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Abstract: *This pilot study gathered information regarding overall levels of psychopathology in a nationally selected, random sample of U.S. Roman Catholic secular (i.e., diocesan) priests using the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 2004). The study yielded a response rate of 45%. One-half of the participants reported marked psychological problems, with interpersonal sensitivity, anxiety, and depression most strongly correlated with the instrument's overall index of psychopathology. Four dimensional scales were elevated (i.e., obsessive-compulsive, interpersonal sensitivity, depression, psychoticism), as were two indices (i.e., GSI, PST). Implications and directions for future research are discussed.*

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Introduction

Roman Catholic secular clergy (i.e., diocesan priests who serve in parochial settings in the secular society) in the U.S. face escalating demands, for as their own numbers age and decline, the numbers of parishioners they serve continue to grow. Approximately 23% of this country's population identifies as Roman Catholic (Kenedy & Sons, 2005), translating to 67,820,883 million people. Serving these numbers, however, are fewer than 29,000 secular priests, reflecting a loss of almost 12% in the last 10 years (Kenedy & Sons, 2005). As Schoenherr (1995) stated, "The stark facts are that, while the diocesan priesthood population will have declined by 40 percent between 1966 and 2005, the lay population is increasing by 65 percent. The laity-to-priest ratio ...will double between 1975 and 2005 …At the same time, recruitment and retention will remain chronic problems and the number of retirements and deaths will soar" (p. 12). Were this trend to continue, one emerging from priests' deaths and departures from the priesthood, as well as from few men seeking ordination into Holy Orders, there may soon be few Roman Catholic priests in the U.S., whether secular or religious-order. Those who remain in their vocation will thus likely have to provide greater services to an increasing priest-to-parishioner ratio. Already, however, many priests report being overwhelmed by their vocational responsibilities (Rossetti, 2004), which may make them vulnerable to psychological distress.

Despite this troubling picture, Roman Catholic secular priests in the U.S. have received little empirical attention. In what research exists on this population, Virginia (1998) found that Roman Catholic secular clergy reported significantly greater emotional exhaustion and depression than their religious-order brethren. Key contributing factors were secular clergy's lack of social support and perhaps relatedly, their sense of isolation.

Virginia and his colleagues (Knox, Virginia, & Lombardo, 2002) then extended this research to examine priests' levels of anxiety, in addition to depression. Their study intentionally focused only on secular priests: Comprising the majority of the Roman Catholic clergy, these men reside in the secular world and may then reflect more

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normative experiences. Through their parish duties, they also bear the greatest pastoral responsibility for Roman Catholics in the U.S. The researchers found that Roman Catholic secular priests reported significantly greater depression and anxiety (both state and trait) than the general population.

In their most recent study, Knox, Virginia, Thull, and Lombardo (2005) again found evidence of marked distress in this population, with secular priests reporting rates of depression approximately seven times greater than are found in the general population. Respondents also indicated that the recent sexual abuse scandal in the Roman Catholic Church had negatively affected their mood. In this scandal, more than 1200 priests were named as potential abusers of over 4000 minors, involving all but 16 of the 177 Latin Rite dioceses in the United States (Goodstein, 2003). While the majority of priests were clearly not implicated in this abuse, they may nevertheless be subject to suspicion and mistrust, experiences that may affect their psychological health.

A few other researchers have also examined psychological phenomena among the clerical population, though not specifically Roman Catholic secular priests. In a study from almost 30 years ago, Kennedy, Heckler, Kobler, and Walker (1977) found that of the 271 American Catholic priests who completed both a 2-hr clinical interview and a battery of tests, 8% were deemed "maldeveloped" and 57% "underdeveloped." Only 29% were considered "developing" and 6% "developed." More recently, Keddy, Erdberg, and Sammon (1990) found that their Catholic clergy participants (i.e., 29 men, 13 women; age 29–64) who had been referred for residential treatment demonstrated an intellectualized orientation, naïve defensiveness, and difficulty handling emotions; furthermore, 30% of the men reported confusion or distress regarding their sexual orientation. Although neither of these studies examined actual psychopathology in their samples, they come the closest to doing so within a very small literature base.

