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AN EXPLORATORY STUDY OF RELIGIOUSLY COMMITTED, PSYCHOANALYTICALLY ORIENTED CLINICIANS

City University of New York PH.D. 1986

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AN EXPLORATORY STUDY OF RELIGIOUSLY COMMITTED PSYCHOANALYTICALLY ORIENTED CLINICIANS

by

E. PETER COHEN

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the Degree of Doctor of Philosophy, The City University of New York.

1986

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

AN EXPLORATORY STUDY OF RELIGIOUSLY COMMITTED,
PSYCHOANALYTICALLY ORIENTED CLINICIANS

by

E. Peter Cohen

Advisor: Professor Laurence J. Gould

This study employs a clinical interviewing methodology to investigate twelve psychoanalytically oriented religiously committed clinicians. The study grounded in object relations theory focuses on three prime question. 1. How do these clinicians integrate their psychoanalytic and religious perspectives? 2. How did they deal with religious issues in their own treatment? 3. How do they deal with religious issues with their own patients? A major funding of the study was that religious involvement and the nature of the patients' God representations are significantly affected by psychotherapy even when these issues were not significantly addressed in treatment. A dual representational model is proposed which postulates that individuals maintain a highly private, personal God which is employed as a special kind of transitional object, and that this relationship is often cloaked by the employment of a more abstract public God.

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INTRODUCTION

The relationship between psychoanalysis and religion has been one fraught with tension and conflict. This acrimonious dialogue marks a major chapter in the chronicles of twentieth century intellectual history. Yet the problematic integration of the paradigms of psychoanalysis and religion has not been merely a source of intellectual debate played out in scholarly journals, the conflicts between religious and psychoanalytic world views have had discernible clinical repercussions as well. The most striking of these has been the flat out avoidance of religious material in much of clinical diagnosis and treatment. This situation has not gone completely unnoticed in the literature. Paul Pruyser (1971), editor of the Menninger Bulletin, as well as a former officer of the Society for the Scientific Study of Religion, notes that case records are "conspicuously devoid of articulate reference to religion" (p. 272). He concludes that "religion (along with money) is one of the two important facets of life of which there is a conspiracy of silence in both diagnostic interviewing and in psychotherapy" (p. 272). This selective inattention to religion, on the part of clinicians, becomes particularly striking when it is placed in juxtaposition with the Gallop Poll finding (1984) that 97% of the American public reports

"a belief in God and believe in prayer," and with the Group for the Advancement of Psychiatry's report (1968) that "manifest references to religion occur in about one-third of all psychoanalytic sessions" (p. 54). This situation -- in which an avowedly religious population, who reportedly bring religious concerns to therapy, yet seldom is it reported by clinicians -- presents a paradox which begs further exploration. Unique resistances and transferential difficulties on the part of religiously committed patients clearly contribute to the fact that religious issues are seemingly selectively avoided in therapy. These special technical problems are just recently gaining attention. (Vide Spero, Lovinger, Stern, Peteet). But it appears that the patient's reluctance to bring his or her deep-seated religious concerns to therapy is confounded by a resistance on the part of clinicians who are equally predisposed to avoid this material. The result is frequently a tacit collusion to systematically exclude issues of religious belief, values and practices from the therapeutic experience.

Pruyser not only points out this conspiracy and the paradox it produces, but he also speculates on its causes. He suggests that religious issues present a "special iatrogenic resistance" (p. 272), but he cautions "that the magnitude and ramifications of the problems buried in this paradox are little less than overwhelming" (p. 273). I agree with Pruyser that the problem of the selective omission of

religious material from treatment, as well as the difficulty in assessing and handling religious issues, is exceedingly complex. Critical factors emanate from many levels: cultural convention; stereotyped images on the part of patients and therapists; and perhaps most importantly, conscious and unconscious elements deriving from both parties to the therapeutic encounter. Pruyser suggests, and here too, I am in agreement, that countertransferential issues, often deriving from the therapist's own "undigested experience with religion," play a particularly prominent role in the relative infrequency of its emergence in therapy, particularly as reported by clinicians. He is not alone in citing counter-transferential factors as a primary factor underlying the avoidance of religious material in the consulting room. This view is shared by a growing number of clinicians who have recently focused their attention on special difficulties in the treatment of religious patients. Indeed, virtually all psychoanalytic commentators who have addressed the subject of treating the religious patient are in fundamental agreement on one point -- psychoanalytic clinicians, on the whole, are highly uncomfortable with religion. W.W. Meissner (1984), a Jesuit, and a Boston training analyst, contends that not only are analysts uncomfortable, but that "they tend to regard religious thinking and con-

victions as suspect, even to hold them in contempt at times." He maintains that there is a "latent persuasion, not often expressed or even articulated with the inner voice, that religious ideas are inherently neurotic, self-deceptive, and illusive" (p. 5). This pervasive, anti-religious bias within the mainstream of psychoanalysis which Meissner describes is by no means novel or surprising. It is a strand of thinking with direct lineage to Freud's original writings.

A.M. Rizzuto (1979), a Boston training analyst, underscores the barely tacit pressure on analysts to relinquish their religious beliefs and on its implications.

> Intentionally or unintentionally, Freud gave the world several generations of psychoanalysts who, coming to him from all walks of life, dropped whatever religion they had at the doors of their institutions. If they refused to do so, they managed to dissociate their beliefs from their analytic training and practice, with the sad effect of having an important area of their own lives untouched by their training. If they dealt with religion during their own analyses, that was the beginning and the end of it. (p. 4).

Rizzuto's comments clearly intimate an unspoken, but barely subterranean conviction within psychoanalytic writings: religious beliefs are illusory notions which perpetuate the gratification of infantile wishes and which are inevitably abandoned upon psychoanalytic scrutiny. Although no analyst will go on record explicitly advocating the relinquishment of religious belief as a necessary goal or as an indication of a successful therapy for most patients, they will acknowledge that the majority of analysts have "rejected all religious philosophies" (Fine, 1977, p. 64), or "if they were completely honest, [analysts] would acknowledge a lack of faith in God" (Eissler, 1965, p. 418).

As Ross (1968) comments, "Clearly the majority of analysts do not find it possible to live comfortably in two such disparate realms" (Psychoanalysis and Religion, p. 260). Indeed, his remarks echo those of Freud fifty years earlier who claimed that he saw no way that the two realms could be reconciled. Freud thus found Pfister's[1] ability to balance the two roles and world views "one of the contradictions that make life so interesting" (Meng, p. 42). More recently, Meissner, himself a religionist, is only slightly more sanguine than his atheistic predecessors and colleagues with regard to the integration of psychoanalytic thought and a religious world view. He

notes, "here and there intrepid souls might be found who could embrace psychoanalysis as a conceptual framework and as a therapeutic technique without finding themselves compelled to surrender their religious orientations and convictions" (p. 4).

As the problem of the integration of psychoanalysis and religion has befuddled many of the greatest minds of the twentieth century, the "interesting contradiction posed by the religiously committed psychotherapist affords us focal access to further exploration of this issue on a highly personal level. Indeed, the clinical exploration of how religiously committed psychoanalytically-oriented clinicians (hereafter abbreviated RPC) integrate these two seemingly irreconcilable world views and as assumptive frameworks, will constitute one of the focal questions of this study. In this regard, the study can be viewed as an exploratory one of a select group of clincians' efforts to negotiate a unique form of role conflict. Although the question of the personal integration of the psychoanalytic and religious world views is of major interest in and of itself, a study of the RPC is of significant value for numerous other reasons as well. In light of the recent recognition and elaboration of the numerous technical problems raised in the treatment of religious patients, a study of RPCs promises pro-

pitious opportunity for the systematic examination of many of these special technical considerations. By virtue of his unique status as a religionist, who is also psychoanalytically informed, and who is (or was) a patient as well as a present clinician, the RPC represents an extremely rare and precious research specimen. Firstly, he or she is ostensibly more concerned with religious issues than the average psychotherapy patient, and thus one might expect the RPC, as patient, to more readily bring these religious concerns to treatment. At the same time, as a function of his subsequent or concurrent clinical training, he or she is highly sensitive to the multitude of technical issues which emerge in treatment, and is uniquely qualified to elaborate upon his or her treatment experiences as a patient. In essence, by virtue of background and credentials, the RPC represents an ideal subject for a study of the experience of religiously committed patients in psychoanalytically-oriented psychotherapy from strictly a technical perspective.

Yet, not only does the RPC provide unique access to clinical material as a patient, she does, as well, in her capacity as a present-day clinician. Here again, she is singularly qualified to be an ideal informant. Again, by virtue of her unique identity as an informed and know-

ledgeable religionist clinician, she represents a figure who is ostensibly more sensitive with respect to religious concerns than the typical therapist. One can speculate that the collusive silence regarding religious material that appears to characterize a majority of the psychoanalytic psychotherapies of religionists will not necessarily be the case with the religious clinician. Indeed, this will be one of the hypotheses that we will explore. In essence, studying the RPC is like examining an ideal-type or a specially selected sample population of a given diagnostic category. While the subjects may not be typical, and are indeed in all probability highly anomolous, they are chosen due to their unique potential to shed new light on a variety of clinical concerns and to place several discrete theoretical and technical issues in bold relief. Thus, while not representative of the field, the RPC is chosen for exploratory examination because he carries a unique valence for placing many of the poorly-defined issues involved in the treatment of religious patients in a more clearly distinguishable and articulated form.

Specifically, I wish to explore in depth two other focal issues regarding the RPC, in addition to the aforementioned question of his or her personal integration of the psychoanalytic and religious world views. These are:

1. How did the RPC, as a patient, address religious concerns in her own therapy, and did her religious beliefs change?
2. How does the RPC deal with the special problems which emerge in the treatment of religious patients?

The three questions on which this research is centered are clearly interrelated. Yet at the same time, they span a broad spectrum of both clinical and theoretical issues. In light of this apparent divergence in focus, I feel some further clarification is in order. Essentially the reasons for the tri-focal approach are ones of both interest and expediency. Firstly, it need be noted that the RPC is not only exceedingly rare, but equally difficult to track down for research purposes.[2] Hence, once "captured," it seems to make good sense to pursue several lines of exploratory inquiry with this "interesting" specimen. Secondly, as is the case with all exploratory research without discrete hypotheses, one runs the chance of coming up with no significant findings. I feel that this situation is particularly the case with the first research question which focuses on how the RPC reconciles his psychoanalytic framework with his religious beliefs. The question has shown itself to be particularly refractory to simple or direct response.

Indeed, many of the psychoanalytic thinkers who have deigned to address this issue have felt compelled to ascend to the plain of "poetic effusion" (Freud, Meng, 1963) or abstruse philosophy in responding. Other RPCs, when asked during piloting interviews how they reconciled the two seemingly contradictory realms, bemusedly confessed, "I don't." Needless to say, the question, albeit an interesting one, presents clear and discernible risks which will hopefully be obviated by utilizing a clinical interviewing technique. At any rate, in light of this clear potential for a research catch of only "smoke and poetry"[3] in response to this question, I have elected to explore specific clinical questions as well with this specially selected population. This avenue of inquiry capitalizes on the fact that the RPC can be expected to be a uniquely knowledgeable, sensitive and articulate respondent with regard to exploring special clinical problems which emerge in the treatment of religious patients. This status is further augmented by the fact that she can respond from the perspective of both patient and therapist.

To a certain degree, exploratory research is often somewhat akin to a fishing expedition in new waters. In view of the fact that one can not be certain of the extent or variety of one's catch, it seems both expeditious

and wise to cast a variety of nets and to cast them broadly. In the case of the RPC, I feel that once one has satisfactorily located this rare and interesting creature, it similarly makes good sense to broadly explore the unique domain at the interface of psychoanalysis and religion, on which he is perhaps uniquely suited to provide information.

Footnotes

[1] A Swiss pastor who was also a highly regarded analyst.

[2] Jeffrey Belgrave, a colleague, and the only other researcher who has explored this population, attained virtually no respondents in canvassing the New York City psychoanalytic institutes for suitable subjects in 1983.

[3] Expression coined by Professor Paul Wachtel in personal communication.

CHAPTER ONE

PSYCHOANALYSIS AND RELIGIOUS BELIEFS

Preface fo Literature Review

A study of the integration of religious belief with a psychoanalytic perspective, focusing on the religious clinician and his or her experience in treatment both as a patient and as a therapist subsumes a host of related yet distinct research areas. First we will survey the interface of psychoanalysis and religious perspectives from a historical and philosophical point of view. This will include an exposition of a psychoanalytic perspective on religious belief and experience as initially suggested by Freud, and as subsequently modified and extended by the ensuing generations of psychoanalysts. We shall then touch upon some of the personal attempts made primarily by psychoanalysts to integrate these two Weltanshauungs. As the issues involved in this historical and philosophical survey are amongst the most prominent of the twentieth century and have attracted the attention of some of its most eminent thinkers, our survey will of necessity be brief and inchoate. It is provided to serve as a necessary historical and cultural backdrop against which to better understand the experience and unique dilemma of the religious psychoanalyst. Our next major area of review will be that of pertinent recent research and theoretical models which may be viewed

as harbingers of a "new wave" in the psychoanalytic study of religion. Finally, we shall examine the recent body of work that addresses itself specifically to the unique clinical concerns arising in the psychoanalytic psychotherapy of religious patients.

The Freudian Perspective

It is only fitting that a history of the clinical interface of psychoanalysis and religion begins with the work of Freud. Freud's interest in religion is clearly evidenced throughout his work. Like his work in most other areas, his writings pertaining to religion were not systematic and are at times riddled with internal contradictions. Yet on the whole, his work in this area is distinguished by striking consistency. For a self-professed agnostic, religion and the origin and nature of the human being's relationship to his God remained one of Freud's primary preoccupations.

Several recurrent theories dominate the Freudian perspective on religion. The first of these is Freud's (1901) contention that man created God in his own image. This notion was not a novel one; but while the germs ideas were not unique to Freud, his development and articulation of them in light of the overall body of psychoanalytic thought marks him as one of the intellectual

giants who laid the axe of science to the root of humanity's belief in God. Freud specifically elaborated on the hypothesis of a God created by projection by giving special emphasis to the rule of the father. Drawing evidence from his clinical cases, he concluded, the psychoanalysis of individual human beings ... teaches us with quite special insistence that the God of each of them is formed in the likeness of his father, that his personal relationship to God depends on his relationship to his father in the flesh and oscillates and changes along with that relationship, and that at bottom God is nothing other than an exalted father. (1913, p. 147).

In line with this patriocentric model religious belief was largely viewed by Freud as a regressive revival of the forces that protected the individual in his childhood to ameliorate his later feelings of vulnerability and helplessness. Another psychic function of religion was its utility as a means of promoting sublimation and a culturally sanctioned defense against unacceptable sexual and aggressive strivings.

In The Future of an Illusion (1927), Freud launched his most direct and polemic attack on religion. His primary thesis is that religious beliefs are "illusions ... fulfillments of the oldest, strongest and most urgent wishes of mankind" (p. 47). While Freud is careful to point out

that illusion is not necessarily false and that "the truth value of religious doctrines does not lie within the scope of psychological inquiry" (p. 56); he nonetheless leaves little doubt as to his own position on this issue.

> We tell ourselves that it would be very nice if there was a God who created the world and was a benevolent providence and if there was a moral order in the universe and an afterlife; but it is a very striking fact that all this is exactly is as we are bound to wish it to be. And it would be a more remarkable fact still if our wretched, ignorant and downtrodden ancestors from whom our religious beliefs and teachings are derived had succeeded in solving all these difficult riddles of the universe. (p. 53).

He concludes "when questions of religion are concerned, people are guilty of every possible sort of dishonesty and intellectual misdemeanor" (p. 51). In this regard he views "religion as comparable to a childhood neurosis" and he unabashedly states his hope that "mankind will surmount this neurotic phase." (p. 49). Indeed he suggests that with analytic treatment, there will

be both a general revision of religious beliefs" resulting in many of them being done away with" (p. 72-73).

For Freud, there was no possible rational reconciliation of science (psychoanalysis) and religion. In his correspondence with Oscar Pfister, he is unsympathetic to those who would advocate that religious beliefs be treated "as if" true because of their unique cultural value. He affirms the naked truth about religion as he experiences it. "The question is not what belief is more pleasing or more comfortable or more advantageous to life, but of what may approximate more closely to the puzzling reality that lies outside us" (p. 134).

For Freud, religion is an infantile compromise solution to the harsh reality of life in the world. He sees only a select few as capable of transcending this solution. He invites psychoanalysts to these ranks, offering the "pure gold of analysis" as opposed to the superficial salve and transference gratifications of religious illusions. Yet he is explicit in noting that his views regarding religion are strictly his own and "form no part of analytic theory" (Meng, p. 117). Indeed he notes that "there are certainly many excellent analysts who do not share them." (Meng, p. 117).

By the end of this life, Freud felt that he had illuminated the individual mechanisms and historical and

cultural factors that underlie humanity's belief in supernatural beings. In his eyes, he had completely unraveled any mystery that religion purported itself to be. The evidence was "incontrovertible."

Yet even in analytic circles, some aspects of his work have met with uniform criticism and dismissal, notably his unique anthropological speculations, his strict patriocentric model, and his postulation of a phylogenetic memory. But on the whole, his ideas have, in the words of Saffady (1976), "held full sway in the psychoanalytic literature" (p. 292). Proceeding generations of analysts have "tended to disagree with him in details more than essentials" (p. 292). Religious experiences are viewed as the epiphenomena of a deeper, largely unconscious, dynamic reality born of repressed infantile wishes and longings which animate and determine them, and to which, if we were only to be fully analyzed and truthful, they could ultimately be reduced. Psychoanalysts do not question the fact that religion works; they simply cannot accept the validity of the illusory assumptions that underly it and render it merely a transference cure.

Integrations of Psychoanalysis and Religion By Religiously Committed Psychoanalytic Clinicians

There is little question that Freud's own atheism and skepticism regarding religious beliefs and practices has been mirrored by the majority of subsequent analytic cli-

nicians. Yet a small core have managed to embrace psycho-
analytic theory and technique while maintaining their religious orientations and convictions. Only a few of these have actually attempted to integrate psychoanalytic thought with religious belief in a public as opposed to private or personal fashion. We will now briefly survey the efforts of some of this select group.

One of the earliest and most prominent respondents to Freud's attacks on religion was the Swiss psychoanalyst and pastor, Oskar Pfister. Pfister was a close personal friend of Freud and he probably served as the model for Freud's imaginary antagonist in The Future of an Illusion. Indeed, with Freud's approval and encouragement (largely to spare the psychoanalytic movement from the negative backlash from Freud's own unpopular atheistic views), Pfister wrote a response to Future of an Illusion entitled The Illusion of a Future in which he defends religious belief -- in light of Freud's psychoanalytic critique. Pfister's defense of religion is further recounted in Psychoanalysis and Faith (Meng and E. Freud, 1963), a compilation of his thirty-year correspondence with Freud.

Pfister responds directly to Freud's claim that religious ideas are nothing more than wish fulfillments or illusions. He concurs that unconscious wishes undoubtedly color the development of religion, but he feels that stopping at this point is premature. Instead, he advo-

cates consideration of the power of "wishful thinking to mobilize reality thinking as an ideal toward which mental development gropes" (p. 51, translated in Meissner, p. 88). While Pfister accepts the Freudian hypothesis that religious belief is prompted by both wish fulfillment and narcissistic needs, he does not see this as sufficient to explain away all of religion. Indeed, he feels that these motivations are more characteristic of less evolved forms of religion; the more mature varieties are typified by far "less egoism and lower instinctual demands" (p. 158-159, translated by Meissner, 1984, p. 89). For Pfister, mature practice of religion demands the direct opposite of the narcissism so prevalent in its less evolved forms. He does not refute the substance of Freud's charges, but faults Freud for addressing only a limited range of religious experience which ignores its most essential features, and "its noblest utterances." Pfister rejects Freud's notion that religion is a form of universal obsessive-compulsive neurosis, on much the same grounds, arguing that this is merely "pre-religion," or religion practiced in a pathological way. Aside from the issues of its roots in wish fulfillment and instinctual gratification, a more fundamental difference underscores the whole Freud-Pfister dialogue on religion. The crux of the issue is the divergent models of reality and our

capacity to have knowledge of reality. Freud maintains that religious belief is based upon teachings which are unsubstantiated and which forbid questions of authentication (Freud, 1927, p. 26). He thus concludes that religion violates the principles of reason and relinquishes any claim to truth. Pfister outrightly rejects Freud's theory of knowledge. He argues that a system of metaphysics underlies all of knowledge, including natural science. Thus he claims that Freud's assumption of a form of empirical knowledge devoid of subjectivity is simply philosophically naive (p. 173-174, translated by Meissner (1984), p. 93).

A major component in both The Future of an Illusion pseudo-dialogues and the Freud-Pfister correspondence is the notion that religious teachings are so valuable and essential to human well-being and harmonious functioning that they therefore deserve to be believed, or treated "as if" true, independent of their veridical authenticity. This "as if" philosophical position regarding religion has been a prevalent one since the time of William James (1902) who states:

> Whatever leads the individual to the higher level of his limits of attainment is worth believing; religious faith is such an option. (p. 490).

In this spirit, Pfister claims that religion is a human treasure beyond all measure, which is a virtual necessity for the happiness of humankind. He thus defends it on epistomological, aesthetic and utilitarian grounds.

Gregory Zilboorg was another prominent Freudian disciple who wrote extensively regarding psychoanalysis and religion over the course of a twenty-year span. Zilboorg was originally a Quaker who later embraced the Catholic faith. The basic premise in much of his writings is that science (including psychoanalysis) and religion address themselves to two distinctly different domains, and that the states of conflict and tension that have emerged result from inappropriate encroachments of each into the territory of the other. In essence, Zilboorg is a Platonist who finds the realm of the spirit inaccessible through the methods and techniques of scientific investigation. Hence he concludes that the domain of religion can neither be reduced nor explained away by the materialistic constructs of science. Indeed in his eyes science can tell us very little about the realm of the spirit.

Zilboorg specifically bemoans the fact that Freud's personal antipathy towards religion has been mistakenly identified with the position of psychoanalysis in general.

He claims,

> While it is true that a great number, if not the majority of Freudian analysts look upon atheism as an earmark of scientific superiority and upon religious worship as an atavism left over from primitive magic or animism, many recognize even though not too pronouncedly, that being religious does not exclude one from practicing well the psychoanalytic profession. (1958, p. 39).

Zilboorg joins a long line of defenders of religion who reject the scientific basis for Freud's views, but instead see them as personal opinions largely tainted by Freud's own emotional conflicts and his unique developmental history. Zilboorg thus summarily rejects most of Freud's views regarding religion and morality while maintaining fidelity to the greater corpus of psychoanalytic theory and technique. He is similarly critical of Freud's penchant for employing the fallacious logic of "psychomechanistic parallelism." By this contrivance, Freud sees fit to label religion as a universal obsessive-compulsive neurosis, or God as an exalted father figure deriving from Oedipal antecedents. Zilboorg describes this mechanism as one whereby when two behaviors are ob-

served to exhibit the same constituents or are reducible to the same elements, this de facto implies that the same psychological mechanisms are at work. Zilboorg finds this logic specious and he thus rejects Freud's conclusions.

In essence, Zilboorg does not actually achieve an integration of psychoanalysis and religion; he instead discreetly segregates them to specifically address separate (and not equal!) realms of reality. His views were attacked sharply by the mainstream of the psychoanalytic community and he confesses himself to be "disconsolate in his somewhat isolated position" (1944, p. 100).

Karl Menninger is another psychoanalytic clinician who has written frequently about religion. He takes issue with Freud's exclusive emphasis on the neurotic determinants of religious belief. He defends religion, focusing on its adaptive aspects. One of these is its capacity to "control and direct aggression," another to "foster life by inspiring love." Menninger, sounding like James, concludes, "If religion enables us to do these realistically, it is no illusion and not a neurosis" (p. 191). Thus Menninger fits into the "as if" school.

Menninger most comfortably concurs with Freud that transference plays an essential part in the unique power of religion. He concludes that "the element of the super-

natural is essential to effective religion" (p. 210), but he concedes that this element "is anathema to most scientists" (p. 210). He chooses to sidestep the question as to the validity of a God and a supernatural world, generally choosing to equate God with love throughout his writings. Yet he is unrestrained in extolling the benefits and values of mature religion. He states, "If, to any one, religion means reverence and affection for the created universe and its creatures, the wish to get the most possible out of it for human beings by the scientifically tested rules of living and the acceptance of the greater wisdom of certain inspired leaders, as guiding principles of life -- if this is what is meant by religion, I could not distinguish it from science, nor withhold from it equally high allegiance" (p. 212).

In essence, Menninger recognizes the need for an other-worldly domain for religious beliefs to function optimally, but he defers from offering his own opinions on this subject. He does accept the fact that much of religion derives from human infantilism, egocentricism, and reflects an escapist intention. But he points the way toward another, more mature religious reality which enables human beings to "face reality without illusion and fear, to find a sovereign good, and give one's self to it in humility and trust" (p. 212).

One of the most enigmatic works attempting to integrate psychoanalytic thought with religious belief by prominent analysts is The Need to Believe: The Psychology of Religion by Mortimer Ostow and Ben-Ami Scharfstein. After seemingly aligning themselves completely with the mainline psychoanalytic position on religious thought for the near entirety of their work, when addressing the issue of religious belief the authors make an almost inexplicably abrupt shift. In a memorable and oft-attacked passage, they claim, "Believing is almost as necessary to humans as eating. What is believed is of course not necessarily useful, any more than what is eaten is always nourishing. But belief is essential to the efficient functioning of the human organism" (p. 155). Their plea that religious beliefs cannot be renounced because humankind "has the need to believe and it is futile to think that many of us can be happy though thoroughly skeptical" (p. 156), strikes one as a symphonic finale performed in a completely different key and style than its preceding movements. In their finale, they depose rationality as a false god in its own house and plead for humility in applying reason to the issue of belief and faith. They argue "while there can be no clear and simple resolution to the issue of the truth of religion, because it provides so much and the pain of living by reason alone is so great --

the authors and all humanity are entitled to suspend this lavish meal of rationality and indulge on the basis of utilitarian justification in their insatiable need to believe." (p. 158). Although Ostow and Scharfstein concede that they cannot supply a rational proof as a basis for belief, and they fully accept the fact that the psychoanalytic exegesis of religion casts strong doubts as to the authenticity of religious beliefs, they claim that in this instance the dictatorship of the rational mind must be suspended.

In essence, Ostow and Scharfstein, like many of their psychoanalytic predecessors, achieve no real reconciliation or integration between the domains of psychoanalysis and religion. Instead, they affect a strange rapprochement by means of granting religious beliefs a special dispensation on the basis of both its unique value and humanity's perceived inability to renounce this unique gratification. Although they claim that all else might be subject to the scrutiny of rational analysis with special attention to lingering infantile wishes and desires, religious beliefs (like churches in a changing neighborhood) are to be accorded "landmark status" on the basis of their beauty and their cultural value, and thus they are exempt from both critical investigation and the threat of demolition. Once more, like in the case of

Pfister, the attempted reconciliation is achieved through a self-acknowledged and philosophically defended compartmentalization of codes.

The work of Henry Guntrip, a former minister and a prominent figure in the British object relations school, points toward a new perspective on the relationship of psychoanalysis and religion. Guntrip employs the object relations model to help ameliorate some of the seemingly irreconcilable differences that exist between a mechanistic, drive-based psychoanalytic model and the supernatural assumptions fundamental to religious belief systems. Guntrip, while humbly disclaiming "any great depth of religious experience" (p. 332), claims to "have sensed enough to be convinced that it is a reality" (p. 332). He addresses himself primarily to religious experience, thus circumventing the highly conflict-laden realm of religious belief and practice. In the process, he systematically excludes all issues of theological doctrine and matters pertaining to the institutional practice of religion. Instead, he defines religious experience as

> . . . an overall way of experiencing life, of experiencing ourselves and our relationships together; an experience of growing personal integration or self-realization to a communion with all that is around us,

> and finally, our way of relating to the universe, a total reality which has, after all, evolved us with the intelligence and motivation to explore this problem: all this is meant by the experience of God. (p. 326)

It is important to note that Guntrip offers no anthropomorphic images nor, in fact, any singular identification of a deity at all. He similarly eschews all reference to supernatural realities. In much the same manner that he espouses a limited notion of God and religious experience, he similarly rejects a vision of psychoanalysis predicated on a psycho-biological "centaur model" which views people as struggling victims with rational egos too weak to control the seething cauldron of animal instincts and unconscious forces that underlie them (p. 326). Instead, Guntrip embraces a more contemporary psychoanalytic model which focuses on the growth of the ego and the internal world in the medium of personal relationships. From this broadened theoretical base, he can move comfortably, addressing issues at the interface of both psychoanalysis and religion. Indeed, he claims that "religious experience is the same kind of stuff as human personal relationship experiences" (p. 328). He extends this notion further, adding, "Religion extends

personal experience to the nth degree to embrace man and the universe in one meaningful whole. Thus the integrating nature of a fully developed personal relationship experience is our most solid clue to the nature of the religious experience" (p. 328).

In drawing this analogy between personal relationships and religious experience, he affirms Freud in acknowledging that the conflict-ridden ego may readily fall victim to illusory and regressive forms of both. But he maintains that "Freud was precipitous in discarding religion because he found neurotic forms of it" (p. 324). Like most other religionist psychoanalysts, Guntrip offers an extended vision where religious experience can parallel the individual's capacity for mature, healthy object relations, and not necessarily serve as an illusory substitute gratification for impoverished, unstable or unhealthy interpersonal relationships. In essence, he suggests that the religious experience is not simply a compensation for impaired personal relations, but that it can be both fostered by healthy relationships and contribute to their mature development, as well. Guntrip sees the aim of both psychoanalysis and religion as personal integration: the cultivation of a sense of wholeness, continuity and relatedness that only can derive from relationship. In offering this vision of religious experience as an emotionally

meaningful and truly benevolent relationship, which allows for the emergence of our true selfhood and wholeness, Guntrip draws heavily on his mentors Fairbairn and Winnicott. In many respects, the religious experience he describes is strikingly comparable to Winnicott's optimal holding environment. He further suggests that personal religious formations can be viewed as transitional objects which symbolize and represent deeply meaningful personal relationships and which enable a person to attain their selfhood at their own proper pace (p. 331). Guntrip concludes, "The fullest personal integration and maturing, the profoundest sense of inner strength and meaningfulness in living, includes the religious way of experiencing our existence in this world." (p. 330).

