Religious Issues in Psychotherapy

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Jane was facing major surgery for cancer. She was full of shock, anger, dread of mutilation, and fear of death. As an agonizing psychotherapy session the day before the surgery drew to a close, her parting request of her psychiatrist was "Doctor, please pray for me!" Prayer was not in her agnostic doctor's repertoire. How was he to respond? After an instant of reflection, he said, "You will be very much in my mind tomorrow. I hope you will come through the operation safely with a minimum of harm to your body." So was resolved, for the moment, an instance of the frequent emergence of religious issues in psychotherapy.

What other options were available to Jane's psychiatrist? Despite being an agnostic, he might have said, "I will pray for you," translating this in his mind to mean what he had actually said in words. But this would have been a lie in the literal sense, and it would have given a false message about his personal religious stance. If he had instead been a religious man, a promise to pray would have communicated that fact, with other potentially limiting effects for the psychotherapy. For example, what if Jane eventually needed to work with deep personal doubts about her faith? Could she trust her religious psychiatrist not to condemn her doubts?

In his quick clinical decision, Jane's psychiatrist also considered the personality of his patient and the nature of the psychotherapy. Although warmth and support were appropriate, Jane was not so dependently needful that she required a literal promise of prayer. Had the therapy been primarily supportive of a patient with a very primitive level of ego functions, he might have responded on a simplistic level, but this was an exploratory psychodynamic therapy in which Jane and he looked closely at the meaning of thoughts and words.

Two important therapeutic principles were involved in this decision. One involves *honesty and trustworthiness* in the treatment relationship; the other, *abstinence and neutrality*. A therapist does not lie to his or her patients, and for some patients this ethical stance is experienced as a radical departure from what has regrettably happened before with parents or authority figures. A therapist also does not pass judgment on patients or try to impose his or her personal views or morality upon them. Entering the patient's mental life, the therapist's aim is to participate in the patient's own understanding of the complex issues of his or her personal life history and conflicting internal and external forces, to find a richer and more workable resolution of those issues.

True, I am describing an ideal situation. The therapist's personality and values, particularly the values that inform psychotherapy itself, do come across to the patient. The therapist cannot be a totally blank screen. Agnostic, atheistic, or religious, the therapist's stance may be sensed by the patient, and this may eventually call for efforts to reinforce the patient's autonomy and independent judgment. At any phase of treatment, attempts at religious proselytizing of the patient by the psychotherapist are incompatible with the aims and technique of psychotherapy.

Psychotherapy itself, like any other significant human endeavor, is not value-free. For instance, it implicitly values conscious awareness of one's mental life, the ability to face internal and external reality, seeking rational thought before action, development towards more mature psychic functions, and a superego that controls behavior before the fact rather than sadistically punishing unacceptable thoughts or deeds afterwards. In a successful psychotherapy, the patient identifies with and implements such values. But this leaves a wide scope for individual moral, religious, political, or intellectual stances. Only what patients work out for themselves will have a lasting effect.

Few aspects of mental life are more closely held than one's religion. For many patients, religion influences large domains of their thinking. When they are at peace with their religious life or engaged in a therapy with narrowly limited objectives, religion may not be relevant to the therapy. But in many instances, it does enter, front and center, onto the therapeutic stage.

John, a single young man of 19, was sent far from home on a 2-year evangelistic mission that all young people in his church were expected to undertake. He was riddled with anxiety and phobic about socializing with young people in the local congregation he was visiting. At first, he was very superficial in his conversations with his psychiatrist. He also resisted using psychotropic medication, feel-

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ing that his church would not approve of mind-altering substances. Gradually he developed trust in his psychiatrist and hesitantly confessed that he was struggling against his sexual thoughts, which he regarded as sinful. His religion forbade him to masturbate, and the conditions of his mission forbade him to form romantic relationships in his host church. This virile young man was in a severe state of anxiety that ill concealed frustration and anger.

