Religion and the Psychotherapeutic Relationship

Transferential and Countertransferential Dimensions

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The salience of religion in society and health care has received increased attention. Recent developments in psychiatry reflect a broader view of religion that includes an appreciation of its adaptive and maladaptive dimensions. An examination of religious countertransferential and transferential reactions provides a framework for examining religious themes. Case examples illustrate the following critical factors that increase therapists' skill in working with religious themes: 1) monitoring the therapist's own attitude toward religious content, 2) attending to religious content, 3) seeking consultation, and 4) using religious content in interpretations.

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The examination of transference and countertransference is an essential and challenging dimension of psychotherapy. Working with religious transference and countertransference poses a challenge because of the historical avoidance of religion in mental health fields, therapists' discomfort in working with religious content, and the limited body of knowledge regarding skills that equip therapists to work effectively with religious themes. Integrating previous research on these aspects of addressing religious and cultural themes, we will use a "religiocultural" framework to analyze the religious dimensions of transference and countertransference in two case studies.

Background

Religion is an integral part of human culture that helps order experience, beliefs, values, and behavior. Clifford Geertz[1] defines religion as a "system of symbols which acts to establish powerful pervasive and long-lasting moods and motivations in man by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations

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seem uniquely realistic" (p. 90). The religious components of the self and culture emerge in a multitude of ways: in increasing attention to Eastern religions, in 12-step recovery groups, in concern about the environment and earth awareness, and in personal and social transformation.[2] For some, religious feeling is personal and self-defined and may be independent of any religious community; for others, it is defined within a religious community.

The salience of religion has been documented. Among the U.S. general public, 66% of those surveyed indicated that religion is important in their lives.[3] The religious beliefs and practices of mental health professionals have also been examined.[4,5] The findings suggest that psychologists view religious and spiritual issues as important in their clinical practice but that most clinicians feel unprepared to address the religious and spiritual concerns of their patients.[5] Mental health professionals receive minimal training in addressing spiritual and religious issues in psychotherapy. In response to this lack, a model curriculum has been developed for residency training,[6] and continuing education opportunities are offered by Division 36 of the American Psychological Association and the Committee on Religion and Psychiatry of the American Psychiatric Association.

Despite the prominent role of religion in people's lives, it has not been routinely addressed in psychotherapy. Koechems[7] noted that attitudes toward religion are frequently polarized; the perspective that religious content is either special or unimportant has prevented therapists from maintaining a neutral stance. Traditional psychoanalytic views of religion, as well as the historical separation between mental health and religion, have contributed to a therapeutic avoidance of the topic. This avoidance has been well documented.[8,9] Although Jung[10] and James[11] viewed religion as an essential function of the psyche, Freud's characterization of religion as an illusion and his depiction of religious belief as an attempt to restore an individual's long-lost relationship with father supported the notion that religion was irrational and an expression of wish fulfillment.[12,13] In this tradition, the organizational and institutional aspects of religion were emphasized rather than the psychological and subjective dimensions. In contrast, developmental approaches to faith (as discussed in the next section) provide critical tools for understanding the psychological aspects of religious experience, including its adaptive and maladaptive dimensions.[9,14] The polarization of views and the history of tension between religion and mental health increase the likelihood that the therapist will be biased either positively or negatively toward religion.

RELIGIOCULTURAL TRANSFERENCE AND COUNTERTRANSFERENCE

Religious themes emerge in multiple ways in the therapeutic process. The appearance of religious themes may be related to conflictual and regressive situations, defensive moves, and transferential feelings.[15] For example, a woman who was treated for symptoms of depression presented after the death of her 16-year-old son by car accident. She described some aspects of her life openly until the focus was on her loss. Then she said, "That's what God wanted, and there's nothing more to say." She held this position for several months, using God as a defense to protect her from uncomfortable affects and unresolved conflicts.