Guntrip refuses to accept what he considers to be the false antithesis of science and religion. Science for him is a tool, a technology and a way of thinking. But science tells nothing about the value, meaning and purpose of life. Guntrip suggests that this is the domain of religion -- "a way of experiencing this universe that does not condemn us all to meaningless schizoid isolation, but relates us to a personal heart of reality, that we refer to by the indefinable term 'God,' experienced but not explained" (p. 331).

Guntrip's statements are amongst the most personal

of psychoanalysts. By adopting an essentially Jamesian notion of religion and an object relations model of psychoanalysis, he provides an enlarged common ground for dialogue. His work explores the religious experience within the context of a dynamic, validating and deeply meaningful, personal relationship. In this regard, the religious experience is akin to any human relationship, and one can study the roots and vicissitudes of its unfolding. Thus Guntrip, following upon the work of prior ego psychologists, opens a new path for the exploration of the religious experience. By invoking Winnicott's notion of transitional objects and transitional spaces to shed light on a person's use of religious symbols and their evolving relationship to God, he anticipates the most recent theoretical and clinical efforts in the psychoanalytic study of religion.

Concurrent with Guntrip's writing in England, Paul Pruyser, the Director of the Education Department at the Menninger Foundation, was developing several similar themes in the United States. Pruyser, himself a religionist, was most adamant in calling for psychology, in general, and psychoanalysis in particular, to address itself to the human being's object relations with God (p. 5). He goes beyond the range of William James and Guntrip in explicitly defining the psychology of religion as "the psychology of

the interaction and interpersonal relationships with supernatural beings, in which not only man but also God, as well as the dialogue between them, become objects for analysis" (p. 11). Pruyser reiterates the acknowledgement of virtually all psychologists that the ontological question is not subject to response from the domain of psychology, but then he goes on to explain that the question is not only an epistemological one, but also and more importantly, a personal one, and a psychological one at that. He feels this personal question, of how God comes to existence for a given individual, with his own unique concepts and/or representations and relationship is clearly in the domain of clinical inquiry. Pruyser admonishes psychologists to adopt a stance of naive realism towards religious objects of study. One accepts the existence of gods, independent of their veridical existence, simply because human beings believe in them and for the sake of studying human beings (p. 18).

Pruyser goes further than Guntrip in his reluctance to accept abstract concepts or vague notions of God. Instead he insists that God's existence must be studied as an individualized and particular phenomena rather than as a general question. Following the line of the object relations model, Pruyser reminds us that "God is never a simple object, one among many, but always a love object

to the devout person" (p. 18). In his eyes, the study of these love relationships represents the clear task for the psychoanalytic study of religion.

Pruyser's poignant call for psychology to directly study humanity's intimate and deeply complex relationship to God is answered in the work of Anna-Maria Rizzuto, The Birth of the Living God (1978). Rizzuto, a Boston training analyst, makes no direct statements about her own religious position. Her contributions towards the integration of psychoanalysts with religious experience are grounded in empirical clinical research rather than personal testimony. She begins "by taking Freud seriously in his honest bafflement with the problem of human religiosity and belief in the divinity" (p. 11). Her efforts are specifically directed towards exploring Freud's question -- how do people come to possess and use an actual belief in the existence of God? When this query is cast in the context of object relations theory, it spawns a raft of essential, related questions. Some of the most compelling include: (1) What is the relation of early object relations to the formation of a God representation? (2) How does the sense of self develop in relationship to God? (3) How is the representation of God modified by changes in real relationships with the person or persons who are used in its formation, or by new object relations

or new understandings of religious teachings? (4) What conditions differentiate between people who maintain a belief and an ongoing relationship with God and those who abandon their beliefs? It is to Rizzuto's great credit that she both carefully articulates these questions and that she then attempts to address them in her analysis of her data and in her generation of theory.

Rizzuto's work is ground-breaking, not only for the questions she poses, but to an equivalent degree for the methods she employs to answer them. Decrying the lack of solid clinical inquiry in response to the hypotheses initially tendered by Freud, and recognizing the extreme delicacy of the issues under scrutiny, she adopts a comprehensive clinical method. Rizzuto's initial research (1974) was carried out on a sample of 88 patients at Boston State Hospital. Her final project (1978) was done with 20 patients, ten male and ten female, admitted to a psychology unit of a private Boston Hospital. Using extensive data compiled from intensive interviewing, special projective assessment techniques focusing on the patient's religious experience, and clinical observation and records, Rizzuto constructs a formulation for each patient's religious experience and God representation. She contrasts these with the patient's psychodynamic formulation in the hopes of exploring both the individual's development and utilization of their God representation.

Rizzuto draws heavily on Winnicott in describing God as a special kind of "illusory transitional object" (p. 77). One aspect of this specialness is that He is created from representations which are derived from the representations of prior primary objects. Secondly, He does not follow the usual course of the other transitional objects. Instead of being de-cathected by the time of the Oedipal constellation, God's meaning becomes intensified. Like all internalized objects, the God representation cannot be fully repressed. Thus it is always available as a life-long source for maintaining psychological homeostasis. She sees this process as not only continuous but following distinct epigenetic and developmental laws. Finally, she views God's special status as a transitional object as deriving from his unique place in our culture, as well as from his atypical psychogenesis. He is a culturally sanctioned creation, offered to human beings for both their private and public negotiation of the critical moments in the life-long process of separation-individuation (i.e., marriages, births, deaths).

Rizzuto explicitly considers God as a highly personalized object representation who profoundly affects a person's sense of self. In this light her conceptual framework essentially charts the development of the God representation against epigenetic models of object rela-

tions, narcissism and Erikson's stages of ego adaptation. At each point, she describes the typical nature of the God representation and the conditions which will allow for belief or unbelief, as well as the type of religious experience it potentiates.

A central thesis of Rizzuto's work is that "no child in the Western world brought up in ordinary circumstances completes the Oedipal cycle without forming at least a rudimentary God representation, which he may use for belief or not" (p. 200). She indicates that this representation may remain unchanged, but if it fails to be revised or keep pace with changes in the self representation, it is experienced as "ridiculous, irrelevant or ... threatening and dangerous" (p. 200). Hence it is discarded or temporarily abandoned. By the same token, each epigenetic challenge offers a new opportunity for its revision and utility. Thus "belief in God depends upon whether or not a conscious identity of experience can be established between the God representation of a given developmental moment and the object and self representations needed to maintain a sense of self which provides at least a minimum of relatedness and hope" (p. 202).

Rizzuto indicates that neither belief in God nor the absence of belief is indicative of any type of psychopathology. She does, though, specifically describe situa-

tions and mechanisms which lead to the repression of a person's God representation, or to the re-emergence of its anachronistic forms, which are frequently invoked in haste to meet regressive needs in moments of crisis. She similarly describes how changes in the self representation can produce tension and symptomatology (massive doubt, religious preoccupations and exercises), as a person struggles to rapidly reshape his or her representation and relationship to God.

One of the primary functions of God, as a special transitional object, is His role as the omnipresent attendant for private communications. Here again Rizzuto draws upon Winnicott's notions of the "non-communicating self" and "transitional space" to argue that "a private God offers each man the potential opportunity for 'silent communication' which allows for increasing his sense of being real and for the maintenance of what he calls a true self" (p. 204). Rizzuto, like Winnicott, sees persons communicating with their God in the silence of a deeply subjective transitional space. Unfortunately, the very characteristics which render this transitional space such a potent one for self-encounter and self-transformation serve to insulate it from and make it highly impenetrable to analytic inquiry. Hence according to Rizzuto, patients are both reluctant and often virtually unable to bring

their Gods to the analytic encounter. Much like imaginary companions, who are so important to a child's world but who only rarely play a significant role in child analysis, Rizzuto claims that "God seems to be equally absent from a vast number of child and adult analyses in spite of His frequently remarkable importance in the analysands' lives" (p. 191). Rizzuto carefully points out that as self and object representations are modified in analysis, this often prompts further modifications of the God representation and religious beliefs. But she maintains that these changes also will continue essentially undisclosed and parallel to the analytic process. Even a painful relationship in transition with one's God in question will not be freely brought to the consultation room.

Since Rizzuto conducted her research to answer the questions initially posed by Freud, it is fitting that many of her conclusions are offered in direct response to his own. She feels that Freud is essentially accurate in positing that God has His origins in parental imagos and that the God representation is consolidated for the child at the time of the resolution of the Oedipal crisis (p. 208). She similarly concurs with Freud's clinical judgment that a person's relationship with God "oscillates with his relationship to his father (or both parents) in the flesh" (p. 208). She expands Freud's original notion from father to parents

because her study reflects the fact that the God representation is formed from internalized representations of both parental figures as well as other primary objects. Thus she rejects his limited patriocentric perspective. Similarly, although she acknowledges the pivotal role of the Oedipal entanglement for the integration of one's God representation, she again extends Freud's original speculations by asserting that a unique image of God is fashioned at each level of development. Thus it does not depend on the Oedipal stage alone. Another area where Rizzuto calls for extension of the Freudian paradigm relates to the girl's creation of her God. In this regard, she finds both Freud and contemporary psychoanalysis totally lacking.

Although Rizzuto affirms and extends many of Freud's critical precepts, she disagrees with numerous others. One area where she takes marked issue with Freud concerns the replacement of a personalized God representation with an abstract notion of God. Freud considers this a triumph of the intellect and a developmental step away from illusory infantile gratifications. Thus in his eyes an abstract God denotes a more highly advanced concept of the divine, and signifies an increase in secondary process and greater mental maturity. Rizzuto claims, however, that Freud misses the mark in this assessment. Instead she calls into question the very notion of an abstract concept of God. She feels that the notion of replacing an internalized object

representation with an abstract idea is essentially untenable.

Essentially, Rizzuto rejects in toto the concept of an abstract God -- she feels that this is merely a rationalized, intellectual contrivance, much akin to a screen memory which conceals a repressed God representation derived of the parental imagos. It often bespeaks an adaptation of the God schema to a self-system that can no longer accept its prior internalized representation of God.

Another prime area of their disagreement concerns the utility of the representation of God. For Freud, belief always represented a longing for infantile gratifications. Rizzuto, on the other hand, contends that an individual's relationship with his or her personal God can be both mature and renewing. Hence she breaks from Freud on the issue of equating belief in God with immaturity and disbelief with maturity. She claims, "Maturity and belief are not related issues" (p. 47), and that the believer may be both emotionally mature and have a mature relationship with his or her personal God. From her perspective, each person's ultimate decision either to believe or disbelieve in a God, whose representation he or she already has, is unique and can be revealed only through detailed individual study. The vicissitudes of people's representations and relationships with their personal Gods span a full range of object relations.

Rizzuto's departure from Freud regarding the equation of belief and immaturity bespeaks a more fundamental disagreement regarding the nature of the human being's psychological reality. In Rizzuto's words,

> Freud considers God and religion a wishful childish illusion, and he wrote a book asking mankind to renounce it .... I must disagree. Reality and illusion are not contradictory terms. Psychic reality -- whose depth Freud so brilliantly unveiled -- cannot occur without that specifically human transitional space for play and illusion .... Man cannot be men without illusions. The type of illusion we select -- science, religion, or something else -- reveals a personal history and the transitional space each of us has created between his objects and himself to find 'a resting place' to live in. (p. 209).

Rizzuto considers human beings' employment of illusions as fundamental to their psychological reality. She contends that all of the inner objects we so indispensably need, including our gods, combine the mystery of their reality with our own private fantasy. In the end, she feels compelled to part company with Freud regarding his

views on the substance and future of religious belief. She states, "Freud's ideal man without illusions will have to wait for a new breed of human beings, perhaps a new civilization" (p. 53). At the same time, she embraces the Freud who offers a vision of God shaped by our early object relations. Like Freud, she concludes, "The idea of a single great God -- an idea which must be recognized as a completely justified memory ... has a compulsive character (it must be believed)" (Freud, 1939, p. 130). But Rizzuto does not see the irresistability of humanity's belief in God as stemming from the reactivation of a phylogenetic memory trace as Freud suggests. Instead, she sees belief as deriving from the strength of an intimate relationship with an inner object and the integration of the self representation with this mental representation of one's God. In this sense, God (or the God representation) must be believed in -- to deny His existence constitutes a virtual annihilation of the self-object representation and one's very sense of self.

In her work, Rizzuto unifies the Jamesian tradition with that of Freud. She addresses the varieties of humanity's personal religious experiences from a phenomenological perspective, contextualized in the framework of contemporary object relations theory. Like James, she claims that people create the gods that they can use, and she explicitly ex-

plains both the genesis and uses of these private gods. Like Freud, she incorporates the genetic, structural and adaptive psychoanalytic perspectives in the process of her inquiry and formulations. In a very real sense, one of Rizzuto's greatest contributions is the fact that her work offers new inroads and, in fact, renewed legitimacy to the psychoanalytic exploration of religious experience, from both a research and clinical perspective.

The work of W.W. Meissner, M.D., S.J., complements well that of Rizzuto. In Psychoanalysis and Religious Experience (1984), Meissner attempts to re-establish a meaningful dialogue between psychoanalysis and religion by reformulating many of the issues which have historically placed them in opposition. He contends that contemporary shifts within the psychoanalytic perspective now enable it to transcend many of the cultural and scientifically embedded limitations of the Freudian paradigm. He similarly sees religious thinkers as retreating from their own hard line positions and increasingly opening their view of human nature to psychological input. He elucidates the growing areas of congruence between the two points of view and clarifies the remaining areas of irreversible divergence. These efforts are aimed at clearly delineating the conceptual working space or interface between psychoanalysis and religion. Meissner specifically expands the original Freudian

perspective by enriching it with the contributions of developmental ego psychology and object relations theory. His own unique contribution is the systematic enumeration of a developmental typology for religious experience. Although his model is much akin to Rizzuto's, his framework is more elaborate and extends its scope beyond the simple focus on one's image and relationship to a personal God representation.

Meissner's essential premise is that psychoanalysis has historically taken both a biased and restricted perspective in exploring the range of humanity's religious experience. He cites Freud's own deepseated entanglements and unconscious conflicts as one contributing factor to this phenomenon. Similarly, Freud's excessive emphasis on infantilism and the equation of religious experiences with psychopathological states is viewed as unduly limiting. Meissner claims that Freud's perspective precludes the acceptance of a more mature religious posture. It is this restriction which Meissner rejects most vociferously. He feels that to see religious experience as deriving strictly from infantile dependency and narcissistic injury and loss relegates it to an exclusively defensive psychological posture. Meissner takes a far more healthy view of religion, with ample consideration of its more constructive aspects. He feels that the unique phase of integration and growth

represented by the religious enterprise cannot occur without a complementary regression or a revival of the psychological roots that "can establish the possibility of trust on a higher level of spiritual maturity" (p. 72). But he cautions that mistaking this regressive phase for the total range of the phenomena provides a distorted and fragmentary picture, which amounts to little more than a caricature of religion.

Decrying the latent climate of prejudice and condescension within both the past and present psychoanalytic communities, Meissner's efforts are geared toward renewing authentic dialogue between psychoanalists and religionists. Firstly, as an analyst of unassailable credentials and one of contemporary psychoanalysis' most prolific writers, his point of view cannot be casually dismissed. The fact that he has elected to both interpret the protracted and strained silence of the psychoanalytic community with regard to religion, and to chart new theoretical paths in this forsaken territory, adds renewed respectability to an area where the psychoanalytic researcher has previously risked sullying his hands in the muddy waters of mysticism. Yet Meissner lends more than just critical historical analysis and an air of legitimacy to the psychoanalytic study of religion. His developmental schema brings the most recent theoretical advances in psychoanalytic thought to the topic

of religious experience, therein firmly establishing a framework for fellow researchers and clinicians. Meissner's developmental typology is based on critical psychoanalytic parameters within which the full range of religious behaviors and experiences may be conceptualized. He presents it as an epigenetic sequence organized around three major dimensions: the development of narcissism, the development of dependence, and the development of faith. In tracing the lines of narcissism and dependence, his work closely follows the thinking of Kohut and Winnicott respectively.

Meissner's developmental typology clearly embraces a wider range of experiences than the Freudian account. Although the model is organized around familiar psychoanalytic constructs, Meissner, like Ruzzuto, feels that the religious experience is best understood as a special case within the realm of transitional phenomena. Meissner takes strong opposition to Freud's perspective on religious experience as illusion. Indeed, he claims that Freud's position is more aptly described as considering religion as "a delusion" (1984, p. 163), or as beliefs which stand in contradiction to reality at many points. As such, they are the enemy of the reality principle, to be slain by the sword of science. Adopting the perspective of Winnicott, Meissner sees illusion in a very different light. He feels that illusion is

inevitable and, in fact, indispensable. He claims that "illusion retains not only its ties to reality but also the capacity to transform reality into something permeated with inner significance" (p. 17). He continues, "Man cannot do without illusion, since it gives meaning and substance to his experience of himself" (p.17). Thus the notion of transitional space and its role in structuring the area of illusion opens up for Meissner and contemporary psychoanalysts a new dimension within which to explore religious experience without compulsively reducing it to a status of an epiphenomenon, which must be purged of all its nonverifiable elements. Although Meissner acknowledges that the religious experience embodies regressive components, he highlights the fact that the experience is not merely a compulsive, repetitive one, but instead a recapitulative and creative regression which allows for an amplified and deeper quality of experience.

In Meissner's efforts to enlarge the common ground of dialogue between psychoanalysis and religion, he performs the much-needed function of brush-clearing and boundary-marking. Shifts in both the theological and psychoanalytic images of humanity have necessitated a clearing away of the dead wood. Meissner specifically cites the increased acceptance on the part of religion of the unconscious components of a human being's life and psychoanalysis' comple-

mentary recognition of the relative autonomy of various conscious ego functions as one point of historical debate which presently affords a more coherent dialogue. He similarly sees the debate over the issue of freedom and determinism as diminishing in intensity. In this regard, he specifically views psychoanalysis' relinquishment of its rigid, mechanistic model of causality as highly significant. The present model now leaves room for the role of intentions, purposes and goals in directing action. Along much the same lines, he sees psychoanalysis' abandonment of its exclusive reliance on reductive explanations in favor of "a more nuanced understanding of epigenetic transformations" (1984, p. 217) as facilitating the rapprochement of psychoanalysis and religion.

Despite these more recently established channels of increased dialogue, areas of important differences and seemingly irreconcilable conflicts nonetheless remain. Issues involving morality and the existence of a supernatural reality persist as points of irreducible tension. Meissner personally advocates "a proper respect for the limitations of human understanding and of the explanatory power of each given discipline" (p. 218). He is critical of premature and contrived efforts to fuse spiritual concepts with psychoanalytic understandings, most conspicuous in the areas of ethics and morality. He is similarly less than sanguine with re-

gard to the prospects of reducing the divergence between the natural and supernatural perspectives. Yet he recognizes this as simply a problem beyond the immediate scope of psychoanalysis, and an inherent limitation of scientific methodology. In his eyes, further progress in the evolving dialogue between psychoanalysis and religion can occur only as we keep acutely and accurately in mind the grounds of compatibility and the discrete areas of incompatibility of the two world views.

As one who is published by both the Paulist Press and the leading psychoanalytic journals, Meissner enjoys a rare status among theologians and psychoanalytic writers. His commitment and expertise in both realms is without question, and uniquely qualify him to perform his self-chosen and multi-faceted role as translator, intermediary and catalyst for the continuing dialogue between psychoanalysis and religion. By virtue of his theological training, Meissner ventures knowledgeably and comfortably where other analysts fear to (or simply cannot) tread. In his discussions of man's ability to "achieve his salvic purpose" and his call to explore the mechanisms embodied in "divine grace," he places his work apart from the rest of psychoanalytic literature, if only by dint of his language alone. Yet it is not simply the occasional use of theological language that sets Meissner apart. The language of traditional religion

represents only the surface level of dissimilarity. It is used in the service of posing new questions which are genuinely located at the heart of the dialogue between psychoanalysis and religion. These include an examination of cultural forces as well as individual developmental vicissitudes that shape the formation and relationship to a personal God and that predispose one to a given level of religious development. From this perspective, Meissner inquires, without implied evaluation or judgment, if different religious traditions operate preferentially at different modalities of his typology of religious experience. On the individual level, he seconds Pruyser in calling for clinical investigation of prayer and meditation. He similarly suggests exploration of the area of religious virtues, particularly those emphasized within the theological tradition. He specifically prescribes a psychoanalytic developmental examination of faith, hope and charity and an elaboration of the structure of the psychological organization that allows for "some helpful, restorative, or enhancing intervention on the part of God" (1984, p. 243). Suspending all judgments on his own efforts at integrating a psychoanalytic and religious worldview, his questions alone place him on the frontier of the psychoanalytic study of religion.

SUMMARY

In sum, efforts at integration between the domains of psychoanalysis and religion have a rather checkered history. Many of the early integrative attempts have, in fact, been characterized by an apportionment of jurisdiction. Supposed integration is affected by clear segregation of matters of the spirit from those amenable to materialistic inquiry. In this regard, the history of psychoanalysis essentially parallels developments in the history of science overall. Thus generations of religionist clinicians have essentially accepted the Freudian paradigm, except with regard to issues pertaining to the realm of religion, which have remained as encapsulated entities sacrosanct from analytic scrutiny. In addition to these efforts at integration by segregation, another frequent mechanism has been that of undifferentiated fusion or merger. Here, psychoanalytic religionists have tended to blur critical underlying assumptions about the nature of humanity and reality to reconcile the religionist and psychoanalytic visions, essentially claiming that both are saying the same thing in different languages.

Clearly one of the major sources of conflict between the psychoanalytic and religious perspectives has been over the issue of the existence of a God and a supernatural

reality. There is clear agreement that the question lies outside the domain of science and psychoanalysis. Hence most psychoanalytic commentators concertedly sidestep the question. Those who have chosen to directly address it have frequently invoked the psychological utility of religious conviction and commitment as valid justification for belief. Ego psychologists, in particular, have acclaimed the unassailable adaptive value of religion as a means for human growth and transformation. Yet they cannot generally accept the infantile gratifications and illusory base which render it such an effective transference cure.

Other major sources of dissonance between the psychoanalytic and religious world views center on issues of free will versus determinism, values and morals, and material reductionism. These inherent points of tension have often crystallized in the form of the question: "Can healthy religion exist?" The general equation of religious belief and practice with psychological immaturity has been barely subterranean within the psychoanalytic view. Those analysts who have also embraced religionist views have labored diligently to extend this perspective.

The contemporary prominence of the object relations school in psychoanalysis has given rise to a small, yet discernible new wave of highly informed and qualified commen-

tators and investigators at the interface of psychoanalysis and religion. The unifying theme in their work is the exploration of the individual's evolving relationship to a personal God. The abandonment of a strictly mechanistic, drive-centered psychoanalytic model has enabled them to move beyond the prior period of reductionistic explanations. Similarly, an expanded definition and perception of the role of illusion in human mental life has facilitated their exploration of religious experience as a special kind of "transitional phenomenon" with God viewed as a unique transitional object. In this light, they have attempted to "re-open the psychoanalytic book on religion," exploring it as an extremely sensitive and deeply personal subject most suitably approached through the clinical methods of psychoanalytic inquiry.

CHAPTER TWO

SPECIAL PROBLEMS

IN THE TREATMENT OF RELIGIOUS PATIENTS

The long history of conflicts between psychoanalysis and religion has not been confined to the realm of scholarly journals and institutional animosity. Indeed, the skirmishes fought out in these arenas parallel those that beset the treatment of the religious patient. The purpose of this chapter is to explore this clinical domain.

Just as psychoanalysis poses a problem for theology as a philosophical system, it does as well for the religious devotee who enters psychoanalytically-oriented treatment. In fact, the tension has been sufficiently great that this factor, in and of itself, serves as a sufficient deterrent to dissuade most religious persons from entering psychoanalytic psychotherapy. And for those that do enter treatment, the fear of loss of faith or exposure and reduction of cherished religious beliefs to analytic scrutiny presents a major resistance to treatment. It is only when a troubled religionist is in great distress that he avails himself of treatment. Even in these cases, he frequently needs to be encouraged to obtain treatment by a fellow religionist, who both recognizes his acute distress and who reassures him that it is not some kind of a breach of his relationship to his religious group. By the same token, much as psychoanalysis poses a unique dilemma for the religionist, so too does the religionist present a special set of problems for the psycho-

analytic clinician. As a function of his involvement in a highly organized and culturally sanctioned system of beliefs and values with idiosyncratic rules of conduct, ceremonials and rituals, the religionist represents a unique clinical challenge.

The purpose of this study will be to review the literature on the special clinical problems presented in the treatment of religious patients. In light of the wide range of writings on the philosophical conflicts between psychoanalysis and religion, it is striking how little has been written on the specific technical difficulties which emerge in working with religious patients or religious formations in treatment. The range of clinical issues raised in the treatment of religious patients is extensive. This review will attempt to focus primarily on familiar clinical concerns, namely: identifying areas of pathology; interpreting and working with resistances; establishing a positive working alliance; working with unique religious egosyntonic defenses; and monitoring both transference and countertransference reactions in the treatment. As a subset of this last consideration, we shall explore unique issues that have been reported upon which emerge in the treatment of religious patients by religious therapists. The review will conclude by commenting on some of the questions left largely untouched in the present literature, and by raising questions for future exploration in light of very recent developments in the psychoanalytic study of religion.

Healthy v. Pathological Religion

Religionists have long taken issue with the psychoanalytic predilection for examining religious formations with the inherent assumption of their underlying psychopathology. Thus, the issue of how a therapist evaluates the relative health of personal religious formations has posed a persistent clinical concern. Woolcott (1962) studied the lives of saints and famous religious figures, clergymen and hospitalized psychiatric patients in order to shed more light on this question. He draws heavily on Allport's (1966) concepts of extrinsic and intrinsic religious attitudes in underscoring the notion that a prominent indicator of pathology in religion is its "use for narcissistic, defensive or infantile purposes" (p. 62). He sees the transformation of this narcissism in the relinquishment of self-centeredness and omnipotence as hallmarks of the more healthy and adaptive, intrinsic perspective. Walcott concludes that integration, rather than repression or need gratification represents the essence of healthy religion. Numerous commentators have attempted to provide specific criteria typifying pathological attitudes towards religion. Pruyser (1971), who was Woolcott's mentor at Menninger, views religious acts as coping devices. He distinguishes between them much as he would assess any other system of coping. He claims, "Normal acts are reality oriented, socially approved, not costly in terms of their psychic price, integrative and healthy; the symptomatic acts entail poor reality testing, social disapproval, a costly investment of energy, regression, or a variety of boomerang effects which further endanger the person's success at equilibration."

(p. 278). In a later work, where Pruyser (1977) elucidates the "seamy side of contemporary religion," he adds other conditions which he sees as indicative of psychopathology in religion. He specifically cites: sacrifice of the intellect; surrender of agency or loss of ego control; and poorly neutralized aggression beneath expressed themes of love or service as reflective of symtomatic religious affiliations. Rubins (1955) offers additional criteria for differentiating healthy v. neurotic religion. He includes: narcissistic displays of piety and good deeds; bargaining with God or the expectation of reward; and dependence on outside authority as indicative of neurotic attitudes towards religion. These patterns are, in fact, merely the most readily apparent manifestations of pathological religion. The more subtle maladaptive patterns, such as a compulsive-submissiveness and piety as a defense against aggressive drives, are far less obvious, yet they are perceived as notably widespread among religious patients. In assessing any religious behavior, Lovinger (1984) emphasizes the clinician's need for both caution and specific information. He notes that beliefs and practices vary widely between denominations and sects and that the clinician often needs to be aware of the socially sanctioned behaviors within a given religious group before he can reliably assess the relative health and pathology of any given religious formation.

Religion as a Unique Resistance

The difficulty in differentiating adaptive versus neurotic

religious beliefs and practices is merely one of many problems presented by the religious patient. Special resistances to treatment pose another major technical difficulty. Peteet (1981) suggests three types of resistances which may present as religious concerns. The most prevalent of these is a peer group pressure which actively or tacitly discourages religionists from entering psychotherapy. Hence the religious patient often feels disloyal, isolated and embarrassed on initiating treatment. Lovinger (1984) similarly underscores the frequent distrust of many religious groups for conventional psychotherapy. He notes that this difficulty is frequently compounded by intense feelings of guilt on the part of the troubled religionist, who often feels that by seeking psychotherapy, he has thus failed in his own efforts to adequately follow his religious teachings or to solve his problems through faith and other prescribed religious practices. Numerous commentators (Bowers (1969), Lovinger (1984), Pruyser (1971), Bronner (1964)) note that typical resistances to treatment on the part of religious patients are markedly attenuated if the referral is made by the patient's clergyman, or when the therapist is affiliated with the patient's religious group.

Peteet (1981), comments "individual psychological resistance (as opposed to group pressures) to treatment expressed in the form of idiosyncratic beliefs, is usually more difficult to overcome" (p. 560). In this case, the patient refuses to accept the psychological basis for their difficulties, but instead prefers to view them as strictly "spiritual."