Given both the number and variety of the sources of psychological distress found by Virginia and his colleagues, the current study sought to gather broad information regarding psychopathology

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among the Roman Catholic secular priest population in the U.S. As indicated above (Knox, Virginia, & Lombardo, 2002; Knox, Virginia, Thull, & Lombardo, 2005; Virginia, 1994, 1998), we have consistent reports of specific types of psychological distress (i.e., burnout, depression, anxiety) among this population. We do not yet, however, have a more global picture of secular priests' levels and types of psychological suffering, the question examined in the present study. Our hope was that this exploration of secular priests' psychological distress would provide a more complete picture of the mental health status of this population, and thereby foster greater awareness that would lead to the development of supportive services to ameliorate their suffering.

Method

Participants

One hundred Roman Catholic secular priests residing in the United States were randomly selected from *The Official Catholic Directory* (Kenedy & Sons, 2005). We received a total of 45 responses, for a response rate of 45%; all but one response was usable, yielding a usable response rate of 44%.

Measures

A hand-addressed packet was mailed to each potential participant. This packet contained a cover letter describing the study and explaining the individual's right to refuse participation, as well as procedures for confidentiality. The enclosed instruments included a four-item demographic form and the 90 items of the SCL-90-R. Thus, there were 94 items in total.

A brief *demographic form* asked priests to report their age, race, years in the priesthood, and the number of clergy and/or religious with whom they lived.

The *SCL-90-R* (Derogatis, 2004) is a 90-item paper-and-pencil self-report instrument that assesses a broad range of current (i.e., the past 7 days including today) psychological problems and symptoms,

and can be completed in 12–15 min. Respondents rate each item using a 5-point scale, where 0: not at all and 4: extremely. The instrument is scored and interpreted with regard to 9 symptom dimensions (i.e., somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and 3 global indices (i.e., global severity index, positive symptom distress index, and positive symptom total). When converted into *T* scores, each of the 9 dimensions has a mean of $M = 50$ and a standard deviation of $SD = 10$. *T* scores of 63 or higher are considered evidence of "caseness," and denote those who significantly exhibit the symptoms represented by the dimension (here referred to as "positive" cases). The global severity index (GSI) is the primary single indicator of an individual's current level or depth of disorder, and as such integrates information regarding both the number of symptoms and the intensity of the distress. The positive symptom distress index (PSDI) assesses the average level of distress reported for the endorsed symptoms, and thus is a measure of symptom severity. The positive symptom total (PST) indicates the number of symptoms endorsed by the participant, regardless of severity, and is therefore a measure of symptom breadth. As with the 9 dimensional scores, *T* scores at or above 63 on the indices denote a positive case (i.e., the individual is exhibiting significant symptomatology and/or severity of symptoms) (Derogatis, 1994). Sample items begin with the prompt "How much were you distressed by" and include such areas as "headaches," "feeling low in energy," "feeling lonely," "having to do things very slowly to insure correctness," and "feeling tense or keyed up."

The SCL-90-R has been normed with four different groups (i.e., adult psychiatric outpatients, adult nonpatients, adult psychiatric inpatients, and adolescent nonpatients). The current study used the male adult nonpatient sample for appropriate norms. This stratified random sample from a diverse county in a large eastern U.S. state consisted of approximately 1000 individuals, 494 of whom were men and 480 of whom were women (Derogatis, 1994).

Internal consistency reliability (coefficient α) for the SCL-90-R dimensions and global indices ranges from .77 to .90 (Derogatis, Rickels, & Rock, 1976), and one-week test-retest reliability ranges

from .78 to .90 (Derogatis et al., 1976). The instrument also has demonstrated good internal structure validity (e.g., Derogatis & Cleary, 1977a, 1977b), as well as acceptable levels of convergent-discriminant validity (e.g., Derogatis, Rickels, & Rock, 1976).

Results

Although we focus primarily on the results of the "positive" cases, we also include some findings related to the "negative" cases (i.e., those who did not exhibit psychopathology).