From an object relations perspective, God's appearance in conscious associations may be understood in transferential terms. Anna Maria Rizzuto described the developmental process of forming a God-representation.[15,16] Rizzuto emphasized the formation of private God-representations that occur in dialectical integration with the formation of other self-representations. Such a God has been created and may undergo transformations that capture the developmental struggles of the individual.

God's appearance in treatment also has meaning for therapists. Comas-Diaz and Jacobsen[17] coined the terms *ethnocultural transference* and *ethnocultural countertransference* to refer

to the major therapeutic responses that may arise for therapists and patients in intra-ethnic and inter-ethnic dyads. Respectively, these terms refer to how the patient's cultural background influences response to the therapist and how the therapist's cultural background influences response to the patient. Although ethnocultural similarities and differences may impede rapport, they may also serve as catalysts for addressing issues such as trust, anger, acknowledgment of ambivalence, and acceptance of disparate parts of the self.

Extending Comas-Diaz and Jacobsen's work, we propose that an examination of "religiocultural" transference and countertransference is a critical prerequisite for determining the salience of religious themes in the psychotherapeutic process. Spero[18] discussed common countertransferential and transferential difficulties that emerge when religious therapists work with religious patients. He emphasized the importance of distinguishing patients' normal needs from their neurotic needs for religious belief and practice, and of recognizing how religious similarities and differences influence the therapist's response. Patients' perceptions of therapists' religious affiliation and patients' fantasies regarding assumed similarities and differences may provide rich material for illuminating transferential themes. Religiocultural transference and countertransference may be explored for various religious and cultural viewpoints, including atheism. We propose that religiocultural transference and countertransference are considerations not only for religious patients and therapists, but for all patients and therapists.

Four types of religiocultural transference and countertransference will be described. The patient's and therapist's reactions may be in response to known, assumed, or fantasized aspects of their religious backgrounds. *Interreligious transference* may emerge when the patient perceives that the therapist and the patient have different religious backgrounds. *Intrareligious transference* may occur when the patient perceives that therapist and patient have similar religious backgrounds. *Interreligious countertransference* may occur when the therapist perceives that therapist and patient have different religious backgrounds. *Intrareligious countertransference* may emerge when the therapist perceives that therapist and patient have similar religious backgrounds.

CASE EXAMPLES

The following case examples highlight the countertransferential challenges and transferential themes that may emerge in response to religious content. In the first case, the primary focus is on the therapist's struggles.

Ms. Y. is a middle-aged, divorced Caucasian Catholic. She was experiencing symptoms of depression and anxiety in response to feelings of inadequacy as an employee, daughter, and mother. She attributed these concerns to her upbringing as well as her Catholic background. Due to her mother's illness during her childhood, Ms. Y. had increased responsibilities and had little time for age-level play. She married at a young age and endured an unsatisfying marriage. She felt inadequate as a mother and was preoccupied with making the right decisions and avoiding failure. Ms. Y. experienced guilt when she pursued pleasurable activities and viewed God as a punitive and wrathful father who sought to deny pleasure.

Therapist C. uses a psychodynamic orientation in her work with adults. Her areas of specialty include occupational stress and anger management. Dr. C. is an African American woman whose denominational background is United Methodist, but she attends a variety of churches, including charismatic churches. Dr. C.'s spiritual beliefs are Judeo-Christian.

First Treatment Course. Treatment occurred in two phases. During the first phase of treatment, the focus was on reducing the patient's depression and anxiety related to her role as a employee and a daughter. Dr. C. was quite confident during this phase of the work, since she was able to use her expertise in occupational stress to evaluate the degree of match between Ms. Y.'s work environment and her personality. She helped this patient manage her stress more effectively and consider work that would be better suited to her talents and ability. Some of her anxiety was understood as deriving from the

demanding expectations that she had internalized from early childhood. Work was done to examine the harshness of her superego and to lessen her expectations for perfection. She was also encouraged to explore feelings of anger and resentment that she might have in response to these demands.