One of the most widely commented upon resistances of the religious patient is the fear of a loss of belief and faith, or an undermining of religious values and practices by a therapist who is viewed as antagonistic to spiritual notions or a secular moral agent. As much as this has been noted, one can hardly emphasize enough its critical importance in the treatment of the religious devotee. Astley (1962) perhaps captures best the underlying intensity and importance in the treatment of the religious devotee. He claims that "the importance of the religious reality is so great for the devotee, that its loss is equated with abandonment and death" (p.57). Lorand (1962) advises that not only is the patient suspicious of the therapist's deprecating and/or threatening his religious beliefs, but that the religious devotee is often equally leery of exposing to himself his own thoughts, feelings, and doubts which are forbidden by his religion. Hence in the process of psychoanalytic psychotherapy and especially when free association is encouraged, the religious devotee often experiences marked blocking to stave off deep-seated fear and guilt and the breakdown of the sense of support and reassurance provided by his submissive adherence to religious precepts. Once again, any questioning of religious authority, which has provided such a significant source of security and protection to the religious devotee, leaves him vulnerable to intense feelings of abandonment and acute separation anxiety. Lorand feels this resistance often leads to a negative therapeutic reaction, or a prolongation of symptomatology as a

defense against achieving independence. Although the fear that therapy will endanger their religious beliefs is considered prototypical for religious patients, Lovinger (1984) cautions that this is not necessarily the only threatening aspect of therapy for religious patients. Indeed, he claims that some are in fact suspicious of therapy as "demanding belief and faith and entailing a loss of freedom" (p. 168) at a time when they, themselves, are seriously questioning their own religious attitudes and affiliations. Peteet (1981) notes that "failure to distinguish among religious resistances to treatment may unnecessarily heighten the patient's sense of conflict between his religious and emotional life, thereby creating an additional iatrogenic resistance" (p. 560). Clinicians are united in expressing the view that patients need to be given license and encouraged to bring their religious concerns into treatment. Religious patients are acutely sensitive towards perceived disapproval of their values, beliefs, and religious practices, and they need to feel that they can bring religious issues to treatment in a non-judgmental climate where they will be treated with respect. In light of the religious clinician's probable greater familiarity with the climate of reductionism and tacit suspicion, which has pervaded the psychoanalytic position on religion, it is expectable that he, too, has often been markedly guarded in bringing his deeply-cherished religious beliefs into his own personal treatment. At this point, questions concerning the religious therapist's experience as a patient in treatment are virtually

untouched in the literature.

Religious Formations in Defense Mechanisms

Similar to their resistance maneuvers, religious patients employ religious formations in the service of familiar psychological defense mechanisms. This utilization of culturally-sanctioned institutions to fortify defenses poses a particularly thorny problem for the clinician. In a comprehensive and provacative article, Novey (1955) differentiates between the constructive use of religious formations and their co-optation in the service of neurotic processes. The essence of the distinction lies in the fact that the neurotic use of religion, instead of being sublimatory, tends to engender isolation, non-communication and interferes with object-related activities. Novey concludes "these defensive patterns are particularly difficult to shatter, as they become rationalized by the neurotic and accordingly assume an investment of virtuosity and righteousness" (p. 83). Two security operations Novey sees as particularly prone to co-optation on the part of religious patients are: scrupulosity, as a defense against self-expression; and the adoption of a masochistic, submissive posture as a means of defending against oedipal strivings and separation anxiety. The values and practice of asceticism, altruism and slavish obedience, all highly prized by many religious devotees, are similarly viewed as highly susceptible to defensive utilization. Lorand (1961) suggests that the extreme submissiveness and masochism of the religious devotee is an institutionally sanc-

tioned defense against strong unconscious feelings of hostility and that they are employed for the purpose of securing protection and love. By the same token, he sees the devotion and obedience and the adoption of rigid moral codes by these patients as similar maneuvers to assure continued love and affection from an omnipotent parental figure in the form of God or religious authorities.

The topic of religious values in psychotherapy has prompted more comment than most areas involved in the treatment of religious patients (Vide: London (1976), Halleck (1976), Belgrade (1983)). Numerous clinicians have pointed up the subtle interplay of many religious value in psychological defense mechanisms. Clearly, the issue of differentiating when religious values and practices are authentic and integrative, as opposed to disautonomous, and maladaptive, poses a particularly problematic concern. Not only is the issue a subtle diagnostic question, but it poses as equally great technical challenge for the clinician who attempts to interpret a pattern he sees as maladaptive to a patient who not only views the behavior or value in question as ego-syntonic, but who often, in fact, holds it in highest regard.

Religious Values and Psychotherapy

The fact that the traits of obedience, self-sacrifice, humility and the value of self-effacement and self-denial are prescribed and/or commended in many religious paths, readily renders them highly esteemed by the religious devotee. Thus, even when

these values are contaminated in the service of pathological defenses, the religious patient can or will not readily acknowledge their maladaptive aspects. This potential clinical impasse highlights the marked dissonance in values between the psychoanalytic perspective and many religious world views. The problem of value conflict has been widely discussed (Vide, Bergen (1980), Vitz (1977), Belgrave (1983) and centers on the differences between a psychological means of integration which prizes autonomy, the pursuit of appropriate satisfaction, the acknowledgement and expression of aggressive and sexual impulses, self-affirmation and the avoidance of masochistic suffering. This contrasts with a religious view which emphasizes what appears to be, the diametrically opposed values of redemption through self-effacement. The potential for collision of these seemingly irreconcilable value orientations represents a continuous source of tension and resistance in the clinical encounter with the religious patient. Another prominent realm of value conflict lies in the fact that therapy generally espouses a position of moral relativism, while religious moral systems tend to be highly concrete and absolute, and often with values deriving their unequivocal legitimacy from divine authority presently vested in the church and its teachings.

Ethics

The treatment of the religious devotee raises ethical considerations as well as questions of values. In light of Halleck's

(1971) contention that treatment inevitably produces changes in beliefs, Peteet (1981) recommends that clinicians adopt the practice of informed consent, much akin to that typically employed by medical practitioners and researchers. He advocates reminding patients of "the unforeseen and pervasive consequences of therapy and the risk of relying on a therapist's guidance" (p. 63). He also urges clinicians to clarify "the relationship between the religious questions under discussion and the therapeutic task" (p. 563). There is significant disagreement over the ethical issue of therapeutic neutrality with regard to religious values. London (1951) argues that therapists are ethically justified in undermining religious faith and practice if the religious formations are patently supportive of maladaptive behavior. McLemore and Court (1976), on the other hand, call for extreme caution in directly intervening in issues pertaining to patients' beliefs.

Therapeutic Alliance With Religious Patients

Negative therapeutic reactions have been noted by many clinicians who have worked extensively with religious patients (cf. Lorand (1962), Astley (1962), Bronner (1964). This is frequently attributed to their marked fears of autonomy and individuation and to the significant secondary gain provided by their moral masochism. Yet another major contributing factor has been the recurrent difficulty recorded in establishing a solid working alliance. Case reports reflect the fact that religious patients present special transference difficulties, upon which treatment can

readily founder. A common negative transference reaction is the previously described situation wherein the patient consciously or unconsciously sees the therapist as a materialist adversary set out to expose the neurotic roots of his religious beliefs. A milder variation on this theme is the patient who simply attributes to the therapist a lack of interest, appreciation, or understanding of his religious concerns. Pruyser (1971) and Spero (1981) further elaborate on a third common transference distortion posed by the patient who insists upon seeing a clinician of similar religious affiliation. Pruyser claims that beneath this demand often lies a number of significant expectations or wishes, specifically:

1. His problems will be more readily understood without the need for detailed explanations.
2. His religious beliefs and practices will be left unexamined or will be reinforced by the clinician.
3. The therapist will assist the patient by assuming the role of religious instructor.
4. A desire for special treatment reflecting underlying grandiosity.

Both Pruyser and Spero caution the clinician to be aware of the psychological traps underlying these budding positive transference patterns, as they belie magical expectations and suggest that the patient "is not very well motivated for the hard work involved in getting psychological help and promoting psychological change" (Pruyser, 1971, p. 284).

The prevalance of strong counter-transferential feelings on the part of both religious and non-religious therapists poses another major clinical issue. Virtually all writers who have addressed this issue strike a common chord in suggesting that a root of these difficulties frequently lies in the clinician's own undigested experience with religion. These undigested religious experiences take many forms: regressed, immature images of God; confusion over childhood moral training; or blanket rejection of all that smacks of illusion or narcissistic gratification in religious belief and practice. Pruyser (1971) suggests that these counter-transferential problems often impel the clinician to steer clear of all religious material under the guise of not "committing the professional sin of being moralistic" (p. 286). In fact, the clinician is often merely quelling his own personal conflicts or insecurity about venturing into the murky realm of religion. Negative counter-transferential reactions are clearly over-determined. A variety of discreet elements underly them. Included among these are: the internalization of the societal taboo on discussing religion; fear of patients inquiring into the therapist's religious beliefs; a recognition of the immaturity of one's personal beliefs and values; and feelings of ineptness in discussing religious issues. (Pruyser, 1971). Pruyser is equally incisive in pointing up positive counter-transferential reactions, wherein religious factors are not systematically excluded, but instead are apparently given undue weight in treatment. These distortions are clearly more common to clinicians who are themselves reli-

gionists and who accept the religious patient's demands to protect his beliefs or to serve as a spiritual companion or advisor. Collusion with these expectations can be either conscious or unconscious.

A unique set of counter-transference reactions is described by Mester and Flein (1981) in their study of therapists' reactions to an extremely religious Jewish patient brought in for involuntary treatment. They report therapists describing "fears of wrong-doing," "being unjustifiably and unnecessarily aggressive with the patient," and envy -- "related to unconscious or conscious convictions that these patients had reached the ultimate psychological solution to existential doubting and emotional pain" p. 300). Other religious therapists acknowledge a reluctance to challenge or explore religious issues with religious patients because of their personal ambivalence as to the "superiority of psychotherapy to traditional spiritual approaches to problem solving" (p. 302). While the context of their work is significantly different than treating an out-patient, the unique reactions reported by these researchers clearly suggests that the range of responses to religious patients is both varied and complex.

Counter-transferential distortions are by no means limited to the non-religious therapist. Religious therapists, though far less frequently discussed in the literature, are similarly predisposed. Moshe Spero (1985) specifically addresses these concerns. He calls for acute attention to counter-transference

reactions and strict adherence to technical analytic parameters in the treatment of religious patients by religious analytically-oriented clinicians. In doing so, he categorically rejects the early views that "one could not be simultaneously free of neurosis and a religious devotee" and the reaction that "psychoanalytic theory cannot adequately address religious issues" (p. 575). While Spero is aware of the increased potential for counter-transferential distortion with the religiously affiliated therapist and patient, he feels this difficulty is in fact merely disguised by religious beliefs and commitments. He feels the collusion is more directly attributable to underlying conflicts with psychosexual and psychosocial themes. He articulates several distinct features which potentially contribute to a misalliance in the treatment of the religious patient by religious therapists. The first of these is an alledged commitment to a relationship of "brotherly love" with fellow religious devotees. Spero views this practice as an uncontrolled neurotic response rather than one of consciously chosen values. This feeling of fellowship, where therapist and patient are seeking the immediate rewards of unanalyzed religious familiarity, poses a major threat to the establishment of a non-contaminated working alliance. He further cites therapist rescue fantasies and the unwitting acceptance of patients' expectations for magical cures or spiritual guidance provided by an idealized therapist as common positive distortions of the therapeutic relationship.

Negative distortions based on unchecked counter-transferential

responses are similarly frequent and problematic. In these cases, the religious therapist is often over-identified with the patient, and tends to project his own insecurity, guilt or prejudice. A variation on this theme is the therapist who disdainfully or condescendingly views his religious patients' struggles as "primitive versions of his own, more sophisticated and well-resolved religious awakening" (p. 570). Spero, like Pruyser, attunes his clinical colleagues to the fact that anti-religious prejudice is by no means confined to the non-religious clinician. The religious clinician can indeed be even more critical and condemnatory of what he identifies as pathological religious formations. This judgmental stance and therapeutic crusade to expose and expunge maladaptive religious formations is often motivated by narcissism and self-righteousness on the part of the religious therapist. Furthermore, these actions both confirm the maturity of his own religious beliefs and bear witness to the fact that his own clinical judgment has not been compromised by his personal religious affiliation. Thus, the zeal of some religious clinicians' efforts to root out neurotic religious formations is multi-determined. It may reflect an overcompensation for their own tendency to collude in an overly close relation based on religious familiarity. It also may reflect the self-image and perceived mission of one, who by dint of his training as both a committed religionist and a clinician, sees himself as highly qualified and responsible for purging patients' religious formations of idiosyncratic psycho-

logical contaminants.

In addition to describing common distortions, Spero provides concrete recommendations for remedying them. He suggests that treatment be conducted through a "therapeutic barrier" as if factors such as religious similarities were not a basis for any additional positive or negative appreciation of the patient. This perspective is employed as a safeguard to enable any contaminants that enter the relation to be brought readily to attention. He also cautions the religious therapist against an overinvolvement with religious issues. He specifically advises the clinician to "tolerate the patient's normal need for an area of emotional and not necessarily rational commitment and belief." The clinician thus "must contain his own need to impart insight into every aspect of the patient's life" (p. 573). He emphasizes that patients' religious beliefs should be relevant to the psychotherapist only to the degree that they are involved in the patient's conflicts and not merely because they are religious beliefs. In sum, Spero, a personal believer in autonomous and healthy religiosity, feels that individual religious attitudes must, of necessity, be open to analytic focus during the treatment of the religious patient by the religious clinician. Since the maintenance of this analytic stance is unquestionably complicated by the religious affiliation of both parties, he advocates stipulating specific ground rules early in the treatment to define and clarify the nature of the analytic task. This definition is operationalized as the therapist

works to establish a consistent focus on the underlying reasons for the patients' apparently religiously-motivated behavior. In a later work, Spero (1985) makes explicit that his therapeutic goal is the cultivation of autonomous religious beliefs, ideals and practices freed from encroachment by fixations at primitive levels of psychosexual and psychosocial development. His aim is "not the removal of the patient's essential commitment to religion, or his basic obligation to religious practice, but aiding him to achieve a less conflicted state of belief ... so that he can experience religion in an adaptive fashion" (p. 41).

Lovinger (1984), another religious psychoanalitically-oriented clinician, similarly addresses counter-transferential issues in the treatment of religious patients. He identifies several distinct indicators of counter-transferential difficulties. These include:

1. Extended "philosophical discussions that have no therapeutic aim."
2. Avoiding religious topics or labeling them as resistance.
3. Premature and insufficiently explained interpretations of religious matters in dynamic terms.
4. Interpreting patient's acquisition or rejection of religious orientation as a sign of progress or regression without adequate investigation (p. 205).

Lovinger's discussion of counter-transferential difficulties is not confined to religious therapists' treatment of religious patients. But he notes that religious therapists, in particular, may overlook or fail to approach psychodynamic problems which are presented in a religious idiom or patients' defensive appeals to religious beliefs and sanctions. he advises religious therapists, when alerted to this, to be more directly confrontive in the face of defensive religious maneuvers. Lovinger also observes that both the religious and non-religiously affiliated clinician will probably receive limited aid with counter-transference issues from supervisors or other professionals. He notes, like Spero, that religious professionals treating religious patients (often affiliated with religious agencies or institutions of third parties (clergy, school officials). This often serves to complicate the treatment. In terms of technique, Lovinger's comments, while far more elaborated, are similar to Peteet's (1981) concise counsel "Therapists who avoid discussion of religious issues miss opportunities to help patients integrate their religious issues risk losing sight of the therapeutic task" (p. 563). Lovinger specifically counsels clinicians to reframe questions of belief and/or the validity of religious doctrine, which can only lend themselves to therapeutic impasses, in more practical terms. He suggests rather than risk entrapment on questions of theology or morality, the clinician should refocus

the issue to ask "Is this a valid (not the true) way to live?" (p. 20). This is in marked contrast with Spero, who advocates an approach to these maneuvers which places greater emphasis on exploring the patient's transference wishes and demands which presumably underly his religious questions.

John Peteet, of the Harvard Medical School, describes himself as a self-professed "Christian psychiatrist." He acknowledges that many of his patients have selected him as a therapist because of his religious affiliation, and he advocates a far more flexible approach to working with religious patients than either Spero or Lovinger. He describes tailoring his interventions with regard to specific religious issues to the patient's clinical needs. Hence he might empathize with the patient regarding his struggles, and share his own "interest in integrating his sense of responsibility to God with an allowance for his human limitations" (p. 67). He will similarly, on occasion, share his personal theological convictions, frequently in an effort to help religious patients modify or question their own harsh moral standards. Despite these deviations from conventional therapeutic technique, Peteet advocates eschewing the role of religious counselor in favor of exploring the origins and meanings of most behaviors. He affirms the value of sharing "religious language to achieve ends ... which are viewed as desirable from both the religious as well as the psychological point of view" (p. 69).

Psychotherapy and Religious Belief

In addition to their delineation of the unique technical problems inherent in the treatment of religious patients, psychoanalytic commentators have historically focused attention on another salient issue - the fate of religious belief in psychotherapy. In his review of the literature, Bronner (1964) directly addresses this concern. He comments that "no patient ever lost his religious belief unless they had been on very shaky grounds to begin with" (p. 485). This attitude parallels that of many orthodox psychoanalysts, who often view the analysis of a patient's religious beliefs or relationship to God as comparable to the analysis of any other relationship. in the works of Nathaniel Ross (1963), "In analysis, we can only analyze; if illness involves religious beliefs, we must analyze it - what the patient does with it later is his own business" (p. 169). Numerous clinical reports describe specific cases of a decrease in the importance of religious beliefs and commitments after psychotherapy. Yet a more systematic exploration of this phenomenon has yet to be carried out. Pattison (1969) citing the reports of numerous other clinicians, suggests that therapy may result in drastic changes in a person's religious beliefs and practices. Indeed, he reminds that the abandonment of religion "was considered necessary for successful therapy by some of the early psychoanalysts" (p. 589). Yet surprisingly, he notes a number of analysts reporting a strengthening and deepening of religious belief as a function of therapy (Ekstein, 1956, Reissner, 1957).

Linn and Schwartz (1958) similarly report on a prominent return to religion or an intensification of religious commitment in seventeen psychotherapy cases. Yet these findings must be seen as anomolous when seen against the backdrop of the majority of cases which discuss the fate of religious belief in treatment. The category of "no change in religious belief" after therapy is also a prominently reported finding. Tarachow (in Mann, 1964) reports "that even after successful analyses, he had not seen patients change their religious beliefs" (p. 169). Tarachow attributes this phenomenon to "ego-splitting and, the fact that much of analysis is left untouched" (p. 169). His comments reflect the prominent strand in psychoanalytic thought. This is Hartmann's (1960) notion of compartmentalization of codes which explains the ability of many people to maintain two sets of seemingly irreconcilable beliefs and codes of values. It is essentially this mechanism which Tarachow refers to as underlying the frequently perceived intractability or immunity of religious beliefs to analytic modification, even when there has been significant progress in the therapy.

The primary conclusions that can be drawn at this point are that the available data on the question of the fate of religious belief with psychoanalytic psychotherapy is scant and fragmented, contradictory and decidedly inconclusive. The question is clearly one that begs more extensive examination. Exploratory research such as that of Belgrade (1983) suggests that religious beliefs are far more refractory to modification through

therapy than are moral values. His results indicate that while eleven of twelve former Catholic seminarians, who are presently clinicians, rejected their former moral values, nine of the twelve still describe themselves as "believers." These findings support the theoretical notions of Rizzuto, which suggest that religious beliefs are far more intimately connected with an individual's core sense of self than are his religious and/or moral values. While questions of values and morality are potentially open to the modification of rational analysis and as such are even subject to change through the church itself, belief involves a highly personal, private and often largely unconscious relationship to a personal God representation. Hence, changes in belief are less readily achieved without a deeper inner restructuring of one's self representation or one's representations of early object relations.

Summary

In summary, the religious patient presents numerous unique technical problems in psychoanalytic treatment. Fundamental and seemingly irreconcilable differences in the underlying world views of psychoanalysis and religion lend themselves to philosophical, moral and ethical points of contention which frequently present a major resistance to treatment. These conflicts similarly often make assessment of the religious patient highly problematic. Not only are religious behaviors hard to assess clinically in terms of their role in maintaining psychic

equilibrium, but they frequently serve as socially sanctioned means for fortifying pre-existing psychological defenses. Teasing out and interpreting this pathological employment of religious formations presents another major technical challenge for the clinician. For once again he risks entrapment in issues of value conflict and charges of psychodynamic reductionism, when, and if, he chooses to directly interpret religious formations. In light of these numerous potential sources of clinical impasse, it is not surprising that therapists report a preponderance of negative therapeutic reactions in their work with the religious patient. While the establishment of a sound therapeutic alliance is clearly an essential condition for effective work with a religious devotee, it is notably subject to a unique variety of specific transference and counter-transference distortions. These distortions are not limited to the treatment of religious patients by non-religious clinicians. Although distinctly different in nature, they are equally prevalent in the treatment of religious patients by fellow religionist clinicians. The need for clinicians to appropriately address these transferential issues as well as to examine their own biases and/or undigested experiences with regard to a religion are crucial in the treatment of the religious patient. Especially in the case of the religious clinician, the tendency for role confusion and/or diffusion presents a recurrent difficulty.

In light of these unique difficulties, religious clinicians, in particular, have adopted a variety of technical maneuvers

which they employ in their treatment of the religious patient. These vary from the issuance of specific ground rules designed to combat the tendency for collusion to discussion of personal theology in an effort to model superego modifications. The exploration of the religious patient's image in relationship to a personal God-representation is prescribed by some clinicians as an essential means of understanding both the patient's religious experience and his psychological development. A major question which remains largely unanswered is that of the fate of religion, specifically religious belief, as a function of psychotherapy. While at one time the abandonment of religious belief was considered a tacit condition for the success of analysis, current case reports reflect a wide range of responses. This question, in particular, warrants systematic study, optimally with research directed at both clinicians and patients.

CHAPTER THREE

METHODS

The conjunction of psychoanalysis and religion has been marked by immiscibility, high surface tension, and a mixture which tends to readily separate itself out, or at best remain continuously murky. It is a mixture which not only is seldom clear, but one that often requires considerable activation energy and agitation to maintain a transitory equilibrium. At the same time, the combination has frequently been known to generate considerable heat of reaction with little discernable light.

The unique reactions of this quixotic combination have had a major impact on the cultural, intellectual and institutional history of the twentieth century. Yet, the combination is not confined to the plane of philosophy and institutional affiliations alone, for the integration of psychoanalysis and religion is always at some level, an essentially personal issue. Commentators are united in proclaiming that by far, the great majority of psychoanalysts have essentially "rejected all religious philosophies" (Fine, 1977, p. 64). They claim that "it taxes the mind to consider how a reconciliation of the two perspectives is effected" (Freud, in Meng, p. 18). They are correct, for indeed, the religiously committed, psychoanalytically-oriented clinician is a highly unique and (equally difficult to find) individual. It is the purpose of this work to conduct an exploratory study of this rare and anomalous population.

Purposes

In light of the dearth of research in this area, particularly with this difficult to locate population, this study is intentionally broad-based and exploratory. The focus is on three broad areas:

1) The subjects' integration of psychoanalysis and religion.
2) The subjects' experiences as patients - with special emphasis on the special fate of religious formations and religious beliefs in psychoanalytic psychotherapy.
3) The subjects' experiences as clinicians - especially their experiences working with religious concerns.

This tri-focal approach was chosen to reap as broad as possible a range of data in light of the unique subject. At the same time, it serves to obviate the very real potential for garnering mainly esoteric, philosophical ruminations or declarations of "no perceived conflict" in response to the question of personal integration. For this reason, clinical issues were also specifically explored. Thus, the aim of the study was both to shed more light on how a select group of individuals reconciles a unique instance of both role conflict and potentially philosophical and/or intrapsychic conflict; with a parallel goal being the exploration of this uniquely informed groups' experience as both patient and clinician

dealing with religious concerns in psychoanalytic psychotherapy. This latter issue is especially significant in light of the subjects' unique status as persons who are highly trained in both psychoanalysis and in their own religious perspectives. In light of the clinical method employed and the limited sample size, the findings obtained will not be of the kind that can be definitively utilized to reject or confirm discreet hypotheses. Instead, their value lies in hopefully providing rich descriptive responses to questions that have either been largely ignored or that are not readily suitable to more reductionistic, empirical techniques. Issues such as: the evolution in a person's God-representation; or their approach to the interpretation of maladaptive religious formation are not particularly amenable to simple quantification. Thus, a clinical approach seems much more suitable for exploring the subtle issues under consideration. It is hoped that the data generated will suggest broad trends as well as specific directions for future research.

Subjects

Twelve subjects were used in this study. All, except for one, were ordained clergy who similarly had received extensive training in psychoanalytic theory and technique. Seven were graduates or presently enrolled candidates in psychoanalytic institutes. An additional three, who are not in institutes, had clinical psychology Ph.D.'s at psychoanalytically-oriented

programs, and one was a third year psychiatry resident. Ten of the twelve had private practices in addition to institutional affiliations, while two worked exclusively with clinics, in terms of their present therapeutic activities. In terms of their religious affiliations, two were presently occupying pulpits, and one was residing in a monastic community. Nine of the twelve were presently involved in consultation with clergy organizations or pastoral counseling programs.

The subjects were all obtained through personal referrals after a canvassing of psychoanalytic institutes. Subjects were best located through prior subjects in a chain-letter fashion. At the end of each interview, I would ask if the subject could think of any other suitable candidates for the study, and often he would know of one or two. Using his name as a reference, I would often gain the cooperation of the next subject.

Piloting Interviews

The initial interview format contained 38 specific questions. (See Schedule A) During piloting interviews with committed religious clinicians, it was found that strict adherence to the interview format tended to create a choppy, controlled interview. In these cases, the subjects accommodated to the perceived task by providing rather concise responses to specific questions. The hoped for climate of self-investigation which was felt necessary for exploring these subtle and often guarded feelings was limited by the fact that the subjects

clearly knew that another major question was always waiting in the wings. Not only were the sessions somewhat constrained and controlled by the sheer number of pithy questions, but some questions simply proved redundant. In light of this experience both the interview schedule and procedure were reworked.

Interviewing

Final interviews followed a much more open-ended format. (See Schedule B) Subjects were informed that the interview would focus on three general areas. The first issue was approached by asking the subject to describe his background and training in psychoanalysis and in religion, and his present involvement in each sphere. After allowing the subject to present this material in his own way, I could then inquire specifically and at the appropriate times, into issues pertaining to God, religious beliefs, and various religious practices. Only when the subject did not spontaneously discuss these issues did I introduce them. The issue of God was the one most frequently passed over by the subjects, and I often injected this topic with a preamble such as: "Many writers consider 'the essence of religion to be a personal relationship to a God, or that which one considers to be divine' (a fusion of William James and Pruyser) - could you discuss your own beliefs and experiences in regard to God?" As the subjects responded to this open-ended question, I could then ask them

to elaborate on his God representation, changes in his God-schema and other religious formations, as well as his explorations of the psychological roots of this material. This approach proved far less restrictive and allowed for the material to emerge following the subject's train of thought. Similar open-ended approaches were used to initiate explorations of the subject's experience as a patient, as a clinician, and his experience integrating psychoanalysis with his religious perspective. In effect, the final interview consisted of four open-ended questions, with most other material deriving from my inquiry into the patient's responses. At the end of the unit, or one area of questions, if the subject had not spontaneously touched upon specific concerns, I would introduce them, often using specific questions from Schedule A.

The issue of integrating religiosity and a psychoanalytic perspective, if it did not emerge spontaneously, was often introduced by a technique of injecting Freud or the voice of an Orthodox psychoanalyst into the dialogue. To do this, I would generally say, "If we were to bring Freud into this discussion, he might say 'Psychoanalysis and religion are essentially irreconcilable. Religion is simply an illusion based on man's deepest wishes and longing.' How do you respond to him?" At times I would often play out the part of Freud and continue this dialogue if the tactic proved especially useful. By the same token, when exploring the subjects' responses to their experiences as clinicians, I would often play the part of a

particular religious patient to test the limits of their approach to specific clinical problems involving resistance, transference and issues of ethical conflicts. A similar technique to this role-playing was one of limit-testing. Again, I would often interject quotes from the position of another therapist in response to the subject's own articulated position. For example: if the subject described a particularly abstract, philosophical God representation, I might comment, "Rizzuto claims that intellectual or abstract notions of God cannot really be seen as tantamount to the former object representations. The relationship to God is essentially a personal one, and requires some kind of concrete object representation. How would you respond to her position?"

All of the interviews were taped and were conducted in either the therapists' homes or offices. Many interviews required two sessions, as they were conducted in between therapeutic consultations. Interviews ranged from one to four hours, with most taking approximately two and one-half to three hours.

As the interviewer, I thoroughly enjoyed the process. Subjects, on the whole, were open and extremely interested. They were eager to participate. Many, if not most, openly expressed gratitude for the opportunity to talk about these subjects, claiming they had seldom had the chance to reflect on these issues so specifically with colleagues and that these issues had seldom been previously discussed at such length. Others expressed feeling obligated or a sense of duty to coop-

erate with anyone attempting to conduct research in this area, as they felt it was simply very important, and an area that had been neglected. Another feeling expressed was one of feeling challenged by the prospect of responding to direct questions regarding their religious beliefs and psychoanalytic perspective after spending so much personal time and energy on the subject.

The interviews themselves generally proved to be enjoyable and rewarding for the subjects. Many acknowledged that they had never addressed these issues so directly before and others claimed that the process was extremely integrative and enlightening for them. As subjects became more comfortable and open during the sessions, they often experienced psychological breakthroughs that were quite surprising to them. One subject after initially describing a very abstract and philosophical and specifically, genderless, God representation, laughing reflected later on, when describing a stage of deep personal anger at God - "You know, it wasn't a she - it was a man! When I really talked to him, it was a man!" Another claimed the experience to be an "epiphany" in that it was especially valuable to him in understanding his congregation's transference to him. He said he felt inspired to write a book, based on the experience, "The Good Enough Rabbi." After the interviews were concluded, the subjects were generally most eager to know of my own background and interests, as well as to exchange references related to the topics we had discussed. Three gave me papers of their

own to read, and several asked that I share my findings with them, and provide them with tapes of the sessions. A number suggested that the study be published, and one offered to help with the venture.