Demographic form

The mean age of the positive cases was M = 53.67 (SD = 11.06), and for the negative cases was M = 60.86 (SD = 16.85). There was no statistically significant difference in ages between the two groups [$F(1,42) = 2.81$; $p = .10$]. With regard to race, there was also no statistically significant difference in race between the two groups [$F(3,36) = .286$; $p = .84$], likely because the vast majority (i.e., 87.5% of those who reported race) were White. In terms of years in the priesthood, the positive cases reported a mean of M = 22.68 (SD = 15.43), and the negative cases reported a mean off M = 30.05 (SD = 17.52) years in the priesthood. There was no statistically significant difference in years of priesthood between the positive and negative cases [$F(1,38) = 1.97$, $p = .17$]. The positive cases lived with an average of M = 1.37 (SD = 1.57) other priests, and the negative cases with an average of M = 1.10 (SD = 1.58) other priests. Again, there was no statistically significant difference in the number of other religious with whom the positive versus negative case participants lived [$F(1, 38) = .30$, $p = .59$].

SCL-90-R

Of the 44 participants, 22 exhibited an elevation (i.e., $T \geq 63$) on at least one dimension or index, and are thus considered "positive" cases; none of the "negative" cases showed such elevations. Thus, 50% of the sample exhibited marked psychological problems. More specifically, four dimensions (i.e., obsessive-compulsive, interpersonal sensitivity, depression, psychoticism) and two indices (i.e., GSI, PST)

were elevated, with the largest number of participants exhibiting elevations on the depression scale. The means and standard deviations for the nine dimensions and three indices for both the positive and negative cases appear in Table 1.

Given earlier findings (Virginia, 1998) suggesting that priests' lack of social support and isolation may be related to emotional exhaustion and depression, we wondered whether, within the positive cases, there was any difference in the GSI score between those who lived with others and those who lived alone. We found no such differences [$F(1,17) = .02$, $p = .92$].

In addition, the Roman Catholic Church defines senior priests as those who have been in the priesthood for at least 25 years, and junior priests as those who have been priests for less than 25 years (Fr. Stephen G. Virginia, personal communication; May 22, 2006). We examined, then, whether there were any significant differences in psychopathology (i.e., GSI scores) among the positive cases, between senior and junior priests. To examine this question, we divided the priests into three groups (i.e., those who had been priests for less than 12 years [$n = 7$], those who had been priests for between 12 and 24 years [$n = 3$], and those who had been priests for at least 25 years [$n = 9$] [Note: Three of the positive cases did not report their years in priesthood.] We chose to use the three-(i.e., instead of two-) way division to see if there might be a type of "pivot point" at which psychopathology begins to manifest itself. There were no statistically significant differences in psychopathology between these groups [$F(2, 16) = .36$, $p = .70$].

Correlations

As seen in Table 2, a number of dimensions correlated with the three indices at the $p < .01$ level among the positive cases. We refer readers to this table, and because of space limitations will here discuss only the three strongest such correlations for each index. The dimensions that correlated most highly with the single, overall index of psychopathology (i.e., GSI) were interpersonal sensitivity ($r = .92$), anxiety ($r = .85$), and depression ($r = .84$). Depression correlated most highly with the positive cases' PSDI scores ($r = .80$), followed by

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interpersonal sensitivity (r = .79) and psychoticism (r = .72). Interpersonal sensitivity again showed the highest correlation with these participants' PST scores (r = .82), followed by anxiety (r = .79) and hostility (r = .77). Given the apparent contributions of the interpersonal sensitivity, depression, and anxiety dimensions, we now look more closely at the intercorrelations related to these three scales.

Interpersonal sensitivity

Interpersonal sensitivity was correlated at the .01 level (two-tailed) with six other dimensions (i.e., obsessive-compulsive, depression, anxiety, hostility, paranoid ideation, and psychoticism). The correlations ranged from r = .64 to r = .82.

Depression

Depression was correlated with five other dimensions at the .01 level (two-tailed) (i.e., interpersonal sensitivity, anxiety, hostility, paranoid ideation, and psychoticism). Here, the correlations ranged from r = .54 to r = .82.

Anxiety

Anxiety was correlated at the .01 level (two-tailed) with seven other dimensions (i.e., somatization, interpersonal sensitivity, depression, hostility, phobic anxiety, paranoid ideation, and psychoticism). The correlations ranged from r = .60 to r = .74.