On multiple occasions, Ms. Y. referred to the prominent role of the church, Catholicism, and her concerns about sinning as contributing factors to her anxiety and depression. Although Dr. C. heard this communication and recognized its salience for this patient, she was less clear about how to respond to this content. Ms. Y. believed that Dr. C. had some understanding of Ms. Y.'s religious background but assumed that she was from a different faith. Ms. Y. assumed that Dr. C.'s background was a traditional African American Baptist doctrine that would emphasize being holy and would view pleasure as sinful. When Dr. C. did not discourage her exploration of pleasure, Ms. Y. began to express more of her desires. She then assumed that religion was not important for Dr. C. and that Dr. C. did not understand the traditions of the Catholic church. Ms. Y. noted that perhaps she should talk with a priest about her religious concerns. Dr. C. attempted to assist Ms. Y. in understanding the underlying dynamics of her beliefs and her selective incorporation of aspects of Catholicism that reinforced her long-standing difficulties. Dr. C. consulted with a colleague and recommended a book to Ms. Y. that highlighted the grace and mercy of God from a Catholic perspective.

Countertransferential Dimensions. Sharing her biases with a colleague helped Dr. C. explore the experiences that contributed to her feelings. Several countertransferential reactions interfered with Dr. C.'s ability to attend to the patient.

First, although Dr. C.'s view of God had evolved from a more legalistic God to a more personal and loving Father who desired fulfillment for her and his creation, Ms. Y.'s depiction of a judgmental God and his sinful view of pleasure resonated with Dr. C.'s early exposure to religion. Dr. C.'s initial response was to feel immobilized by the power of these beliefs and to feel helpless to counter or modify them.

Second, Ms. Y.'s beliefs matched Dr. C.'s stereotypes regarding the Catholic faith, and Dr. C.'s initial unspoken reaction was that this patient would need to leave the Catholic faith and find a less guilt-inducing denomination. This reaction was not communicated to the patient, but the strength of this reaction restrained Dr. C. from responding to the religious content out of concern that this bias would be communicated.

Third, although Dr. C. had contemplated integrating work with religious content in her therapeutic work and valued the importance of this, she could not work with this content as confidently as with other content and was concerned that she would not intervene appropriately or that religious concerns would dominate the therapy.

Dr. C.'s consultation with a colleague who was Catholic provided direction regarding how to proceed. This colleague shared a more differentiated perspective on Catholicism and noted that despite the prevalence of feelings of guilt, Catholics have opportunities through reading, support groups, and conversations with priests to be less overwhelmed by these feelings. This knowledge allowed Dr. C. to view Catholicism from a more positive perspective and to consider that a more differentiated look at Catholicism might be most beneficial to the patient.

Transferential Dimensions. Following the consultation, Dr. C. felt greater freedom to explore the transferential dimensions of Ms. Y.'s communications. Ms. Y.'s view of God as a punitive, wrathful father was similar to Ms. Y.'s perception of her own father. Because Ms. Y. expected disapproval from her father and from God, she also anticipated that her therapist would be disapproving. Although there was some exploration of the transferential dimensions, Dr. C. continued to be reluctant to integrate her religious struggles into the work and used the book both as a resource for the patient and a way of sidestepping the patient's religious concerns related to seeking pleasure.

Second Treatment Course. Following the first course of therapy, Ms. Y. returned for a brief treatment course. Her depression and anxiety had decreased, and she wanted to address some of the concerns that arose for her in relationships. Her goal was to develop more mutually satisfying relationships. When Ms. Y. presented her desire to work on relationship issues, Dr. C. used this as an opportunity to explore Ms. Y.'s feelings about her relationship with Dr. C. This question had been posed before at different times during the first phase of therapy; however, this was the first time that Dr. C. was open to hearing Ms. Y.'s

feelings about the religious dimensions of the relationship. Racial differences had been explored, but not religious differences and similarities.