CHAPTER FOUR

DESCRIPTIVE DATA

The final interviews were completely transcribed onto index cards with each card labelled for its specific category of content. The data was then analyzed in two ways. First, each subject's experience was condensed into a brief biography and interview summary. The purpose of the case summaries was to attempt to give a sense of integrity to each clinician's unique experience and perspective. While an effort was made to keep the summaries concise, notable responses to major questions were frequently quoted, in part or whole, to allow the subject's distinctive styles to emerge. The case summaries were organized to follow the format of interview schedule B, with the subjects' discussions of their experiences as patients and as clinicians, as well as their personal efforts to integrate psychoanalysis and religion following after a brief biography.

In analyzing the interview data it was decided to shun any attempt to individually assess the role of religious belief and commitment in the personality organizations of the clinicians interviewed. Even

though some subjects at times appeared to employ religious formations for either highly adaptive or patently defensive purposes, these subjective interpretations were concertedly withheld from the case reports. The decision to refrain from offering individual psychodynamic formulations derives from two factors. Firstly, in light of the circumscribed nature of the clinical interviews, any dynamic formulations offered would be at best limited, if not, in fact, gratuitous. Secondly, clinical speculation as to the unique role of religion in maintaining the psychological equilibrium of the subjects was felt to be an unnecessary and unwarranted violation of the tacit research contract under which clinicians voluntarily agreed to reveal highly intimate and personal material for this study. Thus the case reports will be primarily narratives with selective inclusion of quotes.

A more integrative and interpretive analysis of the entire pool of data will follow the case summaries. Here our thrust will be to both identify common patterns and relationships and to interpret them.

F.W.

F.W. is an ordained, conservative Rabbi and a clinical psychologist in his late 30s. He has also

recently completed his psychoanalytic training. His primary employment is as a psychologist in private practice. He also serves as consultant to national Rabbinic organizations where he primarily "provides psychological services to Rabbis." Dr. W. has an additional doctorate in Ancient Near Eastern studies, and he formerly taught at a major Jewish Theological Seminary. He has been a Rabbi for over thirteen years, working in a variety of capacities, including a post as campus Rabbi at a major university. He has consciously elected to bypass the role of permanent congregational rabbi in his career as clergyman.

While F.W. grew up in a traditional Jewish family in a large Eastern city, his own religious orthodoxy and commitment significantly outstripped that of his family. His decision to prepare for the rabbinate was, in fact, viewed with skepticism and contention. In his words, the position of his family and friends was, "Okay, be religious, but what kind of career is a Rabbi for a nice Jewish boy?" His present approach to Judaism remains "traditionally oriented." He maintains Jewish dietary laws, and he describes practicing the prescribed afternoon prayers with phylacteries in his office between patients. Congregational affiliation is of less importance to his religious practice, and he

presently attends synagogue only occasionally. F.W., while candid and open in the interview, had considerable difficulty talking about God and religious belief. He continually parried questions about God, and only when decidedly pressed, affirmed his own belief. He emphasized that "the issue for him and Judaism is not so much theology and belief as it is actions." He disavows an external, anthropocentric vision of God. Indeed, he denies having any images of God, but views the deity more in terms of "what the kabalists call a 'vessel for the divine' where each individual is created in the image of God." Translating this image into analytic terms -- he views God as an "ego ideal, with which he checks in to see how he's doing." He realizes that he'll "never get to attain this ideal -- but then if I did, it wouldn't be a very good one to begin with." In contrast to his reluctance in discussing religious beliefs, F.W. was highly comfortable talking about religion and God in psychoanalytic terms. He affirmed that Freud was essentially correct in describing the projected God of most people. He described religion as "a regression in the service of the ego, which allows people to feel a connection, a dependency state -- nurtured in fantasy and from that place of being cared for -- to make a

transition back to a normal, self-reliant adult stage." In effect, he acknowledged much of what Freud claimed about religion as being correct, yet he felt that Freud's view was both limited and biased. For him the distinctions between psychoanalysis and Judaism do not exist. He feels that when these positions are placed in juxtaposition, they are both merely "straw men." This reconciliation is affected by considering the reality of religion as unique and distinct from the truths of which Freud speaks. For him, belief and faith are "existential realities" yet their truth is of an altogether different nature "than the truths of material science or logic." In this regard, he does not feel that psychoanalysis has satisfactorily grasped the full essence of religion. He acknowledged that religious commitment and belief would be difficult for him "without a personal experience about the meaningfulness of religious behavior" and he described having "what I represented to myself as religious experiences" -- at the same time acknowledging that "experimental psychologists might well described these experiences in other terms."

F.W. acknowledged that Freud's contributions to the understanding of religion have been valuable, but he did not accept Freud's views in toto. He commented

"I´d like to think we´ve gone beyond Freud today," and he cited the work of Winnicott regarding transitional space and play, in particular, as expanding the psychanalytic understanding of religious experience. His main objection to Freud´s phenomenological description is that it only describes the neurotic religious experience, and leaves no room for more healthy forms. While he acknowledges that Freud had something valuable to say, he feels Freud was essentially too polemic and biased to be sensitive to "people whole religious experience is more mature than one where God is simply -- `father´ writ large." His partial dismissal of Freud´s theoretical speculations regarding religion is similarly based on his own historical and personal analysis of Freud´s perspective. On the whole, F.W admits "he never took Freud´s writing on religion all that seriously."

In commenting on his how experience in psychotherapy, F.W. felt that while therapy had an affect on his religious beliefs and practices, the primary impact was one of tempering his orthodoxy, In his words, "nothing came up that was terribly earth-shattering. There were no skeletons in the closet whose discovery would have led to a sort of domino theory, precipitating a religious crisis." The main consequence was "an increased tolerance of ambiguity,

with less need for orthodoxy and rigidity -- an overall mellowing." Dr. W. was initially in psychoanalytic psychotherapy, and he later had a four year training analysis. In both therapeutic experiences, he claims that religious issues were not particularly critical concerns and they were seldom "addressed head on." He reports being aware that he could invoke religious issues "if he wanted to create a scapegoat for other, more deep seated conflicts." But in essence, he felt that in his case, the invocation of religious conflicts was generally "a false issue."

F.W. selected an analyst who was Jewish. He claim that he "would not have felt comfortable with someone with whom he would have to do a lot of teaching" (regarding his Judaism). The analyst was "a culturally affiliated but not a practicing Jew." He took a position of positive neutrality towards F.W.'s religious commitments." F.W. maintains that a religious commitment on the part of his analyst was not important to him, but the fact that he be both "sympathetic to his own religious commitment: and a compatible analyst were.

Dr. W. indicated that he had considerable experience working with religious patients as, indeed, many of his cases were referred to him because he was a

Rabbi and someone thoroughly familiar with Jewish law and practice. His views on treating religious patients closely parallel his own experience in psychotherapy. He finds that the core conflicts are "rarely religious ones," and thus his treatment approach is to work "off target," side-stepping religious issues but addressing the underlying conflicts of which they are simply one more manifestation. He feels that religious beliefs and practices can change with therapy, but seldom by being addressed directly. Instead, they "seem to evolve with overall maturation." At the same time as F.W. advocates side-stepping most religious issues, he cautions against the danger of "a compartmentalization of religion in a patient's life." In his eyes, the splitting off of religion is inevitably indicative of a pathological process. He is similarly leery of the rapid development of intense devotion to orthodox religious traditions in many young patients. He feels this often belies an intense need to erect strong boundaries and shore up fragile defenses in the face of an intense experience of inner shakiness. Even in citing this maladaptive use of orthodoxy as a defense, F.W. advises against direct interpretation of the co-opted religion to the patient. Instead, he advocates understanding the phenomenon and working only with the

material brought in by the patient. Only when the underlying dynamics are successfully addressed can the religious practices by expected to be affected. In light of F.W.'s penchant for seeing religious issues as merely one more arena for the manifestation of core psychodynamics, he finds that they present no special problems for him. As a scholar of Jewish law, he is comfortable clarifying misconstruals of doctrine, and he finds it especially insightful to help patients recognize why they tend to interpret or misinterpret religious beliefs and practices in their own unique ways. He minimizes the importance of analyzing unique transferences of patients who especially seek him out in light of his rabbinical credentials and he disavows any countertransferential differences in treating religious vs. non-religious patients. In essence, he does very little analysis of religious formations, much like he spent little time addressing religious issues in his own treatment. He feels that his psychological insights into his unique religious development have essentially been the product of his own protracted self-analysis.

S.G.

S.G. is an ordained Methodist minister who is presently the Head of the Upper School at an independent school in Philadelphia. For the past seven years, he has also been an analytic candidate at the National Psychological Association for Psychoanalysis. In conjunction with his analytic training program, he has been seeing patients for five years at a private Institute. S.G. has a Ph.D from Andover-Newton Theological Seminary, which he attended after attending prior seminary studies in St. Louis.

Dr. H. grew up on a farm in Texas, and religion has been a very important part of his life from an early age. He is married to a church administrator, and they have one child. S.G. is presently an affiliate member of her congregation. He attends services sporadically, after a prior period of no church affiliation.

A deeply personal religious sentiment and commitment traces a continuous thread throughout the events of S.G.'s life. On initially entering therapy, while a student at Seminary, he consciously chose to work with an ordained minister who was then an analytic candidate at the Jungian Institute. Dr. G.'s own decision to pursue Freudian training was, in fact, one

of convenience rather than conviction. He had wanted to enroll in the Jungian Institute, as he felt it more consonant with his religious convictions, but they would not accept his analysis with an individual whose training was not yet complete. Thus, it would have cost him considerable time and money to even qualify to apply without guarantee of his acceptance. A Freudian Institute was willing to accept him, and he began this training solely for "pragmatic reasons." He has subsequently shifted to a psychoanalyst for his training analysis, and he has become increasingly comfortable with psychoanalysis as a therapeutic methodology as a function of his training and clinical experience. Yet even his current decision to practice out of his present Institute reflects his attraction to a program which has made clear attempts to integrate psychoanalytic thought with religious sensibilities.

Religious Beliefs in Therapy

S.G. feels that his religious beliefs and practices were significantly affected by his psychotherapy. He feels that his religious beliefs have "deepened," while both his idealism and perfectionism have been appreciably diminished. He acknowledges that in therapy he recognized "that high idealism and a finely honed

sense of guilt" underlie much of his initial religious involvement. He similarly considers his prior religious convictions more a consequence of conformity and "trying to please everyone, but not something I felt at a deep level." He feels that the deeper integration of his personality allowed him to be more self-accepting and to develop greater spiritual insights -- "but not in a traditional way." He thus now finds himself relatively estranged from the church he was brought up in, and from most traditional churches.

Most of his therapeutic work regarding religion was done directly during his time in Jungian analysis. His present psychoanalytic work has contributed more "indirectly." He feels that his current analyst lets religious themes "unfold rather than imposing any theoretical orientation." At this point, much of his thinking regarding his "spiritual formation" is the product of self-analysis.

GOD

S.G. acknowledged that regarding the subject of God, his feelings are rather "incongruent." While he described an abstract notion of the deity, deriving largely from Eastern religions, he confided that "the God I grew up with was still, in a non-rational way,

part of my mental furniture." Over the course of the interview, Dr. G. described the development of his "faceless, genderless God." He affirmed that this evolution was a product of theological training and psychotherapy. He affirmed that without the therapy, he doubts he would have been comfortable repudiating "the God he was supposed to believe in, even though he did not." Yet, when S.G. related a series of deeply personal anecdotes describing his relationship and direct communication with his God, what spontaneously emerged were images of a patriarchal figure. He was genuinely surprised at this experience, and acknowledged, "This is something I've never admitted to myself -- but when I'm really tired and want comfort, I say, `God, our Father.' I do that! `God, our Mother' or `Ground of Being' just doesn't seem to be the same for me." He attempted to integrate this experience, "In an untidy way, both images are there -- the image I had as a child -- God the Father, who takes care of you and forgives you. `Jesus, I love you, this I know because the Bible tells me so' -- that's all still there. But I think it's in an untidy way. Because of all the intellectual training I've had, God has become more and more abstract. I guess the concrete images most people are taught as a child are with them all of their

life."

S.G. indicated that he did not talk directly about his notion of God or his relationship to God, which centered around his personal prayer life, in therapy. In fact, he commented that he only remembered talking about this material with one other person in his life. In assessing this fact, he confided that since this part of his life "is both so private and so important, I protect it -- as I expect it will be criticized." The theme of criticism of his religious beliefs opened a major avenue of exploration. He explained that the anticipated criticism cannot be viewed as simply the product of his own projections alone, and he related specific incidences of conflicts with members of the institute over issues of religion. Indeed, he shared the fact that he was "red flagged" by a teacher who felt him to be a "rigid and unsuitable analytic candidate," because he had once taken issue with a case presentation regarding religious issues. Since that time, S.G. has been exceedingly cautious, and feels extremely conflicted about expressing his opinions on any religious issues. A similar situation is presented by psychoanalytic examination committees who invariably inquire into his movement from the church to psychoanalytic training. He claims he is more

comfortable in this situation as "I know what they'll like and what they won't like. What I tell them is connected, but it's not from my gut." In sum, he appears to be continually beset with the decision of if, when and how to share his views regarding religion in his psychoanalytic environment. S.G.'s difficulties at the Institute have been circumscribed. In terms of the overall Freudian orientation, he simply accepts it as a useful method and theoretical background that "can also be used for religious and salvific purposes." He is unabashed in indicating that he does not accept all of Freudian theory, particularly regarding religion, and he says "I'm going to think what I think, regardless of Freud's theory." In terms of applying psychoanalytic understanding to his own religious beliefs and practices, he is cautious of being overly reductionistic. He feels it is too easy for Freudians to see religious formations as "nothing but" a variety of psychological defenses, but this misses "a relationship that is broader and deeper." As for himself, he is willing to acknowledge "If I have to go through the defense of reaction formation to keep my relationship to God -- that's fine -- to lose that relationship, and be isolated and alone -- that's what hell is like." In his own therapeutic experience, he

relates no instances where he felt his beliefs were reduced or he perceived them to be under attack, but instead he sees therapy as a place of "important spiritual growth outside of the church."

Clinical Experience

S.G is frequently referred religious patients. He finds that most of his other patients do not bring religious issues to treatment. He generally tends to view most patients' religious experiences in a "mechanistic way -- as part and parcel of their personality." But he finds his patients are very protective of their religious beliefs and values. He has found that interpretation of maladaptive religious defenses has frequently prompted a premature flight from treatment. He is thus increasingly cautious in interpreting the underlying feelings beneath various espoused religious precepts. S.G. described counter-transference concerns as presenting a major problem in his work with religious patients. He finds he must keep a tight rein on himself to "keep from jumping in too quickly." His feeling is that having worked through a lot of these issues regarding religion -- "I can give shortcuts." Increasingly, he finds that he must modulate this tendency to respond too quickly

and to give advice to religious patients.

Transference issues have presented another major concern. A number of his patients have come to him after specifically requesting a "Christian therapist." While he recognizes that this request belies a host of unspoken transference desires, the therapeutic explication of this material has proven to be difficult. Consequently, he chooses to steer away from early transference interpretation or exploration of the request for a coreligionist clinician. On the whole, S.G. claims he is quite cautious with most religious material. He sees these issues as "volatile, and often central to a person's identity." Hence, "you don't want to attack it or say anything critical." He is aware that his caution might well be "more me than them" He concluded by commenting, "I wouldn't be surprised if my own analyst is very cautious about addressing these issues with me -- so despite all I've gone through, this pilgrimage is not finished."

P.B.

P.B. is an ordained Presbyterian minister who works as a pastoral counselor. He has both a private practice, and he works out of a major institute which specializes in training clergy to become psychotherapists. His election of a ministerial vocation was almost fortuitous. He decided to attend Crozier-Chester Theological Seminary, after visiting his best friend there. Finding the "liberal-radical" environment to his liking, he decided to enroll, essentially because "it was a good place to hang out." His subsequent relationship to both the church and to the ministry has been highly ambivalent. He has never functioned as a pastor or preacher, and he does not see himself working in these capacities. Similarly, he is uncomfortable with many aspects of congregational religion, and he no longer maintains a church affiliation.

Religion is primarily a personal issue for P.B., one that embraces philosophy, psychology and daily life. He considers himself to be a religious believer, with God and Jesus Christ both holding major positions in his personal theology. He describes God as "the ground of being ... a mysterious presence ... something we sometimes experiences in life, but for the most part,

only in a reflective way." In this regard, he sees Jesus Christ as "a figure through which Christians understand what God is like." This figure of Jesus is useful for purposes of identification and emulation, and P.B. emphasizes that for him "all experiences of God are invariably manifest through people." On a personal level, P.B. has a God who he addresses in private dialogue. He does not envision a figure, but "talks to a mystery." He claims that "if I were to conjure up an image for God, it would be parental."

P.B. began in therapy while a seminary student. His first therapist was an ordained minister who was a psychoanalytically oriented pastoral counselor. This man served as a significant role model for him. Upon embarking on his own psychotherapy training, he switched to a different analyst, who was on his institute's approved list. Religious issues per se have not represented a significant theme in either of his therapies. But he feels as if "therapy changed his experience of God" by allowing him "to move closer to his true self from which he has a more authentically human relationship with the Divine." In essence, he claims his capacity for a more mature religious life was fostered by the personal integration he achieved through therapy. Despite the limited attention to

religious concerns in his treatment, P.B. noted that at significant times, both of this therapists have expressed interpretations in religious terms, and this has often had a powerful impact upon him.

P.B. does not experience significant conflicts between his psychoanalytic perspective and his personal theology on the level of competing world views. He does, on the other hand, experience significant conflict with regard to the specific professional roles of therapist and minister. Working as a minister, he states, "the boundaries of the therapeutic containers are shot." He cites major difficulties stemming from a "blurring or diluting of transference and the major tendency to drain off conflict out of the therapy into the congregational setting." Finally, he emphatically notes, "the church is repressive, therapy is at least de-repressive." He adds that this fundamental difference is compounded by the fact that "church pastors hate pastoral therapists." Clearly, in terms of the practice of psychotherapy, he finds this dual identity as a pastoral counselor highly conflictual.

In contrast to his limited discussion of religious issues in his own treatment, he had much to say with regard to his treatment of religious patients. In essence, he accepts much of the Freudian paradigm,

notably that patients are essentially projecting their prior experiences in their creation of and relationship to their god images. He finds it "very exceptional when these relationships are something other than parental." Yet, without specifically indicating what, he maintains, "there is something there that's beyond the projection." He adds, when patients make contact with this, which he calls "the ground," he finds the experience transformative. As an individual, P.B. tends to adopt a quasi-Jungian perspective, in essentially equating the experience of God with moving closer to one's true self. But while he embraces this perspective personally, he confided "that in my clinical experience, 95% of the time, a patient who presents with a lot of religious terminology is presenting a massive resistance that often cannot be analyzed." Consequently, he increasingly avoids direct involvement in religious topics in therapy. He responds by reframing issues in non-religious terms or by silence. He finds that these maneuvers are generally successful except in the case of the born-again Christians who virtually insist upon maintaining a shared religious lexicon. One the whole, P.B. noted that religious development essentially parallels psychological maturity. He finds that there is "virtually always

something else concealed beneath a presenting religious issue." Thus, much of his efforts have been geared towards interpreting these unique religious resistances. Contrastingly, he finds himself interpreting special religious transferences or exploring the dynamics of a patient's relationship with God far less frequently. In essence, P.B. feels that his identity as a psychoanalytically-oriented pastoral counselor presents both unique opportunities and difficulties. While it gives him access to a range of religious patients who have essentially shunned the non-religious mental health system, he finds that he must then carefully disengage their treatment from problematic religious entanglements.

G.B.

G.B. is both an ordained minister in the most liberal of mainline Protestant denominations, and a clincal psychologist. He is both the son and grandson of ministers, and he specifically remembers as a boy, "not wanting to be a minister like his father." He changed this position over time, as he recognized he "liked the work with people, and it was something I could do well." He emphatically noted that his work as an inner city, politically active minister still reflects that he "did not become a minister like his father," whose ministry has been served in a prolonged stay with an affluent, suburban congregation. Dr. B. embarked on graduate studies in psychology because the church could not provide ample livelihood for him. He was accepted at both law school and graduate school in psychology, and he opted for the latter. He continued his church duties while a graduate student, and even while working as a therapist at private clinics, he maintained his post as a full time assistant minister. Only recently has he left this position to become the Executive Director of a network of mental Health Clinics. Most of his recent clincal experience has come under the aegis of pastoral counselor, rather than clinical psychologist. This is because he took an

extended time to complete his clinical Ph.D., and obtain his state license.

Dr. B. considers himself a religious believer, but his beliefs, which he finds very difficult to talk about, are not based on "a supernatural God or divine forces." Indeed, he claims, "my doubts about God are greater than my belief." His religious commitment is instead rooted in an acceptance of a Christian superstructure, with its unique symbology, and "its representation of centuries of human devotion." He states, "while I no longer feel a need to anchor myself in a belief in what people traditionally understand to be God, or in the reality of virgin birth or bodily resurrection, these myths express an aspect of human life that is real for me." In referring to God in his sermons or congregational prayers, he has concertedly struggled to break from patriarchal imagery. Yet, like other subjects, under the pressure of inquiry, he conceded, "that the bearded imaged of Jehovah remains implanted in my mind."

In talking about his religious commitment, G.B. shared his skepticism of mysticism, especially in light of his knowledge of the psychoanalytic critique which reflects it to be "a replay of an inadequately resolved mother-infant symbiosis." Nonetheless, after this

initial disclaimer, he shared the fact that "what I then considered to be mystical experiences, which I experienced at an early age, had a significant effect on my attraction to religion." He claims, "the mystical side of my religious involvement has diminished in recent years, but I still accept it as part of who I am." In terms of religious practices, he has become less devotional over time, but believes in the efficacy of prayer, "not in terms of divine intervention, but in terms of its efficacy as an exercise of meditation."

Dr. B's experience in psychotherapy began while he was a divinity student, in the form of twice weekly psychoanalytic psychotherapy for two and one half years. He then spent seven years in analytic group psychotherapy. He began in formal analysis whole a psychology graduate student, and that has lasted for ten years. In all his therapy experiences, he has made little mention of religious issues. The subject of his religious beliefs did emerge in his group treatment because members of the group "confronted him about them." One reason he indicated for his reluctance to bring religious concerns into analysis, was his perception of his analyst's position regarding it. He recalls his analyst remarking "Freud's criticism of religion was well put, and any religion that can't

stand up to it deserves what it gets." Dr. B. conceded that he now essentially agrees with this position, although he doesn't mean that all religion must be given up, but simply better understood in term of its psychological origins.

In his own work with patients, G.B. indicated working no differently with religious and non-religious patients. At the same time, he indicated that many religious patients have specifically sought him out because of his religious affiliation, and in these cases, the transferences have been significantly different. One unique category of patients he identified as seeking him out for treatment were homosexual men. He explained this phenomenon from several perspectives. Firstly, these men were often searching for father figures, and "clergy readily take on the archetype of fathers." Secondly, these men often came seeking absolution and acceptance of their homosexuality from a man who they hoped would be non-judgmental and "who could help assuage their own guilt in the face of the official condemnation of the church." In terms of special treatment problems with religious patients, Dr. B cited the case of some patients who could not relinquish an idealized image of him because of his status as a minister. At the same

time as they insisted on holding him up as an image of perfection, they chose to view themselves as "contemptible and miserable." He noted these patterns were particularly difficult to shatter. In working with religious patients, Dr. B. indicated "most of the changes I have seen in religious belief and practice have not occurred through direct intervention or interpretation, but instead through a reworking of other dynamic issues - specifically, a modification of the super ego." In working with religious formations per se, he indicated working "very gently, carefully seeking to avoid reductionism." At the same time, he noted that "some religious formations probably should be reduced, as they are thoroughly neurotically motivated."

At the conclusion of the interview, G.B. straight-forwardly commented, regarding religion in psychoanalytic thought, "I don't think of myself as having integrated the two fields, but I don't experience them as in conflict, either. There might be a whole lot more conflict there than I am willing to acknowledge, but I don't experience it in that way. I don't think of myself as a Christian psychotherapist, but as a Christian and psychotherapist."

R.L.

R.L. is an ordained Presbyterian minister who presently works as a full time clinical psychologist in private practice. His decision to enter the ministry stemmed from his own very positive experiences with church life in a small Western town. He attended Seminary in the 1960s when the primary focus of his church involvement was with issues of social justice. He subsequently spent the majority of his professional time serving in campus ministeries, which allowed him to continue his active involvement with social concerns. He worked only briefly as a traditional parish minister. A benefit of his college affiliation was that it allowed him to enter graduate courses tuition free. R.L. took advantage of this opportunity in order to work his way into a doctoral program in clinical psychology while still working as a chaplain at a major Boston university.

R.L.'s religious involvement was centered on a commitment to Christian ethics from an early age. He claims "I never had any involvement with the mythologies of Christianity. I never worried about God, I figured God could worry about me ...." Prayer and other religious practices have held minimal importance for him. He acknowledges praying "in the sense that

everyone does when regressing in anxiety-provoking situations," but on the whole, he considers himself "a post-enlightenment person, who doesn't believe in capricious intervention with reality." In essence, he considers himself a religious person "in the sense that he is committed to social improvement and helping his neighbor," but he has essentially rejected the doctrine and dogmas of Christianity. He remains a minister in good standing, but he terms this a "political decision" which allows him access to numerous opportunities such as the teaching of clergy.

Dr. L's experience in therapy began at Divinity school, when he realized he "was gay and wanted to deal with in." Although wishing he could continue, he suspended further treatment while working at a Western university because "I had social relationships with the only two clinicians in town." He resumed his therapy when he came to Boston, with the explicit goal of "curing his homosexuality." He was in treatment with two different analysts: a five year stint of twice a week psychotherapy and then a two year period of four times a week analysis. During this time he got married, but "was aware that this was not where his interests were." He realized "that neither my ten years of fidelity in marriage nor my therapy was going to make

me straight." He also decided during this time, that he wanted to become a psychotherapist, and he elected to pursue studies in psychology "because he really wanted to understand homosexuality."

Reflecting on his treatment experiences, he is now critical, feeling that his therapists were not taking an analytic position about homosexuality by accepting the treatment goal of reorientation. In addition to his analytic experiences, he has been involved with groups that have met as often as four times a week, and he spent one and a half years in couples therapy with his wife. In all of his therapy experiences, he claimed "I never found a therapist who could deal with religious issues." Indeed, he claims " I was resistant to bringing up religious issues because I didn't expect help." At the same time, he acknowledged "religion was seldomly discussed, as it was not the pressing issue." He was a minister who did not want to be one anymore, and the gradual secularization of his religious practices he attributes to being in an urban center more than the process of psychotherapy.

Interestingly, the familiar series of complaints against psychoanalysis's prejudicial and narrow view of religion were absent in the case of R.L. They were seemingly displaced to the topic of homosexuality,

where Dr. L. claimed the "psychoanalytic theory of developmental arrest to be a cultural artifact." Much like the religionist who rails against psychoanalysis's inability to appreciate or recognize a mature religious experience, R.L. found psychoanalytic thinking closed-minded in its inability to see homosexuality as an alternate path of development. He is zealously committed to refuting what he considers to be psychoanalysis's rigid and antiquated vision of homosexuality as, of necessity, an indication of arrested development. Indeed, the night of our interview, he was just completing an invited monograph on this topic for publication in a major psychoanalytic journal. Issues concerning religion hold less importance with him, and he sees the conflict between psychoanalysis and religion as essentially deriving from their being pitched to different spheres of experience and ways of know.

In working with his patients regarding religious issues, Dr. L. recognized that he has a tendency to function in a ministerial way. He now attempts to inhibit this tendency by "attuning himself more to his patients' level of religious understanding." He sees no major recurrent problems nor any general patterns regarding religious issues with his patients. Yet he

noted parental manipulation through religion, and a patient's preoccupation with guilt regarding his religious beliefs and sexuality as two problems he is currently encountering. He tends to view neither of these cases as a special religious problem. At this point in his life, Dr. L.'s involvement and concern with religious issues is minimal. He considers himself religious only in a deeply personal way, and belief in God and adherence to traditional Christian teachings and religion practices have been essentially discarded. He thus experiences no conflict between his psychoanalytic understanding and his religious world view, because his personal religion is not founded on any system of beliefs. He grants that psychoanalytic elaborations of religion tend to be mechanistic, but this simply stems from the inherent reductionism involved in understanding a predominantly emotional sphere (religion) through one that is largely scientific (psychoanalysis). His major conflicts with psychoanalysis do not pertain to its vision of religion as symptomatic of primitive thinking and fixation, but instead to its view of homosexuality as indicative of developmental arrest.

I.S.

I.S. holds the unique distinction of being both a congregational rabbi and a practicing psychoanalyst. He has occupied the pulpit of a reconstuctionist synagogue in New Jersey for the past 7 years. During this time, he has also completed his own psychoanalytic training. I.S. is Canadian born and educated and he comes form an Orthodox Jewish family where both his father and brother were rabbis. In this context, his own adoption of reconstructionist Judaism marks a notable deviation.

