, ANOVAs

Questions	Mean Values and Standard Deviations <sup>a</sup>						Repeated Measures ANOVAs			
	Schizophrenia		Mystical Experience		Mourning		F	Profession	Category	Interaction
	Psych	Rabbi	Psych	Rabbi	Psych	Rabbi				
Religious Etiology	M	1.71	2.37	2.81	3.05	3.63	3.75	20.69 ***	179.94 ***	4.78 *
	(SD)	(.74)	(.91)	(1.06)	(.97)	(.57)	(.56)	.10	.49	.03
	N	84	109	85	108	90	111	(1, 184)	(1.73, 318.60)	(1.73, 318.60)
Medication Helpfulness	M	3.89	3.66	1.42	1.50	1.40	1.35	.59	1140.73 ***	4.43 ***
	(SD)	(.35)	(.53)	(.67)	(.67)	(.58)	(.62)	.001	.86	.02
	N	85	109	82	108	89	110	(1, 181)	(1.95, 353.48)	(1.95, 353.48)
Seriousness	M	3.99	3.99	1.96	2.06	2.89	3.28	9.25 **	420.14 ***	6.09 **
	(SD)	(.11)	(.11)	(1.01)	(1.01)	(.63)	(.68)	.05	.70	.03
	N	85	109	84	108	88	111	(1, 183)	(1.57, 287.35)	(1.57, 287.35)

<sup>a</sup> Response Codes: 4 = Very, 3 = Somewhat, 2 = Not Very, 1 = Not At All

\* p < .05    \*\* p < .01    \*\*\* p < .001