Ms. Y. recalled that she had discussed religion superficially but that she had not felt permission to discuss her feelings about her experience of Catholicism and her feelings of guilt. She realized that a portion of this discussion might be most appropriate with a priest, but she also wanted to discuss it more in therapy. Her wish to discuss these issues with a priest might also reflect her anxiety in exploring her desires. Dr. C. acknowledged her own avoidance of this content in the past and indicated that discussion would have been valuable. Ms. Y. was encouraged to address this issue in her future work by sharing her associations that linked guilt, Catholicism, and avoiding pleasure, sharing her early experiences in the Catholic faith, and examining her religious associations when she engages in pleasurable activities.

Religiocultural transference and countertransference considerations with this patient included the similarities and differences in religious beliefs between the therapist and the patient, as well as the therapist's countertransference struggles regarding revealing or concealing her religious beliefs. Consultation with a colleague, reading, and practicing interventions that incorporate religious content prepared this therapist to work more effectively with this patient's concerns.

Ms. Y. clearly asserted the importance of her struggle with Catholicism throughout her therapy. Her therapist's avoidance of these concerns included interreligious elements. The initial interreligious countertransference involved differing views of God. Her therapist had to resist urges to persuade Ms. Y. that God was not simply punitive. Intrareligious countertransference emerged as similarities in the therapist's and patient's initial exposure to religion interfered with the therapist's ability to respond to the patient's concerns. The therapist's fear of overemphasizing religion and her inability to incorporate religious issues into the psychotherapeutic process resulted in avoiding the issue or only superficially exploring it. Readings were recommended that might assist Ms. Y. in pursuing a Catholic faith that incorporated a more loving God, but the psychological dimensions of her faith were not examined in more depth.

During the second course of therapy, her therapist had been involved in substantial exploration of ways of considering a religiocultural framework in psychotherapy and was more open to addressing Ms. Y.'s religious narrative. The therapist responded to the challenge to address spiritual concerns as they emerged in therapy and appreciated the importance of this exploration in deepening her understanding of her patients. She had also found that this content could be explored in a way that was consistent with and facilitated the therapeutic process. In addition, at this point she was more comfortable with containing the variety of affects that religious and spiritual experiences might evoke in her, such as anger at God or painful feelings about people being mistreated under the guise of religion. Dr. C. was better equipped to differentiate the adaptive and maladaptive aspects of Ms. Y.'s struggle. Ms. Y.'s anger was not only directed toward her father but also toward a God whom she felt did not condone pleasure. Exploration of specific ways that she developed this perception of God, as well as her desire to be free of this strong inhibition against pleasure, increased her ability to pursue pleasurable activities.

Ms. R. is a young adult, married Caucasian Jehovah's Witness. She was experiencing symptoms of depression in response to feelings of inadequacy and worthlessness in her role as a wife, mother, daughter, and member of her faith community. She related these concerns to her early family experiences. She grew up in an environment where parental availability was inconsistent because of her mother's depressive episodes and her father's leadership role in his spiritual community. She initially identified her religious ministry, door-to-door witnessing, as a way to spend time with and to please her father. This religious involvement with her father provided her a consistent source of nurturance and positive regard, since she felt that her mother was not consistently available. Ms. R. experienced anxiety and a fear

of rejection whenever she attempted to display autonomous behavior and was preoccupied with being abandoned.

Therapist N. is a Caucasian man whose religious roots were in Catholicism. He spent a number of years exploring other faiths before returning to his current Judeo-Christian belief system, which emphasizes an openness toward the individual experience of a relationship with the Divine. Dr. N. is psychodynamically oriented.