The psychiatrist gently commented that no one can remove from him the task of reconciling his own needs and moral position with those of his religious heritage, but that perhaps it would be easier to do so if he let himself be consciously aware of what he is struggling with. Here the psychiatrist did reveal a moral position—that the thought or impulse, no matter how dire, is not the same as the act, contrary to some religious teachings. Knowing the wish (to make love, to kill, to get away…) without punitive guilt about the conscious thought allows a person to consider the moral principles and realistic consequences of the wished for action. Being able to face one's impulses honestly and control them enables a person to behave appropriately. If a person is secure in control of his or her behavior, there is no need to be afraid of unacceptable wishes—rather the person becomes wiser and more attuned to the human condition. The vaguely obscure conflict becomes a known dilemma, not a threat to be pushed out of awareness and replaced with nameless anxiety.

The strictures of one's religious and ethnic community can lead to powerful inner conflicts. Sarah, a bright, attractive young woman of 19, presented with panic attacks. Her family had selected her psychiatrist precisely because he was not a member of her religious community, so that she could avoid being stigmatized by seeing a psychiatrist. In her community, a woman of 19 who was not yet betrothed was the subject of much concern, disapproval, and gossip. But she yearned to go to college, get an advanced degree, and have a professional career. Her panic diminished as she realized in psychotherapy how torn she was between these paths. She felt intensely guilty about not welcoming the expected marriage, yet frightened that she might be ostracized by her tight-knit community and never marry or have children. After a few sessions, she resolved the dilemma for herself by arranging a successful introduction to a young man of the same faith in another city. He was in graduate school, strongly supported her educational ambitions, and would work with her to make it possible to combine children and career.

Sin is a powerful religious concept, especially when coupled with the threat of eternal suffering in the afterlife. Hellfire and damnation still thunder from certain popular pulpits, as they do from the "Dies Irae" movements of classical requiem masses. If such messages are taken deeply to heart, they can contribute to a powerfully sadistic conscience that is more successful at punishment than preventive control. Some patients may present with deep guilt about youthful premarital sexual relations or an abortion in their distant past. Others are tormented by scrupulous, obsessive overconcern about trivial misbehavior. Despite the power of their religiously inspired guilt, these individuals seem unable to avail themselves of the forgiveness and possibility of redemption that their religion also affords them. Their perpetual torment already occurs in this life. Often afflicted with deep depression, they may be driven to suicide, a punitive self-murder that may occur despite their claims that the threat of damnation would deter them. Psychosis may also bend and distort religious beliefs to its own extreme uses. Psychotherapy is a crucial part of treatment when such issues arise.

The sadism of a punitive conscience cannot be attributed to religion alone. Many religious perspectives, even a person's vision of his or her God, are likely to be rooted in early childhood development.[1] Our early object relations become a template for our image of God. A view of God as loving, caring, enfolding, healing, and protective may reflect the emotional tone—real or wished for—of one's parents. A view of God as wrathful and punitive may embody the sadistic punishments administered by parents, early teachers, or religious figures. Physical, emotional, or sexual abuse at the hands of clergy severely compounds such distortions, just as does abuse by parents. Issues of extreme idealization—or devaluation—of parents or religious leaders are often the stuff of psychotherapy, as illusions are shattered and the person must come to grips with the fact that these childhood figures are mostly ordinary human beings whose faults, damaged lives, and failures are mixed with qualities that evoke trust and love.

From this broad overview of religious issues in psychotherapy, one can see the importance of identifying and addressing such issues when they arise, with great respect for the patient's autonomy and responsibility for his or her personal beliefs. While potentially ameliorating symptoms in which religion plays a part, the patient's enhanced understanding may also lead to a more mature and conflict-free approach to the religious dimension of human existence. Such therapeutic experiences may also give the therapist much to reflect upon.

Reference

1. Rizzuto A-M. The birth of the living God: A psychoanalytic study. Chicago and London: University of Chicago Press; 1979.