Discussion

Entire sample

What, then, do the findings from this pilot sample of Roman Catholic secular priests tell us? First, whether a "positive" or a "negative" case, these predominantly White men were typically in their mid-50s/early-60s and had been in the priesthood for at least two decades. Furthermore, "junior" and "senior" priests exhibited no differences in psychological suffering. Thus, neither age nor years in priesthood emerged as a factor that differentiated between those with

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and those without significant psychological distress. The number of other priests with whom our participants lived similarly failed to distinguish between more versus less symptomatic priests. This latter finding is intriguing, for it contradicts the earlier work of Virginia (1998), who found that secular clergy's lack of social support was an important factor in their greater emotional exhaustion and depression, as compared to their religious-order brethren. We wonder if the absence of such a finding in the current study is an artifact of our small sample size.

Positive cases

Perhaps the strongest, and most alarming, finding is that fully half of the present sample exhibited significant psychological distress. Although we may not yet have a clear understanding of what may contribute to, or ameliorate, such suffering, its existence here is painfully clear. Feelings of inadequacy and inferiority (i.e., interpersonal sensitivity), anxiety, and depression appeared to play a powerful role in these priests' distress. The presence of anxiety and/or depression among this sample is consistent with earlier research (i.e., Knox et al., 2002, 2005; Virginia, 1998).

Now looking at the findings more specifically, priests' interpersonal sensitivity was highly linked with the presence of unwanted and unremitting thoughts, impulses, or actions (i.e., obsessive-compulsive dimension); dysphoric mood and affect; anxiety; thoughts, feelings, or behaviors indicative of anger (i.e., hostility dimension); disordered and suspicions thinking (i.e., paranoid ideation dimension); and alienation, hallucinations, and thought control (i.e., psychoticism dimension). Thus, these respondents' sense of their own adequacy and worth suffered amid quite a range of undoubtedly unpleasant and disturbing thoughts, feelings, and impulses. In a population whose very vocation often demands that they resist such thoughts and urges, their strong presence here quite understandably contributed to their overall distress.

Participants' depression was likewise strongly correlated with a variety of other dimensions, including interpersonal sensitivity (discussed above), anxiety, hostility, paranoid ideation, and

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psychoticism. Similarly, their anxiety was linked with somatization, interpersonal sensitivity (discussed above), depression, hostility, phobic anxiety (i.e., intense, irrational, and persistent fear), paranoid ideation, and psychoticism. From these correlations, no single or clear pattern emerges. Instead, participants' responses indicate that they are significantly troubled in many and different ways, suggesting that attempts to reduce such distress would most prudently be multi-faceted (see below).

Limitations

This study is limited by its small sample size. It is extremely difficult to achieve statistically significant findings with a sample of 44 persons. The response rate was consistent with Knox et al. (2005), but lower than that of previous research conducted on Roman Catholic clergy (Knox et al., 2002; Virginia, 1994, 1998). These studies followed identical methodologies, with the exception of a stipend: Virginia included a $2 stipend for his participants, whereas Knox has not done so. Both of the Knox studies reported lower response rates than did Virginia. Outside of the stipend, we do not know what else may have contributed to the reduced rate of response, but suspect that continuing stress related to the recent sexual abuse scandal in the Church may have made priests wary about answering questionnaires. In addition, most of the respondents were White, resulting in little diversity within the sample.

Implications and future directions

Based on previous research that has consistently reported specific types of psychological distress among U.S. Roman Catholic secular priests (Knox et al., 2002, 2005; Virginia, 1994, 1998), we sought in the current study to gather more broad-based information regarding psychopathology in this population. The implications of our findings are indeed worrisome. Likely of most importance here is that 50% of the present sample exhibited marked psychological distress. This finding, in and of itself, is cause for substantial concern, for it reflects a shocking rate of suffering in this population. The vocational demands of secular priests are certainly not diminishing; nor, apparently, is their distress. The presence of such pathology calls into

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question secular priests' capabilities of effectively serving their parishes and parishioners, for their daily functioning cannot be immune from their fragile mental health. Simply put, the Roman Catholic Church must attend to such findings, or an already troubling decline in priests may well become even more severe.