First Treatment Course. Treatment occurred in two phases. The first phase of treatment involved reducing Ms. R.'s depressive symptoms related to her role conflicts as a mother and wife. Her difficulties were understood as ongoing separation-individuation struggles that were related to early developmental experiences. This was a framework that Dr. N. was comfortable in using to approach the current psychotherapeutic encounter. The depressive symptoms were related in part to her inability to view herself as capable, as well as the fear that if she were to become a capable person, she might be abandoned by her significant others. Her early experiences fueled this belief. The more independent she was, the more time she was left alone. While addressing these feelings and their place in the separation-individuation process within her family, she described a similar experience of herself within her faith community—that is, the experience of not being a capable individual within that community. Whenever she began to display autonomous behaviors, she quickly became fearful of abandonment and her depression returned. Work was done to help her examine the areas of loss in her life (both real and imagined). She was encouraged to begin to express her sadness and enter the grieving process.

When religious components of her history were explored, she would become vague and return to her depressive position. A couple of months into this psychotherapy, she inquired regarding Dr. N.'s religious background. She initiated this inquiry by mentioning that Dr. N. was respectful and used language appropriate for her faith, but she assumed that he was not a Witness. Exploration with Ms. R. yielded little to explain her underlying need to have this question answered. In response to Ms. R.'s insistence and after attempting to try to understand further her underlying needs, the therapist finally shared that he was not a Witness. She then revealed that she felt stuck in the current therapy and wondered if she should pursue therapy with a person of her same faith who would understand her better. This was explored in the next few sessions, and she decided to see a therapist of similar faith but wanted to keep a connection with Dr. N. for medications.

Countertransferential Dimensions. Dr. N. experienced several countertransferential reactions to Ms. R.'s request to see another therapist. Initially Dr. N. was dealing with his own uncertainty about approaching this component of her distress. Should he send her to her faith leaders to address this component? Would they be able to address the individuation struggles that she brought into therapy? Upon reflection and consultation, Dr. N. understood this position in part as a reaction to accepting Ms. R.'s view that he would not be able to understand this dimension of her struggles because he was of a different faith. Dr. N. had another reaction: he was concerned that he might increase her sense of rejection from her faith community by not being of her faith. This concern was not communicated to the patient, but it limited Dr. N.'s confidence in approaching this aspect of the psychotherapeutic work. Dr. N. also struggled with the fear that finding his own spiritual path might separate him from his faith community.

Transferential Dimensions. The transferential aspects of Ms. R.'s communications contained a dimension similar to Dr. N.'s reaction. She was concerned that individuation would be associated with a disconnection from her faith community. She was fearful that Dr. N. would not view her struggle in a positive way and might respond judgmentally to her efforts toward differentiation. She felt safer exploring these concerns with a same-faith therapist whom she felt would be more supportive.

Second Treatment Course. After several months, Ms. R. returned to Dr. N. expressing a desire to continue their psychotherapeutic work. During this treatment phase she addressed her ambivalent feelings about her level of involvement with service work and her fears about how she would be received in her religious community if she expressed that ambivalence directly. If she was depressed, then it would be okay to not be "involved." She explored her strong identification with her father as a consistent and powerful parental object and her fear of further abandonment. Ms. R. felt that she had lost her mother and would also lose her father if she did not live

up to his expectations. She wanted not only to view herself as more autonomous, but also to behave more autonomously in her family and faith community. In this phase of therapy it was clear that both parties accepted the need to explore the impact of her difficulties with individuation on her religious life. In this second part of her therapy, Ms. R. was able to explore her feelings toward Dr. N. The concerns raised in the previous treatment were now more clearly heard because Dr. N. had reached a more neutral position regarding Ms. R.'s religious content.

In examining the role of religiocultural transference and countertransference with Ms. R., we will consider differences and similarities in religious beliefs and transferential and countertransferential struggles. Ms. R. experienced fears of rejection, loss, and abandonment. Her fear of being an independent person in her family was also present in her spiritual community. The interreligious transference presented itself when this patient assumed her therapist was from a different faith and expected to be misunderstood. She said she expected the therapist to suggest that she reduce her service work, which she had valued from an early age. This led her to seek out a same-faith therapist, where dimensions of an intrareligious transference began to emerge. She found it more difficult to discuss such issues with the same-faith therapist without increased feelings of guilt and inadequacy. She feared a negative response from her same-faith therapist (and her faith community) if she expressed doubts regarding her level of religious involvement. These feelings became intolerable, and she returned to her work with her former therapist. In some ways, Dr. N. was a safer "father" for her because she did not view him as an idealized representation of her faith. This is a potential positive aspect of an interreligious transference. She articulated that the risk of not being understood was preferable to the guilt and shame she had felt with her interim therapist.