His interest in psychoanalysis was initially kindled by his experience with congregation members who he found himself unable to understand and help. This involvement was intensified when he sought treatment for himself, first in Canada and then later upon coming to America. In the States, he saw two different analysts. He saw the first for three years in twice-a-week psychoanalytic therapy. Sometime later, he was treated by a prominent member of the New york Psychoanalytic Association for another three year period of psychotherapy. When he entered a Freudian training institute, he sought to resume his analysis with this noted analyst, but the analyst, after beginning the work, elected to discontinue for

essentially "political reasons." At this point, I.S. returned to his initial therapist, with whom he then completed his analysis, concurrent with his own psychoanalytic training. He has been seeing patients in psychoanalysis for the past six years. I.S.'s religious perspective is clearly influenced by both his psychoanalytic and reconstructionist training. He frequently chose to reformulate questions so that he could answer them in a personally meaningful way. For instance, in response to the question of his own belief in God, he responded, "The question is not do I believe, but what do I do with those psychic elements in me which add up to the notion of believing in God?" Parenthetically, he interjected that reconstructionism rejects "a supernatural God." He elaborated on the unique human conditions which compel religious beliefs. These included "a protracted, post-partum dependency period, which irrevocably and irretrievably casts humanity in a mold which lends itself to a belief in God."

I.S. frequently chose to view religion from a post-Freudian psychoanalytic perspective - in these terms he views "religion as play - as a game ... that man will always need." The question for him then becomes, "What kind of religion?" In developing this

view, he invokes Winnicott's notion of transitional space as the true arena for religion. In essence, by abandoning all supernatural beliefs but, at the same time accepting the uniquely human factors which underlie all religion, I.S. constructs a personal religious perspective largely steeped in psychoanalytic metapsychology. In so doing, he builds on the work of Freud, but at the same time is critical of him. He feels that Freud's work on religion is marred by his own "religious self-hatred", a condition he sees as particularly endemic to Jews. He similarly finds Freud's perspective on illusion too narrow and simplistic and far less rich than that of contemporary psychoanalytic thinkers.

In terms of his own therapy, he recalls spending little time specifically addressing religious issues. He states that "religion emerged as anything else in therapy - something to be analyzed." In this regard, he feels his own religious beliefs and practices have been "improved, purified and sharpened by analysis - whatever was lost was worth losing." Concretely, since his therapy, he noted that he observes himself to be less compulsive about his ritual observance and his religious experience has become more enjoyable.

I.S. reports no particular conflicts about bringing

religious issues into therapy. Similarly, he does not feel that religious affiliation played a major role in his choice of a therapist. The fact that he was referred to a therapist with a rabbinical background was "convenient, but by no means necessary, simply because it made for less translation." The prime areas of religious concern that emerged in his treatment related to congregational issues. In assessing these, he feels it necessary to sort out where his own religious standards and/or consequent congregational policies may be tainted by his own neuroticism, particularly when they are in conflict with congregational expectations. In effect, I.S. has used therapy as an instrument to examine both his religious values and perspectives. For him, these are political as well as ethical and theological issues and, as such, he strives to free them from unconscious contaminants. Over time, he has found that often "much of his religious behavior was neurotic and maladaptive." By the same token, he feels his therapy has largely freed him from his compulsion "to be perfect." (He noted that this compulsion is all too readily collusively shared by most congregations). At this point, he says he has discovered, "it is all right to be a `good enough' rabbi." While he sees therapy as contributing to the

purification and modification of his religious perspective, he emphasized that he "does not feel that his religious beliefs have been attacked or destroyed through therapy." He concluded, "despite the maladaptive aspects picked up, there was and is something positive in the religious quest."

As a clinician, I.S. claims that "I have never had a patient who has not at some point brought up religious issues." In the context of therapy, these cease to be religious issues - "they are analyzed like anything else." He is more cautious, though, with regard to directly attacking religious defenses. He finds it is frequently inadvisable to directly attack them, and he now prefers to work with other issues first, "in the hope that the religious defenses will shift through more indirect effects." Rabbi S. freely acknowledged that many patients have chosen him because of his religious background and "their hope that he will be more tender with their religious beliefs." He responds to this transference wish by making it clear that for them, he is a psychanalyst, not a rabbi. He highlighted this point by telling the story of the patient who asked him for specific technical religious information. He responded to the query, "Ask a rabbi." She exclaimed, "You're a rabbi!" To which he retorted, "But not for

you!" In an effort to impose a separation between his roles as rabbi and psychoanalyst, I.S. will not treat members of his own congregation. Similarly, he periodically finds it necessary to indicate that he will not discuss his own religious perspectives with patients. In one case, where a patient attempted to join his synagogue, the behavior was analyzed in terms of the patient's acting out of unconscious wishes, and the patient finally left the congregation. On the whole, I.S. is highly orthodox as a psychoanalyst, this orthodoxy serves to preserve therapy as a unique and unambiguous domain, purified of any boundary or role confusion. He feels that his analytic training has been particularly helpful to him in understanding the dynamics of his congregation, and working with the inevitable transferences projected onto him as a religious leader.

L.J.

L.J. is a Lutheran minister and a psychoanalyst in private practice. He also teaches at two seminaries and directs a pastoral counseling training program at a major post-graduate center. He was raised as a Lutheran, and decided to be minister at age six. He terms this, "a piece of allegiance that I thought I owed a paranoid grandmother." He acknowledges never really changing that orientation. He went to Harvard Divinity School after attending Williams College because "he was fascinated by both theology and philosophy." He never truly considered what he would do after he completed his divinity training, and he indirectly fell into hospital chaplain work. Finding the role of counselor to his liking, he sought further training in psychology. He began graduate school in psychology at the same time as he embarked on psychoanalytic training. He has subsequently completed a doctorate in psychology, and his analytic training at two psychoanalytic institutes.

Presently, L.J. is "not actively practicing any form of religion." He claims that religion is still important to him in the "non-sayability of what it refers to." He adds, "there are moments when it is so fundamental , that I don't believe I ever forgot it,

and other moments when I forget it completely." Another factor which he cites as contributing to his estrangement from organized church life is his current involvement with a devoutly Jewish woman.

Dr. J.'s clinical involvement with religious issues is significantly greater than that of the majority of the therapists sampled. Similarly, he was a comprehensive informant regarding the fate of religious issues in his own treatment. For these reasons, condensation of his responses to clinical issues will of necessity be far less compact. Dr. J.'s experience in psychotherapy includes a three-year period of psychoanalytic psychotherapy with a Lutheran minister who was also an analyst, and a seven year analysis with a "strict Freudian." The analysis was completed as a requirement for his own analytic training. He found both therapeutic experiences valuable and in both cases, religious issues were addressed. In his first therapy, Dr. J. worked extensively in exploring his selection of a religious vocation, and its relationship to his "paranoid grandmother." He similarly worked in significant depth on his notion of and relationship to "a childhood God whom he could never please." He feels that his God representation has changed "but not enough ... there is

a continual working over of a God who is more interested in character-formation than in pleasure."

An exploration of the treatment of religious issues with his second analyst prompted a host of strong, ambivalent feelings. On one hand, he resented the fact that his therapist invariably asked for "an explication and clarification of all religious issues ... yet nothing memorable was ever done with this." In developing this idea, he claimed that he experienced his analysts as "mad at all religious issues" and he definitely felt his religious beliefs were "under attack in analysis." He didn't want to talk about anything religious "because my analyst was never content just to leave it, and I didn't want to or couldn't prove it - but at the same time, I didn't want to give it up either."

At the same time that Dr. J. reflected almost begrudgingly on his uncomfortable experiences with religious issues in his second therapy, he acknowledged that he ultimately experienced significant beneficial results as well. One positive outcome he noted was the realization that he spent a significant portion of his energies "couching all his feelings in religious terms to make them acceptable." He confides that he now sees that religious rationalizations were employed to

"insulate me from my own selfishness and sadism ... I had no trouble being selfish and sadistic - I just didn't want to acknowledge it." Working through the acknowledgement and acceptance of these ego-alien parts of himself was an important theme in his analysis. The tempering of the highly idealistic and critical super ego which existed under the mantle of enforcer of religious purification was another change which he attributes to his analysis. Previously, he "was a religious pilgrim, and anything that was enjoyable tarnished the religious purity of his experiences. Success and pleasure were just narcissistic gratifications, and even altruism was suspect of contaminated intention." Much of this compulsive and severe self-scrutiny was attenuated over the course of his treatment. While Dr. J did not cite his specific religious practices as changing appreciably, he claims he simply "stopped worrying about it all --- both the preoccupation and intensity fell away." In the process, he indicated feeling significantly better, allowing himself simply to "feel daily pleasure as opposed to complete fulfillment in a greater sense," a feeling which had always evaded him, and left him feeling "like I wasn't getting anywhere along the pilgrim's path." Thus, despite Dr. J's misgivings and discomfort about

having his religious beliefs and practices scrutinized in analysis, he nonetheless described significant salutary effects.

Dr. J. presents the paradoxical image of a man who felt that his religious beliefs were almost over-vigilantly scrutinized and attacked against his wishes during therapy. Yet he concedes that by virtue of his therapy, the modifications of his religious perspective led to a greater emotional well-being. This multi-dimensional picture is further complicated by his claim that in the face of "a rational attack on my religious beliefs which I could not combat, I came out with a recognition of the obsessiveness of rationality and a new sense of respect for the value of mythical thinking." In his words, "It was as if the attack did its worst, and I accepted the attack, but now felt freed up to be non-rational about it."

In describing the process of exploring religious issues in treatment, Dr. J. struggled to articulate some of the unique dimensions of his own multi-determined resistance. He acknowledged that discussing religion in therapy "was like opening up Pandora's box." On one hand, he realized that many of his religious formations "were so irrational or unsupportable that even I could dismantle them, and thus

speaking about them would only identify me as being split and conflicted." The scrutiny of his religious beliefs and practices posed not only the problem of exposing their contamination by his own psychological immaturity, at the same time he experienced another major source of resistance. This was the fear that if he voiced his authentic religious beliefs in the presence of another, "I'd feel bound, because then I would have to live by them." On both accounts, he felt safer to steer clear of many religious issues, and he indicated that this was often the route he took as he simply "was not yet willing to either give them up or say too much and face his own conscience as a sinner." An additional factor which contributed to this reluctance to address religious formations was simply "an intellectual embarrassment about bringing them in" and a difficulty in finding the appropriate words to communicate the nature of his religious experience.

Dr. J. had extensive clinical experience working with religious patients. He reported that in excess of 25% of his patients are people with a religious vocation. For this population, in particular, he sees it as essential to differentiate between problems involving religious institutions and more highly personalized religious concerns. He is generally more

concerned with the latter and he explores these issues from a developmental perspective as a "royal inroad to the archaic super ego of the childhood religious experience." He notes that especially for people who were "serious enough about religion to become professional about it - there is often a fusion of religious imagery with early parental images at the core of the super ego." He envisions his task as the eradication of this infantile component of the super ego and differentiating religious faith and practice from it.

In working with patients who have a religious vocation, L.J. cites a number of unique, but predictable, difficulties. One is helping the religious patient to sort out what is healthy versus maladaptive with regard to his specific religious practice. This situation is compounded by the fact that many religious practices are frequently supported by vows, and a commitment to a set of values which stand in sharp contrast to the fundamental ethos of psychoanalysis which emphasizes independence and autonomy. In this regard, L.J. indicates it is exceptionally difficult to help a patient cultivate and "develop their own voice" when you simultaneously are trying not to attack their commitment to a life of the religious virtues of

celibacy, poverty and obedience. At the same time, he does not want to become "vaguely bland and all-accepting" and not generate on the part of the patient a capacity to work with these important issues. He focuses his therapeutic efforts on helping patients differentiate the authentically valuable aspects of their religious practices, such as a commitment to dependence, from their own, more idiosyncratic, masochistic tendencies. A variation on the problems posed by the unique set of values and practices which govern religious life are patients' maneuvers to adapt them. Dr. J. noted two prominent maladaptive patterns. One is represented by the religious patient who abrogates all autonomy, choosing simply to act as if "the rules are the rules" in the process denying any proscribed feelings or impulses. These patients simply keep wondering "why am I so unhappy?", intently resistant to lifting their religiously fortified barriers of repression. A contrasting approach in dealing with these same religious interdicts is the patient who simply says, "I'll do what I want, no one will ever find out." This situation is exemplified by the nun who has an affair, but denies any conflict in the situation." Dr. J. finds this maneuver equally maladaptive, and often forces the patient to confront

his own feelings about the issue as opposed to simply employing the lower level justification that "It's okay, if I don't get caught." In a similar vein, Dr. J. noted in particular, his own difficulties in interpreting clearly eroticized transferences that emerged frequently with nuns. In this case, he assumed responsibility for the difficulty, claiming it as his own counter-transferential problem, "largely related to his own unresolved feelings about attacking religion."

In speaking of the major difficulties he has frequently encountered with respect to the prominent value conflicts between psychoanalysis and many spiritual paths, (namely regarding sexuality and autonomy), Dr. J. specifically describes clinical findings which have run counter to his own expectations and wishes. While he personally believes in the capacity for healthy, autonomous functioning without a patient's necessary involvement or expressed desire for genital sexuality, his experience with religious patients has contradicted this supposition. He has invariable found that as his patients have become more connected to an autonomous self, they have expressed desires for sexual genitality, or grief over their deprivation of the opportunity to have children.

Bemusedly, Dr. J. noted that "religious patients

can talk about sex much easier than God." While they can talk about God forever in intellectual terms, he feels that he is seldom successful in getting patients to truly explore their personal God representations. He interprets this finding as reflective of the fact that "religious people are simply not going to allow analysts to trample upon their Gods."

Dr. J. has found that religious patients consistently show changes in their beliefs and practices as a function of psychotherapy. He states, They either get more or less active." He attributes these changes to a diminution in the role of the archaic superego, which allows the patient to either abandon his compulsivity, or to be more actively religious without "waiting for someone else's permission." At the same time, he noted that "I have never had a religious patient leave his religious affiliation or order while we were working together," even though this issue has often marked a prime aspect of the therapy. (He did indicate that several left years later).

Like the other clinicians in our sample, L.J. observes special transference dimensions in the treatment of religious patients. He chooses to term them "elusive, rather than unique," adding that this may again be reflective of his own "reluctance to

attack religion." At any rate, he finds religious patients seeking him out as a religiously trained clinician "so that they can feel safe." He consciously chooses to "let this feeling of safety coast for quite awhile, as it generally will get eradicated on its own."

When working with fundamentalists, he attempts to both diffuse and explore the importance of their perceived differences in religious devotion by acknowledging that "you're probably more devout than I, does that make any difference to you?" This technical maneuver is consciously employed in an attempt to attenuate their frequent flights from therapy when the clinician is viewed as not totally supportive or in agreement with their fundamentalist perspectives. Countertransferential issues in working with religious patients are similarly of significant concern for Dr. J. He strives to avoid "the lofty perch, as one who can comment editorially on the authenticity of any religious imago." Instead, he attempts to create a dialogue in which "neither of us can answer as to the meaning or correctness of any of it (religion), but what matters is how alive it is, rather than how correct it is." On the whole, the issue of integrating a psychoanalytic perspective with an openness to religious models has been a lingering concern for him.

At this point, he chooses to see both frameworks as "myths, that can be acknowledged as the best ways we know how to live and not be mad all of the time." He regrets "there is no greater sayable intersection between the two myths."

M.R.

M.R. recently completed his clinical doctorate, and he presently practices out of a major Connecticut teaching hospital. He is also an Orthodox Jewish rabbi who has worked as both an "itinerant preacher" and as educational director and consultant for numerous Jewish schools and cultural institutions. While his jobs as psychologist and rabbi occupy a dominant position in terms of his present career commitment, it is significant to note that he has also been the producer of a major, long-running Broadway show, as well as formerly working as a carpenter and a truck driver. Interestingly, like F.W., he emphasized that his family was less than enthusiastic about his plans to become a rabbi. Indeed, they were not even Orthodox Jews.

M.R. is a devoutly religious man who adheres to all Jewish laws. The belief in God is fundamental and essential to his religious orientation. He envisions God as "a supreme being -- the essence of being, that exists but cannot be seen or located -- but can be felt and whose dominance and influence in world matters is constant." M.R. acknowledged that both his thinking about and relationship to God have changed over time. He attributes these changes to his own maturation, particularly as affected by having his own family. He

describes his present relationship to God as a "deeply personal one, with God seen as someone who is always watching and listening, someone to who he always has access." Prayer is similarly viewed as integral to his religious experience and as a means of "affecting the construction of my own personality and belief system."

Rabbi R. has been in once-a-week psychoanalytic psychotherapy for the past four years. He states "religion has never been an issue in my treatment." Nor was it a factor in picking his therapist. He is presently being seen by a Catholic clinician affiliated with the hospital where he works. The only instance where he can recall an issue in his treatment which involved religious concern was when he "vaguely remembers myself defending the Jewish law of family purity (which proscribes sexual relations during the menstrual period) to his therapist." In terms of the impact of therapy on his religious beliefs and practices, M.R. sees no effects. On the other hand, he indicates that working as a clinician has had significant impact on his religious perspective -- in that his exposure to a broad spectrum of human experiences has made him "greatly appreciate the Jewish legacy he has received."

In terms of dealing with religious issues as a

clinician, M.R.'s position closely parallels that of Dr. P., the other Orthodox Jew in our sample. He too feels "predisposed to finding solutions to problems in living for co-religionists that are consistent with Jewish law. Thus, for example, in the case of a Jewish woman who was having an affair, he would not inform the woman's husband, instead invoking the Jewish dictate to abide by the law of the land and honor professional canons of confidentiality. But he would feel compelled to inform her of her violation of Jewish law. In essence, M.R.'s greatest difficulties were counter-transferential ones, with fellow Jewish patients.

He has far less difficulty recognizing and addressing psychopathology "hidden by some kind of religious guise." He describes in detail numerous instances where a client -- "repeated the same prayer for hours to gain concentration," "destroyed their personal laboratory claiming `it prevented Torah study'" or "refused to touch their children -- believing them to be spiritually unclean." He affirms that all of the patients essentially required a religious therapist because they were "highly distrustful of other clinicians."

While M.R. felt that his own therapy had little

impact on his ability to address the religious concerns of others, he does feel that his patent identity as a religious Jew has had a salutary effect on his therapeutic work. He describes a number of inner city blacks specifically choosing him as therapist because their religion considers Orthodox Jews, who wear skull caps, to be akin to high priests. M.R. is uniquely explicit in claiming that he would share with his patients his personal experiences of struggling with specific religious conflicts, if he felt that the practice would be useful.

While the subject of religious issues in psychotherapy has not been central to his own treatment, it has been the source of genuine intellectual and professional interest for M.R. He has attended a number of conferences on the topic with leading Jewish theologians. From these experiences, he has adopted a clear perspective regarding the treatment of adolescents and children in particular. In essence, he employs a weighted system of Jewish jurisprudence to dictate clinical decisions. For example: if the treatment of a symptomatic child will likely result in the breakdown of a family system and probably eventuate in a divorce -- one nonetheless makes the necessary interventions, risking the family for the sake of the child. Thus by

invoking a hierarchy of Jewish law, where the optimal development of the child always takes precedence over the prescription to honor the family, one implements clinical strategies. Unfortunately, this hierarchy is far less clear when dealing with adults.

W.T.

W.T. is a clinical psychologist in private practice who is presently completing his psychoanalytic training at a major institute. He is also an ordained Anglican priest, although he no longer maintains any official or personal connection to the church. Although he no longer describes himself as a religious believer, his case is included amongst our sample because it illustrates a common means of conflict resolution for the religious person who elects psychanalysis as both a means of personal integration and ultimately as a career. W.T. grew up in England, without any formal religious training. In adolescence, he joined the "Boy's Brigade," which he describes "as sort of like Christian boy scouts." This was his first experience of regular contact with the church, and it continued through his early college years at Oxford. He described his relationship with religion and God at the time as being predominantly "an intellectual and aesthetic exercise." He attributes his decision to joining the priesthood to his allegiance to a group of respected, clergy-professors. Even in selecting a career in the ministry, he reflected that he found his attraction to the Anglican church was primarily based on its aesthetic appeal, and he acknowledged that his attraction was

hard for him to accept intellectually. Throughout his seminary training, he could not really accept or believe in many tenets of his faith, although he continued to find "the ethos and symbology of it attractive." After completing his seminary training, he took a position for three years as an assistant parish priest in a small, British town. While he created intellectual rationalizations for the acts he performed as a priest, the gulf between his actual beliefs and his required actions continued to expand, and he frequently experienced himself as "simply going though the motions." He commented, "I recognized my discontent and inner dividedness, yet I could not fully accept my own decision to leave the parish priesthood, and I had to orchestrate getting out of it by several career moves." The first of these was a decision to embark on training to become a pastoral counselor. Personal therapy was a requirement for this training, and this was Dr. T's first experience with psychotherapy. Despite his conflicts regarding religion, these issues were not of consequence in his first therapy experience, as other personal concerns assumed greater priority.

W.T.'s next maneuver to sever himself from the church was a geographic move to America, where he

entered a special program at the Austin Riggs Institute for chaplaincy training. His continued psychanalytic psychotherapy here, along with his more formal training in psychanalysis, solidified his decision to become a therapist. At the same time, his studies confirmed his doubts about religious belief, and he increasingly saw "religion as efficacious, but of questionable validity," replacing it with a psychoanalytic explanation of human behavior that seemed more interesting and reasonable. From Riggs he went to Chicago to attend graduate school in clinical psychology. Throughout his clinical training in the states, he continued to function in various church capacities, but he confided that his acceptance of this work was simply born of economic necessity.

In terms of his own therapy experience, Dr. T. devoted relatively little attention to religion until his present training analysis. In this experience, he has explored how religion and the adoption of a religious vocation served to "defend against my competitive strivings, yet fulfill my aspirations to occupy a given social echelon in British society." Similarly, he has explored his religious interests in terms of his own unique family dynamics. On the whole, he presently tends to embrace a Freudian perspective

regarding the nature of religious belief.

In terms of the treatment of religious patients, Dr. T. has had two very different experiences. At Riggs, he was clearly identifiable as a priest, and he found that this "constantly got in the way - and caused a certain kind of transference." He intentionally downplayed his religious position when working as a counselor, instead directing his patients "to focus in a different way," despite their wishes to understand things in a religious framework. It became apparent to him at Riggs that when patients specifically sought out a religious therapist, they were often "resistant to getting at something." He believes that the patient seeking the religious therapist was often looking for "easy answers, absolution or benediction." It was a way of avoiding looking at unpleasant or un-Christian feelings. Despite his own personal attempts to eschew the role of theologian at Riggs, the Institute itself marked a clear role distinction between the therapist and pastoral counselor. As part of the treatment team, his role was specifically as a spiritual diagnostician and counselor, working alongside of a psychologically oriented professional. Largely under the influence of Paul Pruyser, who was then the Institute's Director of Education, both perspectives

were seen as valid, but separate, each with its own unique language and model of helping. A clear compartmentalization was maintained, and W.T. was increasingly uncomfortable with the domain he was assigned.

In his subsequent work as a private practitioner, Dr. T. has found religious issues to be of far less concern to his patients, most of whom he describes as non-believers. He is still viewed as a "religious clinician" by his psychanalytic institute, and they frequently refer religious patients to him. (In fact, it was his institute who gave me his name as a religious psychoanalytically-oriented clinician.) Despite this referral source, working with religious patients and religious formations occupies very little of W.T.'s time and energy. He has worked with some patients on the subsequent developmental effects of their religious upbringing, and in helping explore specific religious beliefs as encapsulated "islands of magic" with other patients. But on the whole, exploration of religious formations has been of relatively little significance in his conduct of psychotherapy.

In sum, through a progressive series of occupational and geographic moves, W.T. has completely shifted his perspective and role from that of Anglican

pastor to psychoanalyst. His present ties to the church are simply historical vestiges, and his own religious beliefs, rather tenuous to begin with, have been completely relinquished in the face of his present psychoanalytic understanding.

R.P.

R.P., a Modern-Orthodox Jew, is a third year psychiatric resident at a prestigious Boston teaching hospital. He previously attended Yeshiva University and Mount Sinai College, both Jewish affiliated educational institutions. His secondary education was similarly attained, at Yeshivas, where studies are divided between traditional educational curriculum and Jewish studies. R.P. was brought up in an Orthodox family, and he presently maintains a traditional, Orthodox Jewish lifestyle. He wears a yarmulke, maintains a Kosher home, and prays three times a day. Contribution to the community as well as an observance of Jewish law are the cornerstones of his religious life. He similarly views the application of religious law to human relationships as essential to his religious practice.

Dr. P. describes a deeply ingrained belief in God. He states "I don't know how I could even live without the belief in someone up there, who is for the most part benevolent." While he speaks of God in anthropomorphic terms, he describes seeing him in "different things and different places." His relationship to God is multi-faceted. He describes a feeling of "merging and personal transcendence." At

the same time, he reports being in continuous dialogue with his God: expressing gratitude; asking for consolation and strength; and often fervently demanding "how can you allow this to happen?" in the face of the tragedies he witnesses. R.P. acknowledges that strong belief does not mean "that I don't have moments of doubt," but he takes pride in the fact that "my faith has never been so shaken that I couldn't adhere to the laws." He candidly states -- "maybe God isn't there, and I can't prove that He is, but I'm going to lead my life as if He were."

Dr. P. experiences no conflict in his own life between psychoanalytic thought and his Orthodox Judaism. For him, psychoanalysis is basically a clinical methodology. He is far less schooled in psychoanalytic metapsychology and he acknowledges having only minimal familiarity with Freud's writings on religion. He assumes Freud takes a negative view of religion like most scientists, and he responds by claiming that he feels that science "simply does not have all of the answers." In response to Freud's notion that people create their God in the image of their parents, Dr. P. essentially concurs, but contends that "this phenomenon of projection does not prove that God doesn't exist."

The more significant conflicts for Dr. J. regarding

psychoanalysis and religion concern specific clinical issues. His ready identification as an Orthodox Jew presents the first direct issue, as it immediately contaminates or compromises his ability to function as a blank analytic screen. While numerous supervisors have raised this issue with him, he tends to focus on the concrete issue of whether it is "therapeutic or anti-therapeutic to wear a yarmulke in sessions." In response to this question, he feels, "It makes no difference." But on this specific concrete issue, he does not consider the broader transference implications of his patent Jewish identity and how these might affect his own practice of psychotherapy.

The main difficulties he foresaw in treating and dealing with religious patients were in the realm of ethics, where the norms of therapy and Jewish law stood in sharp disagreement. He related a number of poignant and illustrative clinical vignettes where Orthodox Jewish patients were treated by his Orthodox friends and colleagues. In one instance, an Orthodox therapist was treating an Orthodox woman who was having an affair. This presented the ethical dilemma involving whether to inform the husband, an action which is dictated by Jewish law, or to maintain the patient's confidentiality as therapeutically indicated. In a

number of cases, he presented the core conflict as one which involved aspects of sexuality regarding which Jewish law is very strict. Dr. P. indicated that all premarital erotic contact and any "spilling of male seed" are explicitly proscribed. Each clinical situation posed a major dilemma for Dr. P., as he felt that the only satisfactory solution he could affect when treating an Orthodox Jewish patient was one that was consonant with Jewish law. (Treating a non-religious patient posed no such dilemmas for him.) R.P. said that even though he didn't at this time know how he would respond to many of these dilemmas, he knows that he will be facing them, and he "looks forward to the challenge." He is forthright in his own assessment that the treatment of fellow Orthodox patients poses a major dilemma for him. Yet at the same time, he feels particularly equipped and morally obligated to serve this population.

B.T.

B.T. is a former Catholic nun who now works as a marriage and family therapist. The majority of her present therapy practice is based out of church-housed counseling centers. B.T.'s transition from monastic life to secular psychotherapist in many ways traces a by now familiar course. Exposure to non-cloistered lifestyles, close affiliation with a diverse range of clergy, and personal experience and training in psychotherapy all contributed significantly to her decision to leave her order. At the same time, her experience is highly unique, in that religious doubt and the questioning of her own strong faith and belief in God have seldom been major issues. Instead, the constant changes in her life have paralleled shifts in an evolving religious sensibility and a reworked understanding of and relationship to her personal God.

B.T. was the oldest of nine children in a "chaotic" lower-class, New England family. She describes her father, a fishcutter, an irresponsible carouser, whose sons followed in like fashion. Her uncle, a Catholic priest, played a highly influential role in her own religious involvement. Although not a major presence in her home, she held him in awe. And he consistently arranged for her to attend elite Catholic

schools. They provided her with education, stability, adult commendation and the recognition that "You didn't have to be rich to be able to enjoy thinking." Although her family was in no way religious, B.T. came to take great pride and comfort in her religious education and the church. Still, she had no plans of pursuing a religious vocation until the end of her senior year of high school. At this point, hearing that, "If you think you have a religious vocation and don't follow it, you will probably be miserable, and looking for your place for the rest of your life" -- she chose to become a postulant, entering the monastery at the school from which she graduated. She subsequently made her vows, and continued in the Order of the Sacred Heart of Jesus and Mary for in excess of ten years. During this period she completed college, taught biology in Catholic schools, and began parish counseling work, as well as obtaining a Masters Degree in Divinity. Her eventual decision to leave the Order was largely catalyzed by her exposure to ecumenical pastoral counseling training. During the course of the training, she developed a strong infatuation with a minister who was her supervisor. Soon after, she entered personal psychotherapy, focusing on whether she wanted to spend the rest of her life as a nun. Her

conflicts were not with the legitimacy of her Catholic faith, but simply over the issue of her own lifestyle. She elected to take a leave of absence from the Order to pursue continued clinical pastoral education at a Hospital in the Bronx. Distanced from monastic life for the first time, she soon elected to leave the Order. After formally severing her ties, she developed an active social life and pursued her career interests in the area of counseling, obtaining family therapy training at a Philadelphia Institute and further clinical training at a New York City Institute that caters to religious professionals.