In addition, it seems, at least from the present results, that neither age, years in the priesthood, nor the number of clergy with whom one lives clearly contributes to, nor protects against, psychopathology. If such findings are confirmed in future research, it would appear that time (i.e., across the lifespan as well as in the clergy) is not an active factor in priests' psychological distress, nor is the presence or absence of living companions. Most importantly, however, these preliminary results must be the subject of additional investigation.

With regard to the specific dimensions of the SCL-90-R associated with global pathology, interpersonal sensitivity, anxiety, and depression emerged as most salient. Depression and anxiety are quite often co-morbid, and the consequence of those two forms of suffering may well be feelings of inferiority and inadequacy. Such findings, then, are not surprising, and suggest that any attempts to ameliorate priests' suffering should attend less to distinct forms of distress and more to the presence of broader and pervasive psychopathology.

We certainly recognize, however, that these findings are based on but 44 participants. Thus, we strongly urge that follow-up research be conducted on a larger sample to assess the representativeness of the present results. Doing so may also better illuminate factors that may contribute to, as well as protect against, such distress.

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Notes

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Appendix

Table 1. Descriptive statistics for positive and negative cases

	Cast type					
	Positive cases			Negative cases		
Scale	*T*-score *M*	*SD*	# Cases elevated	*T*-Score *M*	*SD*	# Cases elevated
Somatization	58.14	11.67	8	49.73	8.94	2
Obsessive compulsive	66.14	7.59	13	52.64	6.68	1
Interpersonal sensitivity	67.18	8.34	14	50.91	6.70	2
Depression	70.27	7.83	18	50.73	8.03	1
Anxiety	62.05	11.57	7	46.09	7.34	0
Hostility	59.00	10.37	7	48.05	7.12	1
Phobic anxiety	54.14	10.57	6	48.09	3.53	0
Paranoid ideation	62.73	12.21	10	44.41	4.87	0
Psychoticism	67.14	7.42	16	50.45	7.05	1
Global severity index	67.23	7.83	17	49.32	7.72	0
Positive symptom distress index	59.50	7.92	7	47.95	6.55	0
Positive symptom total	65.82	6.30	17	49.55	8.02	0

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Table 2. Correlations for positive cases