Dr. N.'s countertransferential response included interreligious aspects. The initial countertransference response was one of distancing himself from fuller exploration of the religious components of Ms. R.'s struggles. Dr. N.'s interreligious countertransferential issues centered on his response to her perception that he would be unable to understand her public expression of her ministry. His religious and family upbringing was Catholic, with an active emphasis on service at an early age. Dr. N. had to manage his feelings related to his current decreased level of service due to professional and other commitments. His desire to justify his own decreased service had to be managed to allow the patient room to explore this issue for herself. Dr. N. felt unable to explore these religious dimensions because of his faith background. This sense was based in part on his own feelings and was heightened by the patient's questioning his ability on the basis of her perception that he was from a different faith.

During the second course of therapy, the patient and the therapist were more open to exploring Ms. R.'s religious concerns. Ms. R.'s narrative included fears of abandonment by her faith community in ways that she had experienced from her family. She was concerned that Dr. N. might facilitate this abandonment. Exploration of her ability to be independent and capable without losing her connection to others helped her become more involved in family and faith community life. Dr. N. was able to be more responsive to Ms. R.'s religious concerns with ongoing consultation and discussions with colleagues in the Jehovah's Witness community.

CONCLUSION

The preceding cases illustrate that "religiocultural" transference and countertransference are considerations in psychotherapy not only when the therapist and patient are from different religions, but also when they share the same religion and even the same denomination. In order to work effectively with religious content, therapists need to consider several factors: 1) degree of openness, 2) attunement, 3) consultation, and 4)interpretation.

First, therapists' lack of training and religious heritage may predispose them to avoid religious content. Therapists' religious background may also increase their *openness* to religious content and contribute to an overemphasis on this content at the expense of other important patient communications. Awareness by therapists of their potential automatic responses to avoid or to be overly preoccupied with religious content is an important prerequisite to working with this content. Awareness of these reactions will allow therapists to counter them so that they can attend appropriately to their patients' communications.

Second, therapists must be *attuned* to the meaning of their own perceived religious affiliation and their reaction to the patient's religious orientation. In addition, the transferential and countertransferential power of religious experience is not simply based on current affiliation, but is influenced by associations to past religious experiences. Understanding the therapist's and patient's spiritual journey over time is critical to developing a full appreciation of the affects and cognitions that religious associations can evoke in the therapeutic process.

Third, the role of *consultation* is essential to refining therapists' skills. The work of Larson and his colleagues[6] represents an important direction for residency training that will equip future psychiatrists to work more effectively with spiritual content. Currently practicing mental health professionals do not have access to this training; however, a growing body of experts in the American Psychological Association and the American Psychiatric Association may serve as valuable consultants. In addition, clergy and pastoral counselors may be important collaborators in the effort to clarify religious beliefs and practices.

Fourth, religious content may offer insights regarding a patient's religious life, but it may also serve as an important pathway to the patient's wishes, fears, and conflicts. Religious material, like other content, is subject to *interpretation*. It should not be avoided, and when addressed it should be handled as sensitively and respectfully as other patient communications.

Increased sensitivity to the overt and covert religious themes in patients' communications is an important skill for therapists. Religious differences and similarities between therapists and patients are only one potential countertransferential challenge in therapeutic work. Other cultural issues that may evoke transferential and countertransferential reactions include race, gender, ethnicity, and class. Sensitivity to these issues in addition to the religious dimensions can enhance the therapeutic relationship and deepen our understanding of ourselves and our patients.

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