Since dispensing of her monastic vows, the search for a "religious home" has been a major issue for B.T. She still considers herself a strong religious believer and she feels a powerful commitment to the church as an institution. She has attended church virtually every week since leaving the Order, sampling a wide variety of denominations and congregational styles. After many years of "shopping," she is presently planning to take membership in a Methodist church. This decision is a highly significant one for her, and it is complicated by the fact that she is involved in a long-standing romantic relationship with the church minister. At this point she is considering pursuing ordination in

the church for herself and possibly taking on a congregation of her own.

B.T.'s shift from orthodox Catholicism to Protestantism reflects a prominent change in her personal religious experience and understanding. Previously, she had felt that self-sacrifice and obedience to the wishes of religious superiors epitomized the essence of "doing God's will." "God's will" was virtually always the "harder way, which had to be chosen over the fulfillment of her own wishes.' Her personal experience of a God representation who communicated to her, "I want what you want," proved to be an epiphany. It freed her to search within herself for her own religious fulfillment and to shape the course of her life in accord with her own wishes and aspirations without guilt over deviating from the will of a demanding God. Thus it was this shift in her image and relationship to a patriarchal God that facilitated her changes from a religious life based on guilt and a strict authority to one of increased autonomy and a search for personal freedom.

B.T. states that she feels quite comfortable and natural with the integration of her religious beliefs and her psychodynamic clinical perspective. She sees the spiritual dimension as one that gives meaning to

her life and work. Yet when pressed as to how she integrates these two seemingly conflicting perspectives, she acknowledged that she never chooses to put them "head to head" or in an "either/or position."

B.T. was highly open in discussing her relationship and representation of God. Her representation is of a male figure, very much like Jesus, and her relationship is a "highly personal one, with a God who is interested in me and my personal happiness." In terms of her relationship to God, she stated, "There has always been a God influence in my life, a continuity of feelings with God, a God I could always turn to -- it's not something I can let go of." When directly pressed with an object relations interpretation of God, she ingenuously reflected that the position was totally understandable and possible, while at the same time confirming that "the cognitive indefensibility of my religious beliefs feels all right to me. It's simply an experience I feel connected with in a more total way." While initially disavowing conflict between her religious and psychodynamic perspective, B.T. acknowledged that her rejection of Freud's narrow position on religion had led her to move her thinking in a more Jungian direction. While she accepts the bulk of psychoanalytic thinking, and even employs this model

in her own work with religious patients, she "cannot accept the Freudian reduction of her own experience."

B.T. has had two different psychotherapy experiences. Her first therapist was affiliated with her initial pastoral training program, and her second therapist was a minister. In both therapies, religious issues were prominent. Yet she feels that the significant changes in her religious beliefs and understanding has not so much emerged from direct work in therapy, but instead is the indirect result of a process that has allowed for open questioning. At the same time, she articulated a number of concrete religious issues which were specifically addressed in her treatment. These included:

1. The dynamic reasons underlying her decision to enter the convent.
2. Her personal use of religious virtue as a magical means of making reparation for her family's un-Godly ways.
3. Her guilt about abandoning Catholicism.
4. Her fear of losing God's love and her need to be perfect to gain it.

B.T.'s own extensive experience in working with religious issues in her ongoing therapy has served as a model for the conduct of her own clinical work. She

sees religious experience as an important area for diagnostic work, particularly with regard to patients' object relations. She attempts to weave an exploration of religious issues into her history taking, whenever patients bring up this material. She notes magical thinking and intellectualization as frequent defensive utilizations of religious material by her patients and she is generally quick to interpret these maladaptive patterns. She similarly does considerable work with patients regarding their personal God representations. To illustrate this, she bemusedly noted how one of her religious patients even refers to his "1985 God" as opposed to his "1979 God." She generally attempts to connect the patient's God representations with earlier object relations. Because she conducts most of her treatment out of church offices, she finds that patients frequently develop "nun or teacher fantasies," where they come to her looking for a source of guidance and religious authority. She acknowledges that she takes great pleasure in working with religious issues in treatment, yet she is aware of the potential for significant counter-transferential response, most patent in her case, on issues regarding abortion. She similarly guards against reductionism and inquiry which can be perceived by patients as intrusive. She

highlights this by citing her own therapist's inquiry, "Did she pray?" She initially perceived this as an injunction that she should have prayed, when in fact she was attempting to explore the nature of her prayer life. She feels that the analysis of prayer is a particularly fruitful means of exploring dynamic issues yet at the same time, she is exceedingly careful in her examination of this material. In sum, while she places a high value on religious formations as a unique source of dynamic material, she feels this material must be approached with great care and caution.

J.R.

J.R. is a psychoanalyst in private practice who also serves on the faculty of the Pastoral Counseling Training Program. He is a former Jesuit priest who left the priesthood after coming to the United States from New Zealand. Although dimly aware of his doubts and conflicts regarding Catholicism, J.R. never experienced a major crisis of faith until he was distanced from monastic life and he was actually and openly questioned about his religious values, beliefs and life choices by colleagues and peers. This was exactly the situation he encountered on coming to the States to study pastoral counseling. He found direct challenges to his own religious perspectives to be highly disconcerting, and this led him to question his own religious faith for the first time.

He acknowledges initially beginning analysis as "to be better fortified" in the face of these challenges. In his analysis, religious issues were a major concern at the very outset. Prominent among these was the issue of celibacy. After changing his position on this moral value, he began to question issues of authority, dependence and ultimately the role religion had played in his family and personal history. Eventually, he came to use therapy as a the container for the

examination of all of his religious beliefs. He came to the conclusion that "belief in God supported all of his other religious beliefs and practices." He started to admit that he didn't believe in God, and that his beliefs had been based on his need for a father figure, for an authority to guide his life. His reading of Freud, as well as his personal introspection, proved to be a major force in undermining his religious belief system. After reading Freud, he felt that the psychoanalytic position was essentially valid and irrefutable. He did not defend his beliefs at all, but recognized they served him as a convenience which could no longer be maintained. Hence, he simply decided that "God did not exist for him anymore." In renouncing this need to believe, he felt himself "liberated from his religion and beginning to come alive." He found his ecumenical religious colleagues an especially valuable source of support at this time.

In essence, J.R. completely dismantled his religious world view in therapy, and he replaced it with a psychoanalytic perspective. This conceptual transformation was paralleled by a shift in his concrete work as well. Within two years of beginning therapy, he left the priesthood. But before completely severing his ties with the church he gained entry into a graduate

program in clinical psychology at a Jesuit university in Boston. He continued to work as a priest during this time in order to earn a livelihood, describing his sermons as "more psychological than theological." After beginning clinical training, he obtained a dispensation of his vows and he subsequently chose to marry.

Religious Background

J.R. indicated that he was essentially selected at an early age to be the family's representative to the priesthood. He described himself as "accepting this without question." He began junior seminary at age thirteen, and he describes his religious training as "a socially sanctioned defense in dealing with the typical developmental tasks of adolescence and young adulthood." He describes himself as "very identified with his role and training" although he acknowledged his difficulty "developing a personal relationship with God." He rationalized this difficulty as his "dark night," seeing it as "the way it's supposed to be." He claims he felt there was no sense doubting "since there was no way out - so I kept my conflicts out of consciousness." From the time of his entry into seminary through the age of thirty, most of his life was spent in the monastery, although he did make parish visits.

Therapy Experience

J.R. had two therapy experiences. He spent seven years with his first therapist, the first three of which he combined with group therapy as well. His therapist was a woman who he chose because she was British-educated and he felt she had a Christian upbringing. She did not attack his beliefs, but simply helped him to hold them up to question. He feels that he ultimately dismantled the complete edifice of his religious world view essentially replacing it with a psychoanalytic perspective. In his words, "There was no integration, one world view replaced the other." His second therapy experience was in analysis, a required part of his psychoanalytic training. Again, he explored some of the dynamic reasons for his election of a religious vocation, and the role religion played in his development, but by now, the prior burning issues of guidance and belief had been clearly resolved. After initial periods of being angry and blaming the church, he came to accept his religious experience as simply a stage of or stepping stone in his ultimate development that provided him with many strengths and opportunities.

Experience as a Therapist

In his own experience as a clinician, J.R. feels

very comfortable dealing with religious concerns. He sees his task as simply helping the patient to "understand their behavior, not to take it away." In particular, he emphasizes that he takes religious symbology and its interpretation very seriously in his own clinical work which includes a significant body of religious people. He does not normally tell patients of his own religious background, but he states he "doesn't hide it either." Unlike the majority of the clinicians sampled, J.R. stresses that he frequently explores the psychological roots of patients' religious formations. Similarly, he examines their god representations and their relationship to these representations, if and when a patient brings this material into therapy. He finds that his patients are "either immediately involved with religious issues or not" -- he has "no middle ground people." One of the major difficulties he cites in working with religious patients is that many seek spiritual direction from him. When he interprets this in terms of transference, he finds the patients invariably get angry. Similarly, he finds patients are reticent to truly question religious issues on their own, rather than just hoping to be given answers without their own critical approach. J.R. cites charismatic Christians, in particular, as

provoking clinical difficulty. This is in their demand that he share their fundamentalist beliefs. He addresses this demand with the casual rejoinder "Why is this so important?" J.R. describes unique counter-transferential difficulties with religious patients as well. He cites both his occasional anger at patients' attachment to their religious beliefs and his own contrasting tendencies for gentleness born of identification with their state of religious development. He places a particularly high regard on the interpretation of religious beliefs in therapy. He feels that the nature of a person's religious beliefs is especially valuable in helping him to assess their level of psychological development. Much like Freud, while he acknowledges that religion can be useful to a person, he feels it to be an illusion that at some point must be given up. He presently sees no means of reconciling psychoanalysis with religion. His current perspective is orthodox Freudian -- "religion is a derivative like any other symptom, and if analysis is successful, at the end of it one cannot be religious."

CHAPTER 5

ANALYSIS AND INTERPRETATION

In the preceding chapter, our data was presented in the form of twelve unique and distinct case histories. Few parallels were drawn, and the narratives were by intention descriptive and largely non-interpretative. In this chapter, our aim is to essentially pool these individual cases in an effort to integrate and analyze the collective experiences of our subjects. Furthermore, in addition to delineating common patterns, efforts will not be made to interpret and explain them. Our treatment of the overall data will follow the same sequence as that of the individual case presentations. The nature and evolution of the subjects' religious experiences will be our initial concern, with particular focus on the issue of how the clinicians integrate their religious orientation with a psychoanalytic perspective. The subjects' personal experiences in therapy, especially as it pertains to their religious experiences, will then be addressed. Finally, we will direct our attention to the subjects' clinical experiences in working with religious patients.

Religious Experience and Involvement

Our sample is highly select by virtue of the fact that eleven of the twelve have not only identified themselves as religiously committed (at one time), but have elected to pursue religious vocations. The sole exception was an orthodox Jewish psychiatrist. On the whole, their decisions to pursue religious vocations were made quite early in their lives. Often an early penchant for religion was intensified during adolescence when the adoption of a stronger religious commitment became an increasingly important organizing feature of their identity. In many cases these decisions were made out of allegiance or obligation to family members, friends or mentors. There was marked variation in the degree to which the subjects were conscious of both the overt and tacit factors that led to their election of a religious vocation. This, in fact, was a prime topic in their therapies. Fulfilling family expectations, identifying with esteemed models and mentors, gaining security and status, resolving adolescent conflicts of separation or sexuality, creating clear boundaries and gaining a direction for one's life were all articulated as factors underlying the decision to pursue a religious vocation by a significant number of subjects. Only one

subject's religious involvement was established relatively later in life (after college years) and in his case he seemingly fell into theology as a function of convenience.

Two of the subjects were sons of clergymen and eight consider their families religious. A notable contrast emerged between the Christian and Jewish families' responses to the decisions of their children to pursue a religious vocation. While the Christian families often almost designated specific children for church work, the decision to become a rabbi was viewed with marked skepticism, if not outright disapproval, by the Jewish families, except in the case of the one already headed by a rabbi.

It is significant that despite fact that eleven of the twelve subjects are (or were) ordained clergy, only one presently serves in the capacity of congregational leader. Indeed only six of the sample presently maintain any congregational affiliation. Of these, one is the leader of a synagogue and two are orthodox Jews. The majority of the Christian clergy are no longer involved in church life. One of the most striking findings of the study was that virtually all of the clergy interviewed expressed strong feelings of

dissatisfaction with the traditional role of the congregational clergyman. They cited congregational politics and primarily a marked difficulty in adapting their own personal religious understanding to the expectations and demands of their congregations as fundamental problems. The psychoanalytically-oriented Christian clergy in particular, felt that the need to "play to" the level of their congregations' religious understanding significantly limited the expression of their own, less conventional, religious vision. This experienced dissonance between the subjects and their congregations highlights the fact that the religious perspectives of the clinicians sampled were highly personalized and did not fit neatly within the molds of mainstream denominational belief and practice.

Along with their movement away from institutional religion, there was a decided tendency for the Christian clinicians to temper of abandon authoritarian religious formations. This tendency is highlighted by the fact that the two clinicians who now consider themselves atheists came from highly orthodox religious traditions and the nun who left her Catholic order subsequently chose to affiliate with a more liberal protestant sect. In contrast to this tendency for the Christian

therapists to break from religious orthodoxy, in the case of the two orthodox Jews, congregational affiliation and strict adherence to Jewish law served as hallmarks of their religious commitment. Even for the reconstructionist and conservative rabbis, the observance of Jewish custom and law remained central to their personal religious practice. It is noteworthy that all considered their fulfillment of Jewish law to be more predicted on a sense of personal and cultural identity rather than on a set of beliefs.

Despite the differences between the Christians and Jews studied, the essential findings reflect a decided movement away from mainstream and religious affiliation of origin. For the protestant clergy-clinicians, in particular, their religious commitments were now far more intrinsic and personal leaving them significantly estranged from congregational religion and traditional religious belief and practice.

Evolution of Religious Belief and Practice

The subjects readily identified religion as (at some point) providing a highly adaptive and stabilizing influence in their lives. The cited the provision of comfort, esteem, a source of authority and identity as

major salutary aspects of their religious commitments. Yet for many the nature of this commitment came into question and was gradually diminished or changed over time. In fact, the majority of the sample have eschewed their former religious vocations and have instead adopted full time secular positions, usually in the role of psychotherapists. Despite these extensive shifts in the realities of their daily lives and in their relation to institutional religion, nine of the clinicians sampled still considered themselves "religious believers." This finding essentially replicates a similar pattern reported by Belgrave (1983) where seminary trained Catholics changed moral values but maintained a status as "religious believers" as a function of psychotherapy. The fact that religious belief is not readily or easily abandoned is paradoxically illustrated in this sample by the case of the two subjects who became atheists. In both cases the process of ultimately renouncing religious belief and affiliation took a protracted and circuitous route. This entailed a geographic distancing from family, former friends and colleagues, as well as the replacement of a religious world view with that of psychoanalysis and the assumption of the secular priestly role of psychotherapist.

The fact that the majority of our sample have modified their religious commitments including their values, practices and even denominational affiliations, while maintaining an identity as "religious believers" is a finding that begs further exploration. But regrettably, as anticipated, getting the religionist clinicians to directly address the issue of their personal beliefs was a formidable task. Open ended questions led to digressions, philosophizing and protracted equivocation. Limit testing and pointed inquiry often produced conspicuous silence and self-conscious puzzlement on the part of the ordinarily loquacious clinicians. While they could both elaborate on their own childhood gods and discuss God at great length in theoretical terms, many were surprised and quite frankly embarrassed at their inability to directly respond to questions pertaining to their current personal god representations.

Despite these difficulties in exploring the domain of the subjects' belief system, a sketchy picture nonetheless emerges. The two affirmed atheists, the former campus minister and the reconstructionist rabbi all unequivocally disavow belief in a supernatural god. Of the remaining "believer" only five can be considered to embrace some semblance of a god representation. The

two orthodox Jews described omnipresent, quasi-patriarchal gods with whom they maintained a continuous dialogue. The former nun embraced a "Jesus-like" God, and two ministers described vacillating hybrid-gods. These were an alternating combination of their abstract god, largely the product of extensive theological education, and their more primitive, anthropomorphic progenitors. These more archaic god representations had been intellectually abandoned but they nonetheless recurrently appeared at times of severe stress and mental disequilibrium. The remaining clinicians either discounted the importance of a god-representation to their system of religious belief or were simply unable to address the issue in other than the most abstract or obtuse of manners.

Although both the nature and metamorphosis of the clinicians' god representations were decidedly murky, they nonetheless provide a base for speculation. Childhood patriarchal god representations in the image of familiar religious figures were virtually ubiquitous and highly important to the subjects' early religious experience. Later, largely as a function of their increased training in both theology and psychology, the clinicians generally elected to modify and up-date these god representations. These modifications were

virtually always in the direction of formulating an abstract and highly idiosyncratic god synthesized from an amalgam of personally meaningful concepts and religious teachings. These evolved, abstract personal gods were distinguished by two noteworthy features: firstly, they essentially defied description, and secondly, in certain cases, under psychological stress, they gave way to earlier more concrete anthropomorphic god representations.

The question of why a population of highly sophisticated and articulate religious clinicians was virtually tongue-tied when asked to described their god representations suggests a number interpretations:

1. The subject is such a highly private and personal matter that they were both resistant and inhibited in responding.
2. The creation of a faceless and nameless abstract god is a high order religious symbol which is intentionally kept outside the realm of analysis and description for its purpose is to point the way for the devotee's private contemplation of the mysterious.
3. One's experienced relationship to and representation of God exists in a unique psychological transitional space which is not

readily communicable. (Notion suggested by Winnicott and Rizzuto).

4 The non-representational abstract god which is adopted later in life functions as a secondary process "screen-image" derivative that allows an individual to maintain a largely unconscious inner connection to a more primitive God representation which is no longer intellectually palatable but which is intimately fused with their self representation.

Speculation on the Nature of Religious Belief

The data suggests that for most of the individuals studied, the essence of their religious belief is the belief in and relationship to a personal God representation. This representation functions like an inner object, in that it is intimately connected to an individual's own self representation and, as such, it provides for a sense of personal continuity, integration and well-being. But at the same time, as this personal God representation functions as a highly secret inner object performing unique psychological functions for

each individual, one has, as well, a "public God." This "public God" is the God of churches, literature, and institutional religion. It is the secondary process God that we elaborate in light of reading and study. It is the one we generally refer to when generally called upon to discuss God. (A phenomenon which for most people is quite infrequent). It appears that these two Gods -- our public and private deities -- operate at two distinctly different levels of consciousness. The private God, as suggested by Rizzuto, functions like a special kind of transitional object, operating in a unique transitional space, which is largely outside the realm of normal conscicusness. It plays a unique role in maintaining the psychic equilibrium of each individual in its role as attendant and observer of the real self. The public God, on the other hand, is the God who is shared. It's the God who is largely shaped by conscious mental processes and who must somehow then fit within an individual's overall working conception of reality. In line with our understanding of cognitive development, as an individual progresses through stages of primitive and magical thinking, their God representation must then invariably be modified to accommodate to these changes. But, in the model suggested, the God representation is not a

simple, unitary representation. While the public, secondary process God, must; of necessity, be reworked to accommodate to a new, higher order model of reality, or be dismissed as anachronistic or absurd; the private God, operating at the periphery of consciousness, tends to remain essentially unchanged. In this duality rests a clear potential for disharmony and splitting, for the representations, in fact, serve different psychological functions and essentially operate in different mental environments, according to different rules (primary v. secondary processes). While there is inherent potential for tension between the two representations, I seriously question whether this dissonance is ever a major issue for most individuals. They are rarely called upon to speak about or justify their Gods, and when they do, they generally refer to the socially sanctioned Gods of their religious training. But the situation was notably different for our sample. They are unique in that they are particularly sophisticated in both their theological and psychological training. As such, they have a unique burden. In order to maintain their religious beliefs they must construct public God representations who notably can stand up to Freud's critique of an illusory, and anthropomorphic deity, but who

simultaneously fulfill the requirements of their own contemporary theology. The task is clearly not an easy one. But it is a crucial one, for without some presentable public God, the fate of one's beloved, private God, of consequence, lies in jeopardy. With the stakes this high, the psychoanalytically informed religionist is thus hard pressed to fashion an acceptable God representation. On the whole, the least psychoanalytically sophisticated were the only ones to maintain parental deities, choosing to act "as-if" they existed. The other clinicians were forced to adopt a variety of highly abstract and largely indescribable Gods, occasionally wrapping them in sophisticated theological trim. It is my thesis that both the adoption of an "as-if" philosophy and the construction of an indescribable, non-representational God are highly pressured, intellectual maneuvers to maintain some semblance of a public God representation. They serve as obligatory rationalizations, or intellectual covers that are necessary for the continuation of an on-going personal relationship with a deeply cathected and largely unconscious private God representation. In essence, the accommodation process required for the construction of an intellectually acceptable public God representation is driven by the

largely unconscious need to maintain a continuity and coherence of self which is intimately connected with its relation to a private God representation. It is for this reason that religious belief takes on the compulsive quality so often noted and our subjects could not readily relinquish their status as believers even though they often could neither describe not defend their Gods. To describe them or allow them to be summarily reduced to psychoanalytic artifacts would leave them vulnerable to states of painful fragmentation, inner emptiness and abandonment. In their own words, they would be "bereft," or they "simply could not imagine a world without God." It is precisely because belief is inextricably bound up with this private and largely unconscious connection to a special inner object, that it is not as readily modified as the nature of religious practice or moral values. These latter changes occur at a more conscious level of the personality, which is far more subject to the weight of rational argument. Indeed, moral values and religious practices are subject to modification by the church itself. Relinquishment of religious belief, with the severing of a highly prized relationship to a personal God, on the other hand, constitutes a virtual annihilation of the self.

The dual representational model, with its potential disparate public and private God representations accounts not only for the ineffability or "non-sayability" of the subjects' God, but also for the production of the occasional hybrid Gods, which even surprised their own creators. In these cases, the spontaneous emergence of long-abandoned God images at times of severe stress, reflects the fact that the unconscious private God representation is not unequivocally supplanted by the public, abstract God representation. In fact, the more intellectualized or abstruse modern representation may simply serve as a "screen image," allowing for the preservation of the more repressed, but highly perfected private God representation to continue in its unique transitional realm.

The construction of an abstract God appears like a necessary accommodation of prior God schemata which allows for a continuation of belief in many of our highly intellectually sophisticated subjects. But this shift from a concrete God to an ephemeral variation is not without sequelae. Several clinicians who had consciously modified their personal anthropomorphic Gods to make them more consonant with advances in their own psychological and religious understanding reported that

subsequently, "God was far less available to me," or that their religious experience was now "less personal and immediate." It appears that the intellectualization and abstraction of a highly personalized God representation, while mandated by changes in cognitive structures, frequently results in a qualitatively different religious experience as well.

One can explain this experience of a distancing from God as a direct consequence of the forced regression or significant alteration of the private God representation. In essence for many of our sample, to intellectually maintain their religious beliefs, they systematically modified their God representations purging them of now unacceptable primitive elements. As a function of this process, they unwittingly diminished the intensity of their personal connectedness to the unique inner object represented by their personal God representation.

Possessors of highly abstract and intellectualized God representations shared another common characteristic in addition to their overall experience of an increased "distancing from God." Somewhat paradoxically, all five described having intensely powerful and meaningful religious or mystical experiences. Although the subjects were often highly tentative and guarded in

talking about this material, they confided that the experiences "left an indelible imprint" upon them. These experiences had a "noetic quality which served to validate and confirm the importance of the spiritual quest." (L.J.) Interestingly, virtually all of the clinicians had these experiences prior to their personal therapy and analytic training. None chose to bring this material to therapy, and several reported that in light of their subsequent psychoanalytical reading regarding mystical states, they "presently feel far less open to this kind of experience." (F.W.) Nonetheless, the memory of these "altered states" persist as extremely powerful affirmations of "the reality of the religious experience, and as a factor underlying continued religious belief." (G.B.)

The fact that the clinicians with the most abstract and diffuse God representations had both a history of self-described mystical experiences and presently experienced a distancing from God offers an interesting basis for further speculation. While the correlation of the two phenomenon may indeed by specious, the dual representational model suggests a possible connection. In this regard, the mystical experiences cited can be viewed as unique instances where the subjects experienced a transitory de-repression of their largely

unconscious, but highly cathected private God representations. In each case, the affective experience was extremely powerful and virtually ineffable, in essence constituting and "altered state". All of the five clinicians who reported these events have subsequently had extensive psychoanalytic experiences. (Three are currently analysts). They are highly conversant with psychoanalytic thinking regarding religion, and concede that their present doubts about God to be almost on a par with their beliefs. In the process of their training, they have intellectually abandoned their primitive, anthropomorphic and personal Gods, replacing them with abstruse successors. Their current God representations are, by virtue of their highly amorphous nature, largely impenetrable to direct intellectual or psychoanalytic attack. But, at the same time, they provide little of the psychological benefits of a direct relationship to their personal God representations -- Gods with whom they previously had a more direct and intimate experience. Now, with this personal God representation so highly repressed, but existing as an "indelible memory," they experience a significant estrangement from God.

The Integration of Religious Belief and a Psychoanalytic Perspective

One of our initial research goals was to explore the mechanisms by which our unique sample integrated the seemingly irreconcilable positions of religion and psychoanalysis. In assessing the cases both individually and collectively I can only conclude that this "integration" seldom, if ever, occurred. Instead, the clinicians adopted a variety of maneuvers to reduce the tension and experienced conflict between the two positions. The simplest and most direct means of doing this was to simply to reject one's former religious beliefs or to reject the psychoanalytic critique of religion. This unequivocal selection of one paradigm over the other was effected by four members of our sample. Three clinicians rejected their religious beliefs altogether, while one orthodox Jew, in essence, completely dismissed the psychoanalytic critique of religion. The remaining clinicians employed a number of variations on the theme of Hartmann's (1960) "compartmentalization of codes" to facilitate a mental coexistence for the two perspectives.

A common means of compartmentalization was to split reality into spiritual and material domains. In effecting this dichotomy the subjects could then be

selective in their employment of a conceptual system for each of the separate domains. The materialist perspective was applicable to virtually all of the subjects' conventional reality. Inherent in this perspective was a largely psychoanalytic model which explained all behavior and which was employed for clinical work, including the clinical understanding of most aspects of religion. The spiritual domain, in contrast, essentially was confined to solely the subjects' personal beliefs and experiences with regard to religion. This separate reality, which the clinicians generally conceded to be intellectually indefensible, was cordoned off from psychodynamic scrutiny and a feared reductionism, as this mode of analysis was felt to be inappropriate to the nature of the experience.

Five of the sample,in effect, "integrated" their psychoanalytic and religious world views by adopting these dichotomized universes. While the psychoanalytic model was, in general, fully accepted and even the psychoanalytic critique of religion considered appropriate for the understanding of many of the inevitable projections onto religious formations, the special realm of experience which lies beyond the "screen of projections" was considered exempt from

analytic explorations. The nature of this experience was essentially considered so special and valuable by virtue of its unique capacity for personal renewal, transformation and the attribution of meaning, that it was given a special immunity from analytic inquiry which was frequently perceived as a form of reductionistic attack. Thus these clinicians, in essence, employed a combination of the spirit - matter duality and acting "as-if" philosophy employed by previous generations of religious analysts to preserve a sacrosanct refuge for the divine in their own psychoanalytic houses. Two other clinicians employed a post-Freudian psychoanalytic perspective to defend their religious beliefs and experience from the inherent criticism and implied neuroticism of the traditional Freudian perspective. They invoked in particular the ideas of Winnicott and Guntrip to defend creative and transformative play in the unique transitional space afforded by the religious experience. These subjects, both ordained clergy-analysts, fashioned a new variation of the "as-if" philosophy but instead of relying on prior utilitarian philosophies to defend "acting as if" God is real and belief is justified, they now employ contemporary psychoanalytic authorities. They cite the necessary, inevitable and extremely beneficial aspects

of illusion in psychic life to justify their religious beliefs. Similarly they affirm that "the religious experience provides for a socially sanctioned regression in the service of the ego, which can be especially valuable in fostering a higher level of dynamic integration" (F.W.). These two clinicians stand out as examples of religionists who far more comfortable exploring religion in psychoanalytic terms. They ask not whether "God really exists", but what are the psychological conditions that lead men to believe in God and what kind of beliefs, practices and services are most conducive to healthy personal growth in the unique transitional space represented by the religious experience. For them the religious experience is not of the same reality as ordinary life but this does not mean it is any less real from a psychological perspective. The fact that the religious clinicians, on the whole, experienced so little conflict between their religious beliefs and their psychoanalytic understanding attests to the strength of "compartmentalization of codes" as a mental process. Many were forthright in acknowledging, "I don't experience a conflict between psychoanalysis and my religious beliefs, because I never placed them head to head or in an either or situation" (B.T.). Instead for many the essential indefensibility of

religion when juxtaposed with the psychoanalytic critique is essentially accepted without either undue tension or genuine resolution. In the face of Freud's challenge that "when questions of religion are concerned, people are guilty of every possible sort of dishonesty and intellectual misdemeanor," (1927, p. 5) our clinicians were remarkably sanguine. Many had simply stopped trying to intellectually synthesize their psychoanalytic and religious perspectives. The inherent conflicts were at this point personally accepted much like the paradoxes that characterize other realms of contemporary thought. The clinicians expressed neither the need nor the desire to further integrate their personal religious experience with their psychoanalytic understanding. Perhaps more importantly they accepted almost indifferently the indefensibility of their religious beliefs in the face of the Freudian argument. Their personal experience and beliefs were such that vulnerability to intellectual argument was by no means sufficient for their relinquishment. Indeed for many the fact that their religious beliefs and especially their belief in God did not rest on intellectual supports represented the essence of a faith they experienced as commendable.