	Reside	Age	Yrs Priesthood	SOM	OC	IS	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
# Religious reside															
Pearson correlation	1	-.093	-.018	.175	.135	.035	-.146	-.104	.079	.209	-.125	.049	.025	.026	.013
Sig. (2-tailed)	-	.704	.940	.474	.583	.885	.551	.673	.748	.390	.610	.843	.920	.917	.959
Age															
Pearson correlation	-.093	1	.773(**)	.182	.224	.107	.436 (*)	.208	.266	.008	.119	.089	.258	.276	.221
Sig. (2-tailed)	.704	-	.000	.417	.317	.637	.043	.352	.231	.972	.597	.694	.247	.214	.323
Yrs. in priesthood															
Pearson correlation	-.018	.773 (**)	1	.010	.233	.111	.325	-.144	.008	-.298	.017	.065	.116	.260	-.034
Sig. (2-tailed)	.940	.000	-	.967	.336	.652	.174	.557	.975	.216	.945	.791	.637	.283	.889
SOM															
Pearson correlation	.175	.182	.010	1	.509 (*)	.533 (*)	.383	.656 (**)	.513 (*)	.606 (**)	.432 (*)	.394	.714 (**)	.465 (*)	.771 (**)
Sig. (2-tailed)	.474	.417	.967	-	.015	.011	.097	.001	.015	.003	.045	.069	.000	.029	.000
OC															
Pearson correlation	.135	.224	.233	.509 (*)	1	.635 (**)	.523 (*)	.399	.650 (**)	.443 (*)	.402	.664 (**)	.706 (**)	.681 (**)	.648 (**)
Sig. (2-tailed)	.583	.317	.336	.015	-	.002	.013	.066	.001	.039	.064	.001	.000	.000	.001
IS															
Pearson correlation	.035	.107	.111	.533 (*)	.635 (**)	1	.821 (**)	.741 (**)	.657 (**)	.498 (*)	.702 (**)	.804 (**)	.919 (**)	.791 (**)	.817 (**)
Sig. (2 tailed)	.885	.637	.652	.011	.002	-	.000	.000	.001	.018	.000	.000	.000	.000	.000
DEP															
Pearson	-.146	.436	.325	.363	.523	.821	1	.669	.669	.344	.538	.773	.840	.797	.703
correlation		(*)			(*)	(**)		(**)	(**)		(**)	(**)	(**)	(**)	(**)
Sig. (2-tailed)	.551	.043	.174	.097	.013	.000	-	.001	.001	.117	.010	.000	.000	.000	.000
ANX															
Pearson correlation	-.104	.208	-.144	.656 (**)	.399	.741 (**)	.669 (**)	1	.642 (**)	.639 (**)	.717 (**)	.602 (**)	.854 (**)	.706 (**)	.792 (**)
Sig. (2-tailed)	.673	.352	.557	.001	.066	.000	.001	-	.001	.001	.000	.003	.000	.000	.000
HOS															
Pearson correlation	.079	.266	.008	.513 (*)	.650 (**)	.657 (**)	.669 (**)	.642 (**)	1	.524 (*)	.527 (*)	.586 (**)	.780 (**)	.593 (**)	.774 (**)
Sig (2-taile)	.748	.231	.975	.015	.001	.001	.001	.001	-	.012	.012	.004	.000	.004	.000
PHOB															
Pearson correlation	.209	.008	-.298	.606 (**)	.443 (*)	.498 (*)	.344	.639 (**)	.524 (*)	1	.535 (*)	.486 (*)	.636 (**)	.483 (*)	.606 (**)
Sig. (2-tailed)	.390	.972	.216	.003	.039	.018	.117	.001	.012	-	.010	.022	.001	.023	.003
PAR															
Pearson correlation	-.125	.119	.017	.432 (*)	.402	.702 (**)	.538 (**)	.717 (**)	.527 (*)	.535 (*)	1	.579 (**)	.734 (**)	.621 (**)	.683 (**)
Sig. (2-tailed	.610	.597	.945	.045	.064	.000	.010	.000	.012	.010	-	.005	.000	.002	.000
PSY															
Pearson correlation	.049	.089	.065	.394	.664 (**)	.804 (**)	.773 (**)	.602 (**)	.586 (**)	.486 (*)	.579 (**)	1	.786 (**)	.720 (**)	.695 (**)
Sig. (2-tailed)	.843	.694	.791	.069	.001	.000	.000	.003	.004	.022	.005	-	.000	.000	.000
GSI															
Pearson correlation	.025	.258	.116	.714 (**)	.706 (**)	.919 (**)	.840 (**)	.854 (**)	.780 (**)	.636 (**)	.734 (**)	.786 (**)	1	.842 (**)	.925 (**)
Sig. (2-tailed)	.920	.247	.637	.000	.000	.000	.000	.000	.000	.001	.000	.000	-	.000	.000
PSDI															
Pearson correlation	.026	.276	.260	.465 (*)	.681 (**)	.791 (**)	.797 (**)	.706 (**)	.593 (**)	.483 (*)	.621 (**)	.720 (**)	.842 (**)	1	.597 (**)
Sig (2-tailed)	.917	.214	.283	.029	.000	.000	.000	.000	.004	.023	.002	.000	.000	-	.003
PST															
Pearson correlation	.013	.221	-.034	.771 (**)	.648 (**)	.817 (**)	.703 (**)	.792 (**)	.774 (**)	.606 (**)	.683 (**)	.695 (**)	.925 (**)	.597 (**)	1
Sig (2-tailed)	.959	.323	.889	.000	.001	.000	.000	.000	.000	.003	.000	.000	.000	.003	-

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Note. Reside: number of clergy/religious with whom participant resides; Age: age of participant; Yrs Priesthood: number of years since ordination; SOM: somatization; OC: obsessive-compulsive; IS: interpersonal sensitivity; DEP: depression; ANX: anxiety; HOS: hostility; PHOB: phobic anxiety; PAR: paranoid ideation; PSY: psychoticism; GSI: Global Severity Index; PSDI: Positive Symptom Distress Index; PST: Positive Symptom Total.
**Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).