Only two of the clinicians interviewed acknowledged

significant conflicts regarding their integration of their personal religious beliefs and their psychoanalytic orientation. One was an analyst minister who had "essentially dismantled much of his religious edifice" (L.J.) in the course of his own analysis. While he no longer maintained any formal religious affiliation nor systematically practiced religion, he felt some unshakable and (unspeakable) connection to his belief in a spiritual reality. He could find no way to justify or reconcile his beliefs with his analytic thinking but he nonetheless maintained it. Like the physicists' particle and wave models of light, he sees spiritual and analytic models as two valid but irreconcilable myths for reality. In the case of the other clinician who experienced conflict, the tension was not between his present religious beliefs and the psychoanalytic critique, but instead his conflict was essentially of a clinical nature, where psychoanalytic wisdom seemed to run counter to the recommendations of Jewish law.

In sum the religionist clinicians can not be considered to have achieved a unique or novel synthesis of psychoanalysis and religion. Instead they basically compartmentalize the irreconcilable perspectives or modified their personal interpretations of the

conflicting paradigms to lessen the tension between them. They clearly tempered their religious views becoming less authoritarian and extrinsic in their religious styles. Psychoanalysis as both a theoretical model and clinical methodology was virtually universally embraced. This included an acknowledgement of the contribution of psychoanalytic theory in pointing up many of the neurotic distortions of religion. But the psychoanalytic critique of religion was accepted only up to a point. While the clinicians could not directly refute Freud's position, by and large, they rejected it as unduly limited in its exclusion of the possibility of a more healthy and integrative religious experience. Thus on this circumscribed topic they parted company with the orthodox analytic position. Familiar invocations of the value of acting "as-if" religion was true and of the irreducible nature of the spiritual realm when employed to bolster a compartmentalization of religious experience. A novel variation on these themes demonstrated by some of our sample was the adoption of current strands within contemporary psychoanalytic thought to defend religious experience from harsh reductionism. In this vein, an increased understanding of both the nature and psychic value of illusion and transitional phenomenon was employed to give credence

and justification to the potentially integrative aspects of religious experience.

Psychotherapy and Religious Experience: the Clinicians Experience as Patients

Personal experience in psychoanalytic psychotherapy was a condition for inclusion in the research sample. This requirement was instituted for the expressed purpose of facilitating an exploration of the impact of therapy on religious formations from the perspective of the patient. It was hoped that the present sample would provide a set of uniquely informed voices to break the "conspiracy of silence" that has surrounded the topic of religion in psychotherapy. The impact of psychoanalytic psychotherapy on religious belief and on the religionist clinicians' integration of their religious and psychoanalytic perspectives were focal areas of inquiry.

The religious clinicians' therapy experiences were extensive. Nine of the twelve had completed or were currently involved in either psychoanalysis or intensive psychoanalytic psychotherapy. And all but the two orthodox Jewish clinicians had more than one therapy experience. Yet surprisingly despite the extent and intensity of the therapeutic experiences, the treatment of religious issues played only a minor role. Only five

of the subjects reported addressing religious concerns in anything more than a superficial manner. For one of these the analytic scrutiny of religion was conducted on a post-mortem basis in his training analysis after he had already severed all religious affiliations and relinquished his former belief.

While the overall tendency to shun religious issues in treatment is consonant with all prior reports in the literature, the finding was nonetheless surprising in a sample virtually hand picked for their extensive religious and clinical involvement. When directly questioned as to their reluctance to address religious concerns in their treatment, most responded that they experienced other conflicts as significantly more painful and more pressing and that they simply did not experience religious issues as an area of major conflict or of prime concern. A few clinicians explicitly expressed their direct resistance to approaching religious material claiming that they didn't find that their therapists were equipped to deal with this material. Only one acknowledged consciously avoiding religious topics because he experienced his therapist as continuously placing them "under attack".

Ironically, despite the predominant contention that religion was not a major issue for them, eight of the

subjects chose for their first therapist someone who they felt to be sympathetic to their religious commitment or someone who they felt could understand their religious orientation without undo explanation or translation. In this regard, three of the ordained ministers, who chose to enter therapy in their seminary years elected to be in treatment with ministers who were working as therapists. In each case these figures served as prominent role models and had a major impact on the subject's own ultimate career plans. In light of this conscious choice of religiously sympathetic and/or knowledgeable therapists, the fact that in the majority of cases neither the patient nor the therapist spent much time addressing this realm of experience is especially noteworthy. It leads one to question if the therapists were chosen because religious concerns would not need to be clarified or explained to them, as suggested by the subjects, or because the subjects felt that in choosing these therapists their religious perspective was essentially safe from challenge.

In the cases of the four subjects who reported more extensive exploration of religious issues, they all specifically brought these concerns to treatment and they chose clinicians who they felt were particularly well suited to this task. Three selected

psychoanalytically trained clergy therapists and the fourth chose a therapist of similar cultural background who he felt to be religiously sensitive. In each of these cases a significant component of the therapeutic work focused on conflicts regarding religion and personal autonomy. Therapy became a place where each of these individuals came to authentically question and explore the nature and dynamic roots of their religious commitments. In two cases (the priest and the nun) the prime religious conflict centered around whether or not to maintain a monastic lifestyle. In the other two cases the modification of a harsh and punitive superego which was highly enmeshed with religious formations marked much of the therapeutic work. In all of these cases there were notable changes in religious commitment. Both the nun and the priest dispensed with their vows and the two other ministers similarly parted ways with their prior institutional religious affiliations. These major concrete changes in the level and nature of the subject's external religious commitments reflect more intrinsic transformations. Each of these subjects came to feel that their prior religious commitments were heavily influenced by strong family pressures and neurotic contaminants. Consequently, much of their therapeutic work centered on

consciously reworking these disautonomous aspects of religion. In each case the result was a lessening of religious preoccupation, a diminution of guilt and an increase in capacity to pursue personal pleasures and desires. A religious orientation previously based on obedience, self sacrifice and dependence was supplanted by one that allowed for increased individuation and self direction.

Despite the major modifications in their relationship to their religious paths of origin, only one of the subjects ultimately relinquished his religious beliefs. Two of the others held assiduously to a belief in a personal God and the remaining clinician, while rejecting the "God he could never please", maintained belief in the "value of the religious myth" (L.J.). Once again we have evidence of the fact that even when the topic of religion is consciously brought to the consulting room, with significant modifications in the realms of affiliations and practices, religious belief is particularly resistant to change.

In describing their examination of the dynamic origins and maladaptive aspects of their religious styles three of the subjects reported addressing the nature of their God representations. Using therapy as a

sounding board they came to question their relationships to harsh and punitive Gods who are more concerned with "character formation than personal fulfillment" (L.J.). In each of these cases the modification of their representation and relationship to God was viewed as a highly valued therapeutic gain. Somewhat surprisingly however the subjects did not see their therapists as contributing directly to these changes. They experienced the work as largely self analytic with the therapist viewed as essentially providing an environment for the process to safely occur. It is significant to note that whenever therapeutic work with the subject's God representation occurred, the process was initiated by the patient. In the instance where a psychoanalyst attempted to directly explore and interpret this material on his own the subject reported that he became notably guarded.

Although conclusions based on our data in this area are admittedly suspect, it appears that religious formations (such as an individual's God representation) are highly sensitive material that patients only bring to treatment when they feel exceedingly comfortable or in acute conflict. This material represents a pocket of highly private and often unconscious experience and feelings and perhaps even an island of magical thinking

which patients often hold especially precious. Consequently they guard it from any perceived attack. Indeed most of the changes in religious formations acknowledged by our sample, including those who specifically brought religious concerns to treatment, occurred indirectly or were experienced as a by-product of their direct therapy experience.

The modification of religious formations as a corollary of overall change in psychotherapy characterized the experience of the subjects who seldom or never explicitly dealt with religious material as well as those that did. These subjects (the majority of the sample) who did not bring religious issues to therapy nonetheless reported changes in their religious experience, which essentially paralleled their overall psychological maturation in treatment. They noted in particular less obsessiveness and compulsivity surrounding religious concerns. This specifically took the form of diminished scrupulosity regarding religious practices and less preoccupation with issues of religious morals and values. Epistemological concerns, such as the veridical existence of God, became far less important to them and they described themselves as being far more tolerant of ambiguity and generally "mellower" in their religious styles. They similarly described

their religious experience as feeling more authentic and connected with their real selves as opposed to merely being acts of conformity. On the whole, for both subjects who dealt directly with religion in therapy and for those who did not, there was a clear decrease in their involvement in religion and in the perceived importance of religion in their lives. This change is concretely evidenced by the fact that virtually all of the sample moved form exclusively religious vocations to more secular ones. While it appears that this overall diminution of religious involvement indirectly derived from personality changes resulting from therapy, this conclusion can not be drawn without caveat. For the very fact that this unique sample of religionists (all pertinant subjects were clergy or clergy in training) chose to enter psychoanalytic psychotherapy potentially bespeaks the notion that their religious commitments or specifically their religious vocations were already on shaky footing. When seen from this perspective, the consequent diminution in importance of religion in their lives as a function of psychotherapy may merely reflect the fact that they were consciously or unconsciously looking for an escape from their circumscribed religious vocations all along. Therapy simply became the legitimized mechanism for an "exist

with honor". This does not mean that therapy did not directly or indirectly effect their diminished religious involvement, it only cautions us against simplistically concluding that it caused it. Summarizing our subjects' experiences in psychotherapy, the most significant finding is that most did not address their religious experience to any significant degree. Those that did frequently had to contend with religious issues because they were embodied in major conflicts concerning their lifestyle and vocational choice. In both of these cases where the fundamental conflicts in therapy were between religious obedience and personal autonomy, the subjects ultimately decided to dispense with their vows. Despite this minimal overall attention given to religious issues most of the subjects chose religiously affiliated or sympathetic clinicians.

A second major finding was that independent of whether subjects chose to directly focus on religious concerns in their therapy, they noted significant changes in their religious experience. These changes generally took the form of an attenuation of guilt and compulsivity and an overall tempering of their religious approach. On the whole, with a few notable exceptions, religious involvement diminished during or following the

subject's psychotherapy experiences. Nonetheless only one subject saw the process of psychotherapy as contributing directly to the undermining of his religious beliefs. For most, while their religious involvement diminished, therapy did not irrevocably lead to a relinquishment of belief. Most subjects, even those who did not directly address religious concerns, attribute major changes in their religious style to the indirect effects of therapy and its impact on the overall maturation of their personalities. Notable in its absence was the direct exploration in therapy of subject's private religious experience, particularly their God representations. It is important to note that subjects were candid in indicating their own resistance to bring this material into treatment. It appears that while highly personal religious formations indeed underwent modification, roughly concurrent with the treatment experience, this process was for all intents and purposes split off from the therapy itself.

A number of subjects acknowledged that in retrospect they had come to feel that in a circuitous way therapy played a significant role in purging their religious perspective from what they now consider to be neurotic elements, notably magical thinking and infantile gratifications. They now feel that the

process was a constructive one in that "whatever was lost was worth losing" (I.S.). The primary conclusion is that while religious formations were clearly modified, these changes essentially paralleled the therapy process. Only when subjects explicitly chose to bring religious concerns into treatment could this material be approached without significant resistance. Even then it appears that, except in the cases of direct conflicts regarding religious issues and fundamental life decisions, the primary changes in our subjects' religious experiences seldom resulted from their attempts to grapple with religion and therapy head on. Instead the changes seemed to largely occur as spillover effects of other intrapsychic transformations.

The Subjects' Experience as Therapists with Religious Patients

As expected most of our subjects reported that they have had significant experience working with religious patients who had been specifically referred to them because of their own religious backgrounds. Yet despite the fact that they had been especially sought out by religiously committed patients because of their own religious affiliations, attention to religious concerns was only infrequently a significant aspect of the

therapeutic work with these patients. On the whole this relative paucity of work with religious formations is reflective of two major factors: First, the religious patients often did not present religious concerns; and second, even when they did, the religious clinicians often opted not to directly address this material. Thus subjects expressed marked variance with regard to specifically working with religious issues in psychotherapy. Responses ran the gamut from one clinician who felt that all of his patients brought in religious material at some point to those who only rarely encountered religious issues. Even when patients present conflicts and concerns in religious terms, the religious clinicians again display wide variation in their clinical responses. While some attempt to work directly with this material, many are, in fact, highly leery of prematurely ensnarling themselves in the arena of religious concerns. A number of clinicians pointedly stated that when critical issues are presented in therapy in a religious fashion, this usually reflects significant resistance. Thus they either attempt to reframe the conflicts or work "off target" addressing the dynamic issues underlying the manifest religious concerns. A significant distinction drawn by religious clinicians regarding manifest religious concerns is the

need to differentiate between institutional religious conflicts and more personal religious concerns. The latter are considered to be far more clinically rich by most in our sample both in terms of their diagnostic potential and their suitability for dynamic interpretation.

The distinction made by religious clinicians between the diagnostic significance of religious formations and concerns and their decision to make direct clinical interpretations regarding religion is a significant one. Virtually all of the clinicians placed great value on personal religious formations as a uniquely powerful means of gaining insight into a patient's object relations, personality style and overall level of psychological maturity. Despite this unequivocal acceptance of religious formations as a uniquely potent means of tapping core elements of personality organization, the religious clinicians were far more cautious in directly focussing their therapeutic interventions on conflicts couched in religious terms. This reluctance derives from three primary factors:

1. The unique technical dilemmas posed by interpreting religious belief and practices which the clinicians envision as potentially derailing

the therapeutic work.

2. A preference for restating religious conflicts in a non- religious context.

3. Countertransferential factors.

A significant number of the clinicians noted that interpreting religious formations directly, especially early in the treatment, has proven to be a highly risky technical maneuver. In their experience it has often precipitated a hasty flight from treatment or intensified patient's guardedness. In light of these difficulties they have often chosen to work with the dynamic conflicts which they recognize in maladaptive religious formations but they chose to interpret them as they appear in a less sensitive domain. A major factor cited by all commentators as underlying the religious clinicians reticence to directly address religious concerns was that of countertranference. This topic will be developed in greater detail at a later point, but for the moment let us merely say that the clinicians expressed a number of significant countertransferential concerns varying from their own discomfort "attacking religion" to compensatory reaction formations to their own annoyance at patients clinging to naive belief systems. In both these instances the end result was a shying away from the interpretation of

religious formations.

One of the most significant findings related to the subjects' strategies in working with religious issues was that their own therapy experience appeared to be the single greatest determinant of their personal clinical style. Thus subjects who dealt explicitly with personal religious formations in their own treatment tended to address these concerns more directly with their own religious patients. This finding held up independent of the subject's current religious perspectives. In this regard both the former priest and nun, who ended up taking very different positions regarding religious belief, were united in their highly active therapeutic approach to religious issues.

In light of our subjects' reports, it appears that the suggested collusive tendencies of the religious therapist with the religious patient [Pruyser (1970)], [Spero (1985)] which are ostensibly based largely on unexamined transference wishes and unresolved countertranference issues may be an overgeneralization or at least an oversimplification. While the present data suggest that the religious patient clearly harbors the wish for unanalyzed friendship and fellowship based on shared religiousity and with it the desire to keep his religion safe from scrutiny, the religious

clinician does not necessarily unconsciously join in this unspoken pact. The fact that the clinicians did not generally inquire into or directly interpret religious formations can not be summarily viewed as indicative of this countertransferentially based collusion. Instead this study suggests that more often than not, the religious clinicians' decision to stay clear of religious issues in treatment is frequently a more conscious one based on prior clinical experience. The fact that our sample report widespread evidence of pathological or maladaptive religiousity bears testimony to the fact that religion is not inevitably a blind spot for the religious affiliated clinician. Indeed if the clinicians in our sample seemed biased in any way it was probably in the direction of being overly zealous in their identification of religious formations which reflected the encroachment of significant psychopathology.

But beyond this point of identifying maladaptive religiosity, clinical styles varied markedly. Only a small percentage of the sample elected to address these contaminated areas directly. These clinicians were generally the more orthodox analysts who attempted to treat religious concerns or material like anything else. If the patient brought it in, it was grist for the

analytic mill. The majority of the sample, on the other hand, elected a more indirect clinical approach. They found that addressing religious issues directly frequently presented a raft of potential clinical impasses. These included role diffusion and entrapment in extensive philosophical and ethical debate; charges of reductionism; and in many cases, as a result of these difficulties, a hasty flight from treatment. These clinicians instead chose to work on the core conflicts which were embedded in the maladaptive religious formations by addressing them in a less highly charged sphere. This often enabled the patients to decrease and modify their defensive styles so that a more fundamental reorganization of the personality could occur. Direct changes in the religious sphere itself then later emerged as a function of these more core transformations.

In terms of working with maladaptive religiosity the issue of religiously sanctioned defenses was one of the most commonly mentioned problems encountered. In particular, our sample noted the adoption of a highly valued but repressive religious style where obedience and submissiveness were employed to defend against autonomous strivings and the consequent fear of separation. While patients who presented this defensive

style complained of depression and great unhappiness, their religious orientation was heavily employed to bolster and give added merit to their defensive organization and the two were highly intertwined. Clinicians, experienced this constellation as particularly impenetrable and most found it more productive to steer away from challenging ego-syntonic religious beliefs and practices, but instead attempted to interpret the patients' compulsive submissiveness and their tendency to employ reaction formation as a characteristic defense against feelings and impulses. As the patient developed greater tolerance for their own impulses and wishes, this often resulted in significant shifts of both their defensive organization and religious style. Once again, the changes in religious formations occurred largely by working "off target".

Similar to their calculated and indirect approach to interpreting ego-syntonic religious formations in the service of defense, our sample were notably cautious in making transference interpretations with their religious patients. This is not to say that they did not observe significant transference, for in fact, this finding was reported by virtually all of the sample. They noted in particular the desire for a sympathetic figure who would understand and support their religious beliefs. A

prominent variation on this theme was the desire for a spiritual director, or an idealized figure who could give counsel, support and at times absolution to the religious patient. Similarly several clinicians noted that religious patients often sought religious instruction in therapy and answers for their problems without wanting to work them out on their own.

In by far the majority of cases, even when significant transferential material was readily apparent to the religious clinicians, they found it inadvisable to interpret or explore this material, especially early in therapy. Thus, even if the patient specifically requested a religious therapist at a clinic and they were referred as the therapist they consciously elected to forego exploration of the reasons or fantasies underlying the request. This position was generally defended in the interests of establishing and maintaining a positive working alliance. Numerous clinicians indicated that they had found transference interpretation or inquiry to be highly problematic. Often their interventions had prompted feelings of anger, misunderstanding and had precipitated flights from treatment. In light of these experiences most clinicians now allowed their patients unspoken desires for collusive friendship or protection of their beliefs

based on religious familiarity to go unexplored until the therapeutic alliance was firmly established. And even then, these issues might never be addressed head-on. This decision on the part of religious clinicians bespeaks the intensity of the patient's fears of having his religious beliefs challenged in psychotherapy. He has often explicitly chosen a religious clinician to minimize this possibility and when or if the therapist moves too quickly out of the unspoken but prescribed role of religious ally, the patient frequently experiences significant anxiety, betrayal or both. Recognizing this problem of a tacit demand for a level of shared religiosity, many religious clinicians, in fact, attempt to forestall future impasses by directly minimizing the importance of perceived religious differences on the part of their patients. This type of maneuver is exemplified by the liberal Christian therapist who attempted to anticipate resistance in his fundamentalist patient by suggesting, "you're probably more devout than I am, but that doesn't matter to you, does it?" (L.J.). The major exception to this tendency to refrain from interpreting transference distortions was in the case of the strict Freudian rabbi, who not only explored patients' religious based distortions, but who even

interpreted their efforts to cast him in the role of rabbi or join his congregation as specific instances of acting out. Given the fact that he was the sole remaining congregational leader in the sample, his position apparently pulled for more concrete expressions of transference wishes. His transference interpretations can thus be seen as deriving from the need to directly respond to these maneuvers as well as from his orthodox Freudian orientation. At any rate, his direct approach, whether dictated by theoretical orientation or by necessity, was highly anomalous. As in the case of their reluctance to directly attack religiously fortified defenses, our sample, on the whole, was highly cautious with respect to interpreting unspoken religiously based transference wishes and distortions. But once again this finding does not lead to the inevitable conclusion that the therapeutic relationship was simply a collusive one. If collusion implies that the clinician as well as the patient was unconscious to the presence of unspoken wishes for familiarity and mutual affirmation of beliefs based on shared religiousity, our sample pleads not guilty on technical grounds. True, they did not readily interpret the transference distortions, but these omissions were ostensibly consciously elected in the name of preserving

the therapeutic alliance and allowing the patients to work with underlying dynamic conflicts. Hence, unless we consider the therapists' claims massive rationalizations for their own unresolved issues, their general reluctance to tackle religion in the transference must be seen as a deliberate technical maneuver.

Countertransference

The religious clinicians were quick to acknowledge their own countertransferential difficulties as well as their observation of transferential distortions. In fact this was probably the area of clinical concern that they addressed in greatest detail. A marked tendency for projective identification and at times an overidentification with their religious patients lie at the core of most of the described difficulties.

Paradoxically despite their reticence to directly interpret religious formations, most of the clinicians noted a strong tendency to get excited by or drawn into patients' descriptions of religious material. Many experienced the pull toward role diffusion and the pressure to adopt a more ministerial posture in working with religious patients or religious issues. They specifically expressed strong desires to help patients cut through maladaptive religious formations which they

had worked on in their own lives. As one clinician (S.G.) put it, "I knew first hand about his struggles with religious guilt and I felt like I could give him short cuts to see his way through it". This identification with the patient as undergoing a similar (but often less evolved) form of their own religious struggle prompted negative as well as favorable responses. A number of the religious clinicians described feeling angry at their religious patients' clinging to patently maladaptive religious beliefs and understandings. Having largely modified their own relationship to religion, the religious clinicians were especially attuned to its utilization in the service of the psychopathology of their patients. They thus frequently identified their religious patients with more primitive parts of themselves that they now viewed as infantile or defective. Interestingly, instead of directly attacking these maladaptive religious formations of which they were critical, they generally responded to their own annoyance in a compensatory way by being overtly gentle. The clinicians saw this response as essentially an undoing of their initial countertransferential reactions. Thus we see in instances where therapeutic interest was evoked by feelings of positive or negative identification with the

religious patient, the clinicians tended to temper their initial reactions and adopt a more neutral stance. This response was largely a conscious correction. Yet, at the same time, it reflected a further identification with a highly guarded religious patient who lies in waiting, feeling that his beliefs will be attacked in therapy. This countertransferential identification, in particular, was commonly voiced. Religious therapists and even those who had, for all intents and purposes, renounced their former religious beliefs projected their own conflicts about attacking or reducing religion onto their religious patients. The most frequent projection was of a religious patient who would be sent into a panic or who would become monumentously quarrelsome and resistant upon perceived reductionistic attack of his religious beliefs. It was generally difficult to sort out to what degree the religious clinicians' manifest reluctance to work directly with religious formations stemmed from prior impasses prompted by premature efforts to interpret religious concerns; or from the projection of their own "religiously vulnerable" parts. At any rate the net result was a highly cautious and sensitive approach to religious concerns, unless the patient essentially opened the path to more interpretive work. Another prominent source of countertransferential

difficulty centered around ethical conflicts which emerged when therapists were treating co-religionist patients. These were clearly illustrated by the cases of the orthodox Jews who felt compelled to obtain resolutions to the problems of their orthodox Jewish patients which were consonant with Jewish law. They thus adopted a significantly different set of expectations and parameters in working with co-religionists which were not necessarily clinically based (or in line with accepted canons of therapy), but which were instead determined by the therapist's own personal compulsion to adhere to Jewish law. The former nun manifest a similar bias in terms of the issue of abortion. But in her case her religiously based values were not circumscribed to co-religionists nor were they as categorically imposed. The religious clinicians overall reluctance to address religious issues stands in contrast to their professed interest in the psychoanalytic study of religious experience. Many were familiar with recent theoretical advances in this area and conveyed genuine appreciation for the idea of studying the patient's personal God representation as a means of exploring object relations. Yet despite this theoretical affinity and interest only two of the clinicians had actually successfully explored this realm

of highly private material with patients in therapy. Most found that their religious patients rarely brought their personal Gods into the treatment room. Similarly if the clinicians attempted to directly push into this realm of experience they reported that their patients became highly evasive and guarded. As potentially clinically rich as the religious patients' relationship to a personal God might be, this material was virtually inaccessible to the psychotherapy process unless the patient elected to directly bring it in. In these exceptional cases in which the patients did explore their God representations and relationship significant changes in overall religious experience were noted. The two clinicians who related direct experience in working with patients' God representations were the former priest and nun, both of whom worked extensively on their own relationship to a personal God representation in their own therapies. All in all, the clinical experience of our sample suggests that while direct therapeutic work with highly personalized religious formations is given strong commendation from a theoretical perspective, the transition from theory to clinical practice is a most difficult one. Most of the clinicians noted significant changes in religious belief and in personal religious formations as a function of

psychotherapy but similar to their own therapy experiences, they saw these changes primarily occurring as indirect results of the therapeutic process. While the analysis of personal religious experience may indeed mark a royal road to the unconscious, it is a path that is highly defended and one that presents very real clinical dangers. As such, despite its clinical richness, it is one that is only rarely transversed.

CHAPTER SIX

CONCLUSION

This study was conceived as an exploratory effort designed to employ clinical interviews with a rare pool of subjects, psychoanalytically oriented religionist clinicians, as a unique means of shedding light on major issues at the interface of psychoanalysis and religion. The study was organized around three broad, but related, questions:

1. How did the subjects integrate their religious perspectives with a psychoanalytic understanding?

2. What was the impact of psychoanalytic psychotherapy on the subjects' religious beliefs and practices?

3. How did religious therapists work with the special clinical problems often presented by religious patients?

Subsumed in these general questions lie a host of related issues: Did the religious clinicians fashion unique God representations? Did these representations shift as a function of therapy? Did therapy help the clinicians in their integration of psychoanalysis and religion? Can religious formations be addressed without reducing them to psychoanalytic artifacts? As questions

of this nature tapped extremely sensitive and highly allusive personal issues a clinical interviewing methodology was employed with a sample of twelve subjects. The final clinical method employed a series of open ended questions followed by pointed inquiry and limit testing to provide an in depth examination of each subjects' experience. The data was then analyzed along the forty-one specific dimensions of the initial research questionnaire (see schedule A). A descriptive case history for each of the subjects was prepared and then the collective pool of data was analyzed and interpreted. The first major conclusion of the study is that the anticipated higher order personal integration of the seemingly irreconcilable perspectives of psychoanalysis and religion seldom, if ever, occurred on the part of our sample. This is not to say that the subjects did not affect some form of compatible conjunction for the two perspectives; for, in fact, this they frequently did. But to call this coexistence an integration sorely taxes the essential meaning of the term. The fact that a reconciliation of the two perspectives was not achieved should in no way suggest that the subjects were not both flexible and zealous in their efforts to fashion one. The inherent tension between the two perspectives inevitably led to major

modifications of their religious understanding, involvement and practice or in their acceptance of orthodox psychoanalytic thought. Generally it led to both.

On the whole the clinicians' personal and institutional involvement in organized religion decreased significantly as a function of their increased exposure to psychoanalytic therapy and psychoanalytic training. Only one of the eleven ordained subjects continued to function in a role of congregational leader. Most severed institutional affiliations and evolved religious formations of far less conventional and more intrinsic nature. Yet despite these major alterations of their religious perspectives only two of the subjects cast aside religious belief all together. For most of the subjects the primary final common pathway to a rapprochement of the two perspectives was a "compartmentalization of codes" (Hartmann, 1960) whereby the subjects' private religious experiences and their psychoanalytic understandings were simply maintained as highly separate domains of experience and thought. Thus religious experience was considered an encapsulated sphere of mental life which became exempt from psychoanalytic scrutiny. In some cases this compartmentalization was philosophically

supported by dividing the world up into spiritual and material realities or by invoking the need to "act as-if" God and religious beliefs were real for utilitarian reasons. But in other cases the compartmentalization seemingly emerged as a last ditch effort to reduce the experienced tension between two irremediably irreconcilable perspectives. The emergence and employment of compartmentalization appears to be largely an unconscious mechanism. But once instituted it appears to allow the coexistence or, at least, the acceptance of major contradictions and paradoxes.

The most remarkable finding regarding the mechanism of compartmentalization was its effectiveness. For despite recognizing the intellectual incompatibility of the two perspectives the subjects seldom experienced further intrapsychic conflict. They accepted the essential irrefutability of the Freudian critique of religion when viewed from an intellectual perspective, but at the same time they maintained the sanctity and undeniable reality of their personal religious experiences.

The one new wrinkle on the familiar theme of invoking utilitarian philosophical arguments to defend religious beliefs was the employment by several subjects of

contemporary strands of psychoanalytic object relations theory as intellectual ammunition to fortify their religious perspectives against the charges of psychological immaturity that have characterized the tacit, if not overt, attitude of preceding generations of orthodox analysts. These clinicians employed an expanded notion of both illusion and transitional phenomenon to justify their personal religious practices. In so doing they were in effect pitting aspects of psychoanalysis against itself. It is interesting to note that while invoking aspects of contemporary object relations theory can be viewed as simply the newest variation upon the well worn theme of employing authoritative justifications for acting as if religious beliefs are true; other psychoanalytic writers view these maneuvers in a vastly different light. In this regard Edmund Wallace (1985) attacked those that defend belief in God by virtue of his unique power as a special kind of transitional object as simply the newest wave of psychoanalytic reductionists.
On the whole, the clinicians who employed the mechanism of compartmentalization were able to not only accept the foundations of psychoanalytic theory and clinical technique, but also the bulk of the psychoanalytic critique of religion. It was only a narrow realm of

spiritual experience, as beyond that contaminated by the mechanisms of projection and infantile gratifications, which was viewed as the sacrosanct domain of authentic, mature and healthy spirituality.

The compartmentalization of the subjects' psychoanalytic perspectives from their personal religious experiences had clear clinical ramifications. Most subjects brought neither their religious experiences nor their conflicts concerning religion into their psychotherapy. This finding was striking in view of the fact that the subjects were expressly selected because of their perceived high potential for addressing religious issues in their therapies. Their reticence to bring religious issues to treatment confirms prior findings regarding the treatment of religious patients and it appears to be multidetermined. Clearly a strong resistance to subjecting one's cherished religious beliefs and highly meaningful subjective experiences to perceived reductionistic attack played a major role. At the same time one can not summarily dismiss the fact that our subjects reported the conflicts and difficulties that led them to seek psychotherapy frequently did not center on religious concerns. In fact only one third of the sample dealt with religious issues in their therapy in any substantive manner.

Two other major clinical findings present an enigmatic contrast to the subjects' reported reluctance to address religious concerns. One is the fact that virtually all of the subjects selected religious or "religiously sympathetic" clinicians as therapists. A second is that despite their minimal attention to religious issues in treatment, their relationships to religion and their religious formations showed major changes both during and following their therapy experiences. A full three-fourths of the sample displayed a significant diminution of their personal and institutional religious involvements subsequent to their therapies. Clearly, therapy, even when not specifically addressed to religious concerns, was in some way impacting on the subjects' religious experiences. The subjects tended to explain their diminished religious involvement as an indirect result of therapy. They felt that as they became more autonomous and mature as a function of their therapies, their highly dependant and or rigid religious styles evidenced parallel transformations. These changes were seldom, if ever, discussed in the therapy directly and the subjects viewed them as deriving in large measure from their own self analytic efforts.

The fact that, on the whole, the subjects'

religious involvement and behavior showed such marked transformation despite only minimal direct treatment lends support to the orthodox Freudian position that much of religious behavior can be viewed as compromise solutions deriving largely from unresolved developmental conflicts. Somewhat surprisingly, the majority of our subjects would probably to a great extent agree with this assessment. But this is not to say that they would simply dismiss all of religion as inherently neurotic. Instead they part company with Freud in finding a realm of mature and healthy religious experience that they describe as uniquely beneficial to psychic integration.

The significant changes in religious involvement shown by our subjects as an indirect consequence of therapy is similarly congruent with Rizzuto's prediction that changes in religious formations will essentially parallel the treatment process. She sees this as stemming from changes in the patient's self-object representations as a direct result of therapy. This transformative process inevitably leads to a corresponding reworking of both their God representation and related religious formations. A third possible explanation for the subjects' marked decrease in religious involvement is the notion that they had

already essentially decided to break from their prior highly extrinsic religious commitments and their election to pursue therapy merely became a means to carry out this end and facilitate their development of a new life structure. While one can not unequivocally conclude that therapy either directly or indirectly caused the subjects' decrease in religious involvement and the manifest changes in their religious style - the strong correlation of the two phenomenon is quite striking. While the mechanism of this transformation can not presently be fully elucidated, if our present findings are generalizable, the impact of psychotherapy on religious formations, independent of whether religious issues are directly addressed, is unquestionable.

While the changes in religious involvement and formations as a function of therapy were striking, the fact that only two of the sample totally relinquished their religious beliefs in the face of these changes is perhaps an even more dramatic finding. The resistance of religious beliefs to change despite major transformations in the realms of religious values and practices agrees with a similar finding reported by Belgrave (1983) in his study of an analogous, all Catholic, sample. Despite the fact that

our sample were often virtually incapable of describing the nature of their belief systems and the objects of their beliefs, belief was nevertheless central to their subjective religious experiences. (The strength of religious belief was interpreted in light of the object relations model provided by Rizzuto (1974, 1976).)

Our sample's difficulties in describing and discussing their God representations was seen as stemming from the relatively unique burdens placed upon them in maintaining these special inner objects. On one hand, they had largely abandoned their former anthropomorphic deities as infantile and anachronistic, in light of their familiarity with a psychoanalytic critique of religion. On the other, they had developed a rich and diverse fund of religious images and concepts as a product of their sophisticated theological training. As a function of these two factors their present God representations were now often highly abstract and amorphous, if not, in fact, abstruse. They were similarly distinguished by their propensity to give way to more concrete and personalized representations at times of great stress. It was theorized that the religious clinicians' God representations were uniquely formulated to be highly resistant to psychoanalytic attack while at the same time acceptable to their level

of theological sophistication. A dual representational model was postulated, whereby the preservation of one's ongoing relationship to highly personalized and private God was contingent on the creation of a suitable public God representation which intellectually allows for continued religious belief. The public God representation must be consonant with individual's overall level and style of cognitive development. Thus the abstruse and ineffable Gods of the religious clinicians were construed as necessary intellectual covers for the continuation of a largely unconscious object relation with a more highly repressed, private God representation that was no longer acceptable to secondary process censors. The adoption of these abstract, conceptual Gods was directly linked to reports of diminished intensity in the clinicians' religious experiences. It appears that the price to be paid for a God representation that was intellectually acceptable was a decrease in one's perceived closeness to God. At the same time an inability to synthesize some suitable, or at least passable, God representation appeared to have far greater untoward consequences: the subjects would be bereft.

The subjects' experience as clinicians with religious patients closely paralleled their own

treatment experiences. Most of their religious patients, while choosing them because of their religious backgrounds, seldom brought religious issues to therapy. When patients did bring religious concerns, the religious clinicians varied markedly in their approaches to dealing with this material. Most chose to work on the core dynamic conflicts expressed in religious terms by working "off-target" - outside the realm of the specific religious problem. This approach was chosen because they envisioned the task of addressing religious conflicts head on to be fraught with a potential for major therapeutic impasse. This preference to work on dynamic conflicts outside the realm of religious concerns stood in sharp contrast to the religious clinicians' predilection to view religious material as an especially valuable diagnostic tool. All in all, the prime determinant of a religious therapist's clinical style in working with religious issues appeared to be his own therapy experience. Those that dealt most extensively with religious concerns in their own therapies tended to address these issues more directly with their religious patients as well. As suggested by all writers who have addressed this issue, countertransferential factors appeared to play an especially critical role in the treatment of religious

patients by religious therapists. The general reluctance to move directly into an exploration or interpretation of personal religious formations appeared to arise from two opposing tendencies. On one hand, the religious clinicians were often highly sympathetic and respectful of patients' feelings that their religious formations were under reductionistic attack. And, on the other hand, they often checked their own negative reactions to what they perceived as patients' highly primitive or maladaptive religious formations by withholding their comments. The result in both cases was an avoidance of religious material. This major predisposition toward projective identification on the part of the religious clinicians with their religious patients was a prominent finding. It casts suspicion on the therapists' claims that their reluctance to address religious issues was solely a conscious clinical decision. Yet at the same time, the religious clinicians' reports that their religious patients were extremely sensitive and resistant to any encroachment or perceived attack on their religious beliefs were both frequent and compelling. Thus to summarily conclude that the religious therapists' decisions to avoid problematic ensnarlments in religious matters was simply collusive as opposed to a conscious decision seems

overly simplistic. The truth is probably that both factors played a significant role in predisposing the clinicians to give wide berth to religious issues in the name of maintaining a positive and productive working alliance.

This rationale of preserving a decidedly (or at least potentially) tenuous working alliance underlie the religious clinicians' frequent decisions to refrain from both interpreting religiously sanctioned defenses and tranference distortions based on wishes for fellowship born of familiarity.

The religious clinicians were candid in their acknowledgement of their countertransferential difficulties. They recognized that they had experienced significant pressure toward role diffusion, if not outright role confusion, in working with co-religionists in particular. Yet at the same time this was often the group they felt most compelled to serve.

Limitations of the study and directions for future research

In light of the nature of the exploratory clinical research design employed, many of the conclusions offered must be viewed as highly tentative, if not outright speculative. Though a broad range of data was

amassed only portions of it coalesced into reasonably clear patterns for analysis and interpretation. Nevertheless the present study allows for significant comment on methodological difficulties and refinements and offers potentially fruitful hypotheses and suggestions for future research.

It appears that one of the prime limitations of the present study, especially in terms of the generalizability of its findings, was the nature of the subject pool itself. This is in no way surprising, for from the outset it was clear that the subjects were a highly anomalous lot - they were explicitly chosen for this reason! The presumption being that as individuals conversant with both theology and psychoanalysis they were uniquely qualified informants. In retrospect, it is by no means clear that this presumption was in fact valid, or if the liabilities that went along with the subjects' unique status were sufficiently great so as to offset their superior capacities as "articulate and fully self-conscious" informants (James 1902 (p. 22)). So while our subjects were indeed highly conversant with both psychoanalysis and religion, it is highly questionable whether they were at all representative of prototypical religionists. In essence the dual identity that rendered the subjects so interesting in terms of

their rare capacity to integrate and speak about these disparate perspectives, served to make them highly suspect in terms of their ability to speak for the "average - expectable" religious patient. In fact their religious perspectives turned out to be in no ways conventional. The subjects' status as religionists was questionable for another reason as well. Religion was not simply a set of beliefs and practices for them. In view of the fact that eleven of the twelve were ordained clergy, religion was more than just a way of approaching life. For them it was a vocation - in a secular as well as a spiritual sense - for it was a way in which they earned their livelihood in the world. In light of this special status as highly trained, committed religionists, their religious understanding and practices as well as the nature of their conflicts regarding religion seemed significantly different than those one might expect for your mainstream religionist. A further difficulty with the sample emerged as a confluence of both the limited pool of suitable subjects and my desire to include a diversity of religious backgrounds within it. In retrospect it is now abundantly clear that the religious and clinical experiences of the different denominations were highly divergent and by no means comparable. This finding is

in and of itself a highly useful one for an exploratory study. It leads to the recommendation that further research will be needed to more fully delineate the differential impact of psychoanalytic psychotherapy on patients of different religions and the unique clinical concerns that are most typical for each of these denominations. Presently only Lovinger (1985) addresses this issue in sufficient detail. Similarly research exploring the psychological nature of the religious experience for different denominations with particular focus on God representations and relationships now seems increasingly possible in light of the typologies constructed by Meissner and Rizzuto.

The unique backgrounds, role conflicts and ideological tensions of our subjects were viewed as underlying their highly intellectualized, if not arcane, God representations. But both this finding and its interpretation are tenuous and demand significant further confirmation and clarification. First, it is by no means clear whether the observed tendency to fashion highly abstract God representations derives primarily from the need to fulfill the competing demands of a psychoanalytic perspective and a longstanding history of religious belief and involvement; or if this is simply a general pattern

common to highly intellectualized or intellectually sophisticated religious believers. Until more systematic work is done exploring the God representations for a variety of religionists, questions regarding the interpretation of our present data must remain moot. The need for more extensive study of the evolution and development of the concept of God, with a wide range of subjects, using both longitudinal and cross-sectional techniques is now clearly in order to clarify many of the questions raised in this study. My experience strongly suggests that employment of a clinical interviewing methodology is essential to tease out the extremely subtle and illusive aspects of this phenomenon.

Both the limitations of the current research and the tentative findings suggest several concrete topics for further investigation. One would be the study of the impact of psychoanalytic psychotherapy on religious patients who are more representative, specifically subjects who are neither clergy nor psychoanalytically informed. The findings of this study predict a clear diminution of religious involvement as a function of psychoanalytic psychotherapy. In conducting such a study it is strongly advised to use both the patients and therapists as informants. Another study is

suggested by the significant transferential and countertransferential difficulties observed with co-religionists coupled with the frequent demand of religious patients for a therapist of similar religious background. This would be to compare treatment outcomes for religious patients with co-religionist therapists, religious therapists of other denominations and non religious therapists. The results of the present study suggest that the perceived treatment outcome for religious patients is best with co-religionist therapist. Along similar lines, a study employing protocols or audiotapes of simulated religiously enmeshed clinical problems could be used to compare the therapeutic styles of religious and non religious clinicians in a more controlled manner. Again, the current study leads to the hypothesis that co-religionist therapists will be most likely to address religious concerns. Finally, more systematic examination of the nature of an individual's God representation and the quality of his religious experience is strongly suggested.

In line with the suggested future research five distinct hypotheses are tendered by the present study:

1. Religious involvement/commitment and strength of religious belief will vary inversely with

the degree to which these concerns are directly addressed in psychoanalytic psychotherapy.

2. The level of religious maturity as assessed by a developmental scale (similar to those constructed by Fowler (1974) or Meissner (1984)) will increase as a function of psychotherapy. (Independent of whether religious issues are addressed directly.)
3. God representations and ones relationship to this representation (as assessed by Rizzuto's (1979) God questionnaire) will change significantly as a function of psychoanalytic psychotherapy. (Again, the change will be independent of whether religious issues or the patient's God representation are specifically addressed in treatment. The changes will essentially parallel the changes in the patient's self-representation and his relationship to critical inner objects.)
4. Individuals who are ideologues or who show strong ideological commitments will have had a strong relationship to a personal God representation in their early lives.

5. Religious clinicians who have addressed religious formations in their personal therapy will address the religious concerns of their patients to a greater degree than either the religious or non-religious therapists who have not worked with these issues in their own therapies.

Final Speculations

The present study depicts a situation in which religious beliefs and the maintenance of a God representation seemed to persist as the derivitives of vitually vestigial psychological structures that have undergone significant transformations over the course of cognitive and emotional development. The noted strength of religious belief appears to be directly related to the unique properties of God and various religious formations in their capacity to serve as special kinds of transitional objects or phenomenon. Yet along side this seemingly strained continuity of belief, one can not help but notice the rather remarkable changes that have occurred in terms of the contents of these systems of belief. Rizutto explains these changes as necessary transformations which enable an individual to maintain a God representation which affords and thus preserves "object and self-representations needed to maintain a

sense of self which provides at least a minimum of relatedness and hope" (p. 202). Their belief systems have not only frequently been reshaped with both the modification and occational exclusion of God representations, but they have come to include a strong adherence to one of the prime components of the rationalistic weltanshauung of twentieth century thought - psychoanalysis. While we have seen that the synthesis of these two fundamentally divergent world views is seldom, if ever, a tidy one, a novel variation on the nature of transitional objects perhaps offers us a useful perspective in better understanding the strange philosophical admixture demonstrated in our subjects. The notion I am referring to is suggested by Helfaer (1972) who invoked the concept of an "ideological object" (p. 319). In developing this concept he emphasizes the fact that "any ideology or way of life can take on the character, for the individual, of an object... (in which) it is experienced as a source of hope, meaning and wholeness" (p. 319). It appears that for many of the sample ideology played and plays a highly significant role in their identity formation. At the same time these highly cathected ideologies appear to be derived from relationships with prior inner objects. Thus the nature of their relationships to

ideologies, be they theological, political or scientific, have the unique quality and feel of object relationships. When seen in this perspective our subjects become representatives of <u>believers</u> - homo religious. They are perhaps unique in that they demonstrate a rare tolerance for ambiguity and incompatibility within the content of their belief systems, but nonetheless all clearly exemplify individuals whose lives have always been and continue to be strongly centered upon ideological systems. The questions of what particular constellation of forces or tendencies predisposes an individual to be an ideologue, or how, or if, abstract ideas can take the place of object representations? (a notion questioned by Rizutto) point toward broad avenues for further exploration. At this point there can be little doubt that belief systems and ideologies play a highly unique role in the integration of an individual's needs, defenses and identifications. Similarly they allow for the development and stabilization of a coherent sense of personal identity and a meaningful and trustworthy relationship to the world at large. It appears that Freud is correct in describing man's compulsive need to believe. The problem faced by our subjects and all of humankind is finding something they can wholeheartedly

believe in. The task does not appear to be one described by a single "leap of faith", but instead it is a continuous dynamic process that essentially lasts throughout all of one's life. I leave the last words to Erik Erikson (1959) who has devoted much of his psychoanalytic writing to the topics of both ideology and religion.

> It is not the psychologist's job to decide whether religion should or should not be confessed and practiced in particular words and rituals. Rather the psychological observer must ask whether or not in any area under observation religion and tradition are living psychological forces creating the kind of faith and conviction which permeates a parent's personality and thus reinforces the child's basic trust in the world's trustworthiness. The psychotherapist cannot avoid observing that there are millions of people who cannot really afford to be without religion, and whose pride in not having it is that much whistling in the dark. On the other hand, there are millions who seem to derive faith from other than religious dogmas, that is, from fellowship, productive work, social action, scientific pursuit, and artistic creation. And again, there are millions who profess faith,

yet in practice mistrust both life and man... Whosoever says he has religion must derive a faith from it which is transmitted to infants in the form of basic trust; whosoever claims that he does not need religion must derive such basic faith from elsewhere. (p. 63)

APPENDIX 1

SCHEDULE A

QUESTIONNAIRE

A. Background Information

1. Please describe your clinical background and training and your present clinical work.

2. Please describe your training and involvement in religion.

3. Could you tell me about your religious upbringing and your decision to pursue a religious vocation?

Religion: An assessment of the clinician's religious involvement

1. Do you consider youself to be a religious believer?

2. Are you presently or were you formerly affiliated with a religious denomination? If so, which one?

3. Which aspects of religion do you find to be most personally meaningful and important to you?

4. Do you consider reliigon and religious belief to be important to your sense of identitiy?

C. God

1. Is a belief in or a relationship to God important to your practice of religion?

2. Do you believe in God?

3. Could you describe God according to your own expereience or vision?

4. Do you have a mental image for God or could you describe the feelings you experience from your relationship with God?

5. Do you address a God in prayer? Can you describe how you envision this God?

6. Do you feel that your notion and / or rleationship to God has changed over time? Can you describe these changes?

D. Personal Psychotherapy and Religion

1. Are you presently or have you been in psychotherapy? Describe your psychotherapy experience in terms of orientation, duration and frequency?

2. Have you discussed religious concerns in your therapy?

3. Do you feel that your religious beliefs and/or practices have been affected by your therapy? If so, which ones, how affected? Please describe.

4. Did you know of the religious position or affiliation of your therapist? Was this a factor in your choice of a therapist?

5. Did you feel that your therapist was comfortable and/or interested with regard to the exploration of religious concerns and material? Please elaborate.

6. Do you recall any personal conflicts about bringing religious concerns to therapy? Please describe.

7. Did your therapist interpret your religious beliefs and practices in terms of your unique psychological development? If so, did this affect your religious position?

8. Did you explore your notion of and relationship to God in therapy? Please elaborate. If not, why do you feel that this was not explored?

9. Did your concept of and relationship to God change over the course of your therapy?

10. Did you explore the adaptive and maladaptive or defensive aspects of your religiious orientation in therapy?

11. Did you feel that your therapist was supportive of your religious beliefs? Please elaborate.

12. Did you feel your religious beliefs under attack or "reduced" to psychological underpinnings during the course of your therapy?

13. Did your therapist share aspects of his religious orientation with you during the course of your therapy?

14. Some people consider psychoanalytic thinking to be antagonistic toward or in conflict with religious belief, have you experienced any conflict between your psychoanalytic understanding and your religious commitment?

16. Do you feel that your personal therapy has helped you to integrate your religious beliefs with a psychodynamic perspective? Plase elaborate.

E. Dealing with Religious Patients

1. Have you experienced religious issues to be a significant concern of many of your patients?

2. Do you find that your patients feel comfortable bringing religious issues to therapy?

3. Have you/do you explore with patients the psychological roots of religious formations?

4. Have you found that religious issues present any special problems in the course of your conduct of psychotherapy? Please elaborate, what kinds of problems?

5. Have you explored with patients their god representation and their relationship to this god in terms of their own unique experiences and psychological development? Please elaborate.

6. Have you witnessed significant changes in religious beliefs, practices or values which you attribute to psychotherapy?

7. Do you find that religious patients have chosen you as a therapist because of your religous beliefs?

8. Do you find that religious patients develop unique transferences? Please describe.

9. Do you find yourself feeling or functioning differently in your treatment of religious patients?

10. Do you feel that religious beliefs can be interpreted and explored in therapy without "reducing" them to illusions or artifacts of psychological mechanisms.

11. Are you comfortable dealing with religious issues in therapy? Do these issues present special conflicts for you?

12. Has your own therapy contributed to your ability to address religious concerns in treatment?

APPENDIX 4

SCHEDULE B

SEMI-STRUCTURED CLINICAL INTERVIEW

I. Background in religion and psychoanalytic psychotherapy

Lead Question I: Would you describe your background and training in religion and psychoanalytic psychotherapy and your presrent involvement in each area?

Specific areas of inquiry:

A. Religious affiliation
   1. Denomination
   2. Formal training and decision to pursue religious vocation
   3. Extent of commitment and involvement
   4. Major beliefs and practices
   5. God representation and relationship
   6. Childhood religious background

B. Psychoanalytic Background
   1. Training
   2. Institutional affiliations
   3. Clinical Experience

II. Psychotherapy and Religious Experience

Lead Question II: Could you talk about your experience in psychotherapy particularly in regard to the exploration of religious issues and the impact of your therapy on your religious beliefs and practices?

A. Description of therapy/therapies
   1. frequency
   2. duration
   3. orientation
   4. therapist characterisics and choice of therapist

B. Religious formations in therapy
   1. Religious issues addressed
   2. Conflicts regarding religion in therapy
   3. Explorations of resistance to address religious formations
   4. Maladaptive vs. Healthy reliigion
   5. Transference issues
   6. Therapists' perceived response to religious issues
   7. Changes in religion with therapy
   8. Evolution of God representation
   9. Understanding and explanation of changes in religious formations.

III. Clinical experience with Religious Issues and Religious Patients

Lead Question III: Would you describe your experience as a clinician working with religious patients and / or religious issues in treatment?

1. Prevalence of religious issues.
2. Special clinical problems
   a. resistance
   b. ethical problems
   c. interpretation vs."reduction"
   d. working with maladaptive religion
   e. transference and countertransference
   f. clinical strategies

IV. Integration of Psychoanalytic and religious perspectives

Lead Question IV: How do you integrate your religious commitment with a psychoanalytic perspective?

A. Personalized religious perspective
   1. Priorities
   2. Importance of Beliefs
   3. Role of prayer and God relationship
   4. Intrinsic vs. extrinsic religion

B. Psychoanalytic Orientation
   1. Familiartiy with Freud's critique of religion
   2. Response to Freud
   3. Direct response to religion as "illusion and wish fulfillment"
   4. Response to God as a "projected Father figure"

C. Mechanism of Integration
   1. Changes in religious perspective
   2. Psychoanalytic accommodations
   3. Experienced Conflict between religion and psychoanalysis
      a. Belief in God
      b. moral and ethical issues
      c. epistemological issues
      d. professional issues
      e. Maintaining religion beyond the psychoanalytic explanation
   4. Special problems

References

Allport, G. The Religious Context of Prejudice. Journal of Scientific Study of Religion. 5: 447-452, 1966.

Astley, M. Comment on Dr. Lorand's Paper, International Journal of Psychoanalysis, 43: 56-57, 1962.

Belgrave, J. The Impact of Psychoanalysis on Some Traditional Christian Moral Values Unpublished doctoral dissertation, City University of New York, 1983.

Bergin, A. Psychotherapy and Religious Values Journal of Consulting and Clinical Psychology, 48: 96-98, 1980.

Bowers, M. Psychotherapy of Religious Conflict. In E.M. Patterson (Ed.) Clinical Psychiatry and Religion. Little, Brown: Boston, 1968.

Bronner A. Psychotherapy with Religious Patients: Review of the Literature. American Journal of Psychotherapy 18: 475-487, 1964.

Draper, E. On the Diagnostic Value of Religious Ideation. Archives of General Psychiatry, 13: pp. 202-207, 1965.

_____. Psychoanalysis and Religion: A Metaphysical Approach to Religious Data. In R.H. Cox (Ed.) Religious Systems and Psychotherapy. Springfield, Illinois: Charles C. Thomas, 1973.

Eissler, K. Medical Orthodoxy and the Future of Psychoanalysis. International University Press: New York, 1965.

Ekstein, R. A Clinical Note on the Therapeutic Use of a Quasireligious Experience. Journal of American Psychoanalytic Association., 4: 304-313, 1956.

Engler, John H., Ph.D., Vicissitudes of the Self According to Psychoanalysis and Buddhism: A Spectrum Model of Object Relations Development, Psychoanalysis and Contemporary Thought, 6(1), 29-72, 1983.

Erikson, E.H. Identity and the Life Cycle. International University Press: New York, 1959.

_____. Young Man Luther. Norton: New York, 1962.

Fine, R. Psychoanalysis as a Philosophical System, Journal of

Psychotherapy, 5: p. 1-66, 1977.

Freud, S. 1953-74 Standard Edition of the Complete Psychological Works. London: Hogarth

_____. 1901. The Psychopathology of Everyday Life. In SE 6.

_____. 1913. Totom and Taboo. In SE 13

_____. 11927. The Future of and Illusion. In SE 21.

_____. 1939. Moses and Monotheism In SE 23.

Group for the Advancement of Psychiatry, The Psychic Function of Religion in Mental Illness and Health, (report) 67: 1968.

Guntrip, H. Religion in Relation to Personal Integration. British Journal of Medical Psychology, 42: 323-33, 1968.

Hallack, S. The Politics of Therapy, Science House: New York, 1971.

_____. Discussion of "Socially Reinforced Obsessing." Journal of Consulting and Clinical Psychology 44: 146-147, 1976.

Hartmann, H. Psychoanalysis and Moral Values. International Universities Press: New York, 1960.

Helfaer, Philip M., The Psychology of Religious Doubt. Beacon Press: Boston, 1972.

James, W. The Varieties of Religious Experience Penguin: New York, 1983 (1902)

Lind, L. and Schwartz, L. Psychiatry and Religious Experience. Random House: New York, 1958.

London, P. The Modes and Morals of Psychotherapy. Holt, Rinehart and Winston: New York, 1964.

_____. Psychotherapy for Religious Neuroses? Journal of Consulting and Clinical Psychology 44: 145-146, 1976.

Lorand, S. Psychoanalytic Therapy of Religious Devotees: A Theoretical and Technical Contribution, International Journal of Psychoanalsis, 43: 50-55, 1962.

Lovinger, R., Working with Religious Issues in Therapy. Jasen Aaronson: New York, 1984.

Mann, J. Clinical and Therapeutic Aspects of Religious Belief: A Report. Journal of the American Psychoanalytic Association, 12: 1960-1970, 1964.

Meissner, W.W. Psychoanalytic Aspects of Religious Experience. Annual of Psychoanalysis, 6: 103-41, 1978.

_____. Psychoanalysis and Religious Experience. Yale University Press: New Haven, 1984.

Meng, H., and Freud, E. (Eds.) Psychoanalysis and Faith: The Letters of Sigmund Freud and Oskar Pfister. Basic Books: New York, 1963.

Menninger, K. Love Against Hate. Harcourt Brace and Jovanovich: New York, 1942.

Mester, R. and Klein, H. The Young Jewist Revivalist: A Therapist's Dilemna. British Journal of Medical Psychiatry, 54: 299-306, 1981.

Novey, S. Utilization of Social Institutions as a Defense Technique in the Neuroses, International Journal of Psychoanalysis, 38: 82-91, 1955.

Ostow, M. and Scharfstein, B. The Need to Believe: The Psychology of Religion. International University Press: New York, 1966.

Pattison, E.M. (Ed.) Clinical Psychiatry and Religion. Little, Brown: Boston, 1968.

Peteet, J. Issues in the Treatment of Religious Patients. American Journal of Psychiatry, 35: 559-564, 1981.

Pruyser, P. A Dynamic Psychology of Religion, Harper and Row: New York, 1968.

_____. Assessment of the Psychiatric Patient's Religious Attitudes in the Psychiatric Case Study. Bulletin of the Menninger Clinic, 35: 272-291, 1971.

_____. The Seamy Side of Current Religious Beliefs. Bulletin of the Menninger Clinic, 41: 329-340, 1977.

Reissner, A. Religion and Psychotherapy J. of Individual Psychology, 13: 165-170 1957.

Rizzuto, A.M. Object Relations and the Formation of the Image of God. British Journal of Medical Psychology, 47: 83-99, 1974.

_____. The Birth of the Living God. Univerisity of Chicago Press: Chicago, 1979.

_____. The Father and the Child's Representation of God. In S. Coth, A. Gurwitt, and J. Ross (Eds.) Father and Child, Little, Brown: Boston, 1982.

Ross, N., Beyond the Future of an Illusion, Journal of Hillside Hospital, p. 259-275, 1968.

Robins, J. Neutotic Attitudes Toward Religion. American Journal of Psychoanalysis, 5: 71-81, 1955.

Saffady, William, New Developments in the Psychoanalytic Study of Religion: A Bibliographic Review of the Literature Since 1960. The Psychoanalytic Review, 63: (No. 2), 291-299, 1976.

Spero, M.H., Clinical Aspects of Religion as Neurosis, American Journal of Psychoanalysis, 36: 361-365, 1976.

_____. Countertransference in Religious Therapists of Religious Patients, American Journal of Psychotherapy, 35: 563-575, 1981.

_____. Psychotherapy of the Religious Patient. Springfield, Illinois, Charles C. Thomas, Publisher, 1985.

Stern, Mark, Psychotherapy and the Religously Committed Patient. Haworth Press: New York, 1985.

Vitz, P., Psychology as Religion: The Cult of Self-Worship. Eerdmans: Grand Rapids, 1977.

Wallace, Edwin R., Further Relationships Between Psychoanalysis and Religion, Listening: Journal of Religion and Culture, 20 (3): 175-195, 1985.

Winnicott, D.W., Transitional Objects and Transitional Phenomenon. International Journal of Psychoanalysis, 34: 2, 89-97. 1953.

_____. Playing and Reality, Basic Books: New York, 1971.

Woollcott, P. Pathological Processes in Religion. In E. M. Patterson (Ed.) Clinical Psychiatry and Religion. Little, Brown: Boston, 1969.

Zilboura, G. Psychoanalysis and Religion Farrar, Strauss and Cudaby: New York, 1962.